CY2026 Medicare Physician Fee Schedule

Key takeaways for physicians

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Executive summary

On Oct. 31, the Centers for Medicare & Medicaid Services (CMS) issued the CY 2026 Medicare Physician Fee Schedule final rule, which includes updates to physician payment policies, the Medicare Shared Savings Program (MSSP) and the Quality Payment Program (QPP). Most significantly, CMS has made positive adjustments to the 2026 Medicare conversion factor (CF), consistent with statutory requirements. Beginning in CY26, physicians who are qualifying participants (QPs) in Advanced Alternative Payment Models (AAPMs) under the Quality Payment Program (QPP) are subject to a different conversion factor than physicians who are not qualifying participants (i.e. Merit-Based Incentive Payment System participants). Both conversion factors will see an increase over 2025, with the qualifying APM CF increasing by 3.775% to 33.568, and the non-APM CF increasing by 3.260% to 33.401.

The rule makes critical changes to payment that will impact osteopathic physicians across specialties. This document outlines key changes finalized across the rule, including:

- Implementation of CMS' newly finalized physician efficiency adjustment to work relative value units for non-time based services
- Refinements to billing for the G2211 care complexity add-on code, advanced primary care management and upstream drivers of health screening
- Changes to CMS telehealth policies
- Details of the newly created Ambulatory Specialty Model (ASM), a mandatory Center for Medicare and Medicaid Innovation (CMMI) model for clinicians treating heart failure and low-back pain episodes of care

The rule also contains a range of changes to the QPP and MSSP. Overall, CMS has made modifications to measure inventories across the Merit Based Incentive Payment System (MIPS) performance categories and made substantial changes to the MIPS value pathways.

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 who applied for extreme and uncontrollable circumstance exemptions from the MIPS program through 2024 and who are now just resuming participation. However, CMS' strong interest in driving participation in MIPS Value Pathways, and ultimately sunsetting traditional MIPS, remains a concern. This guide highlights key policy changes finalized under the MIPS program, including scoring changes and modifications to MVPs.

Physician Fee Schedule provisions

This section outlines key changes to payment policy under the physician fee schedule, including changes to the conversion factor, practice expense changes, service relative values, telehealth service coverage, evaluation and management services and other payment changes. This section focuses on policy changes 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 new relative values for a large number of codes under this rule. A list of new and revised codes can be found in Appendix D of this document.

Conversion factor and rate setting

AOA's strong advocacy secured enactment of legislation that includes a positive 2.5% increase to the 2026 CF and successfully defended the 0.75% and 0.25% positive increase to the CF that was included in the Medicare Access and CHIP Reauthorization Act (MACRA), which takes effect in 2026. CMS is implementing these changes, resulting in an overall increase to the conversion factors. Beginning in CY26, physicians who are qualifying participants in AAPMs under the Quality Payment Program are subject to a different conversion factor than physicians who are not qualifying participants (i.e. Merit-Based Incentive Payment System participants). Both conversion factors will see an increase over 2025, with the qualifying APM CF increasing by 3.775% to 33.568, and the non-APM CF increasing by 3.260% to 33.401. CMS has also adjusted the anesthesia conversion factors. The anesthesia qualifying APM CF will be 20.600 and the anesthesia non-APM CF will be 20.498.

It is important to note that the increase to payment is only for CY2026. The Medicare Economic Index, a measure of inflation for healthcare, is expected to increase 2.7% in the coming year, and AOA will continue to advocate for a long-term reform to the Medicare physician payment and ensure that payment keeps pace with the cost of practicing medicine.

Figure 1. CY 2026 Medicare conversion factor changes

	2025 conversion factor	2026 conversion factor	Percent increase
APM QP	32.347	33.568	+3.775%
Non-APM QP	32.347	33.401	+3.260%
Anesthesia APM QP	20.318	20.600	+1.388%
Anesthesia Non-APM QP	20.318	20.498	+0.886%

Practice expense methodology changes

CMS is finalizing its proposed change to indirect practice expense (PE) methodology, reducing PE RVUs for facility-based services. CMS will reduce the portion of facility PE RVUs allocated

based on work RVUs to half the amount allocated to non-facility PE RVUs beginning Jan. 1, 2026. CMS argues that this change is necessary to promote site-neutral payment as physicians are increasingly employed by hospitals and practicing in facility settings, and only a minority of physicians remain in independent practices. AOA will continue to advocate with lawmakers defending payment to independent practices.

Physician efficiency adjustment

CMS finalized its proposal to impose a -2.5% efficiency adjustment to work RVUs for non-time based services, with few services exempted. The AOA is deeply disappointed in CMS' decision to implement this policy, which will partially mitigate the upward conversion factor adjustment for many specialties.

The total efficiency adjustment was determined by summing the last five years' of the Medicare Economic Index (MEI) productivity adjustments – adjustments applied to MEI reflecting average growth of private nonfarm business total factor productivity – as calculated by the Bureau of Labor Statistics. CMS also finalized policy to continue applying efficiency adjustments every three years following the same process, summing up the prior three years' MEI productivity adjustment to determine the total reduction.

CMS will apply the efficiency adjustment broadly with few exceptions. The adjustment will not apply to time-based services. This includes, but is not limited to, E/M services, care management services, behavioral health services, maternity care services with an MMM global, telehealth services, time-based drug administration services, time-based physical medicine and rehabilitation services, and remote therapeutic monitoring. CMS will also exempt services newly added to the fee schedule, as it would not be possible for efficiency gains to have been achieved for new services. CMS has published a full list of excepted services.

CMS states in its rationale that they believe the current process for valuing services does not adequately account for efficiency gains over time as physicians become more experienced in a service. However, AOA highlighted how this assumption is inaccurate and worked to educate CMS on the process by which the physician community makes relative value recommendations to CMS and the harmful consequences of applying this reduction across services. AOA led an osteopathic specialty affiliate sign-on letter opposing the efficiency adjustment and outlining our concerns. AOA also specifically urged CMS to exempt osteopathic manipulative treatment (OMT) codes, as physicians offering OMT struggle with underpayment for this well-established service, and it is unlikely to see further efficiency gains. AOA will continue to advocate for removal of this policy.

Telehealth services provisions

Telehealth Service List changes and facility originating site payment

CMS finalized changes to the Medicare Telehealth Services List Review Process to streamline and simplify the process by eliminating steps that compare proposed services to permanently approved services and determining if the telehealth version delivers the same clinical benefit as

in-person care. CMS also eliminated the “permanent” versus “provisional” service distinction, and all services on the Medicare Telehealth Services List will be considered permanent.

CMS finalized several additions to the Medicare Telehealth Services List, many of which were added on a temporary basis during the COVID-19 public health emergency. Added codes include HCPCS codes G0473 and G0545 for behavioral health counseling for obesity and infectious disease add-on, and CPT codes 90849, 92622 and 92623 for family group psychotherapy and auditory diagnosis analysis. The full code descriptions are available in Appendix C.

CMS finalized the increase of the originating site facility fee for telehealth services, $31.85 for CY 2026, an increase from $31.01 in CY 2025.

Frequency limitations on Medicare telehealth subsequent care services

In alignment with AOA’s recommendation, CMS finalized provisions to permanently waive frequency limitations for Subsequent Inpatient Visits (99231-99233), Subsequent Nursing Facility Visits (99307-99310), and Critical Care Consultation Services (G0508-G0509). Frequency limitations for these services were temporarily waived during the COVID-19 public health emergency, and CMS determined through the temporary waiver that the limitations were not beneficial to patients nor were they generating meaningful oversight or cost savings to the agency.

This change will allow physicians to use their clinical judgement to determine the type and frequency of visits that meet the patient’s needs while maintaining the appropriate standard of care.

Direct supervision via audio/video communication technology

CMS has modified its definition of direct supervision such that, for telehealth services, the physician or practitioner does not need to be physically present. CMS finalized making virtual supervision permanent after years of temporary extensions. Real-time audio/video communication is permitted as long as the physician or practitioner is "immediately available." Exceptions include higher-risk surgeries with global surgery indicators 010 or 090, which would still require in-person supervision. Lower-risk services, such as CPT 99211, would remain eligible for virtual supervision.

CMS’ definition of direct supervision allows "immediate availability” of the supervising practitioner using audio/video real-time communications technology (excluding audio-only) only for the following subset of “incident-to” services:

- Services furnished incident to a physician or other practitioner’s service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying Healthcare Common Procedure Coding System (HCPCS) code has been assigned a professional component/technical component (PC/TC) indicator of 5
- Services described by CPT code 99211 (office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional)

CMS will also allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to use audio/video communications to meet direct supervision requirements for their applicable services and supplies.

AOA expressed concern that permanent adoption in some cases raises 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.

CMS finalized a permanent policy allowing teaching physicians to maintain a virtual presence during services involving residents for three-way telehealth visits where the teaching physician, resident, and patient are in separate locations. Documentation in the medical record must clearly indicate if the teaching physician was physically present or participating virtually and must also specify which portion of the service was performed under virtual supervision.

Distant site reporting and home address

In response to the CY 2026 MPFS proposed rule, AOA urged CMS to permit physicians to use only their physical practice location's address, rather than their home address, when they furnish telehealth services from their home. AOA urged this policy was critical to protect physicians' privacy and safety. While not addressed in the final rule, CMS issued telehealth guidance on Nov. 14, 2025, outlining that physicians "who furnish telehealth services from their homes but have a physical practice location are not required to report their home address on their Medicare enrollment application." Physicians who are virtual only, and whose only practice location is their home, must enroll using their home address. However, the physician should mark the address as a "Home office for administrative/telehealth use only" location in their enrollment application to suppress the street address details from the practitioner's profile page on the CMS Care Compare website. Physicians may also email the Quality Payment Program service center at QPP@cms.hhs.gov to suppress the street address and/or phone number from the page.

Remote therapeutic monitoring and remote physiologic monitoring

CMS accepted new CPT codes, and revisions to existing codes, which support improved billing for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services. First, RPM code set revisions create a device supply code for two to 15 days of data collection, in addition to the current code, which accounts for 16 to 30 days. CMS also added a treatment management code to allow the first 10 minutes of treatment management. Existing codes for the first 20 minutes and each additional 20 minutes thereafter of service time remain. Additionally, CMS added three RTM device supply codes to report respiratory, musculoskeletal and cognitive behavioral therapy for two to 15 days and 16 to 30 days within a 30-day period. Regarding RTM, CMS also created one new code and made code revisions to report RTM treatment management services for the first 10 minutes, first 20 minutes, and each additional 20 minutes thereafter; and revised remote monitoring guidelines. However, CMS deviated from RUC valuation recommendations across the code sets.

Code	Descriptor	Final work RVU
Remote physiologic monitoring		
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); initial set-up and patient education on use of equipment	0.00
99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30- day period	0.00
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30- day period	0.00
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes	0.31
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 20 minutes	0.61
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	0.61
Remote therapeutic monitoring		
98984	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period	0.00
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period	0.00
98985	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period	0.00
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for	0.00

	data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period	
98986	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period	Contractor price
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period	Contractor price
98979	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes	0.31
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0.62
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	0.61

Evaluation and management visits

CMS is finalizing policy to permit the G2211 add-on code to be billed with home and residence evaluation/management (E/M) visits. The descriptor for G2211 has been revised to read as follows: *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established).*

In the CY 2024 Medicare Physician Fee Schedule Final Rule, CMS implemented a new O/O E/M visit complexity add-on code, G2211. The G2211 code 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 (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 continuity over longer periods of time. The code is intended to be used widely across O/O E/M visits. Resources from AOA on G2211 can be found here.

Enhanced care management

CMS is finalizing its proposal to establish optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or Psychiatric Collaborative Care Model (CoCM) services. In CY 2025, CMS created three new HCPCS codes for advanced primary care management (APCM) services. These codes were part of a broader effort to support payment for primary care services, recognizing the importance of primary care to promoting population health, as a "long-term relationship with a primary care provider leads to reduced emergency department (ED) visits, improved care coordination, and increased patient satisfaction." These three new care management codes, stratified into different levels based on patient characteristics, were finalized to recognize the "resource costs associated with maintaining certain practice capabilities and continuous readiness and monitoring activities to support a team-based approach to care, where significant resources are used on virtual, asynchronous patient interactions, collaboration across clinical disciplines, and real-time management of patients with acute and complex concerns, that are not fully recognized or paid for by the existing care management codes." Details regarding APCM codes can be found here.

In CY2026, CMS is building upon this effort to support comprehensive primary care by creating two add-on codes for behavioral health integration and one code for psychiatric collaborative care management.

Code	Descriptor	Work RVU
G0568	Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies (list separately in addition to the Advanced Primary Care Management code).	1.88
G0569	Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation,	2.05

	participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment (list separately in addition to Advanced Primary Care Management code).	
G0570	Care management services for behavioral health conditions, 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 (list separately in addition to Advanced Primary Care Management code).	0.93

These codes are intended to support integration of mental health care into primary care without creating additional administrative burden for practices. As a result, these codes will not be time-based, and billing clinicians are not required to document time in the medical record.

Payment for skin substitutes

CMS has finalized its proposal to establish a single payment methodology for skin substitute products furnished in both non-facility and hospital outpatient settings, effective Jan. 1, 2026. Under the new payment methodology, skin substitutes would be paid as incident-to supplies and grouped into three payment categories based on their FDA regulatory pathway: Premarket Approval (PMA), 510(k) clearance, and Section 361 HCT/P (Human Cells, Tissues, and Cellular and Tissue-Based Products). As a result, skin substitutes would no longer be paid as biologics. Instead, CMS has finalized a single payment rate. Physicians will continue to bill existing HCPCS codes, and CMS will apply the applicable rate to each.

Ambulatory Specialty Model

CMS finalized the Ambulatory Specialty Model (ASM) as a new five-year mandatory alternative payment model that would begin Jan. 1, 2027, and end Dec. 31, 2031 (payment years 2029-2033). The five-year model targets heart failure and low back pain episodes of care, conditions that together account for 6% of Medicare parts A and B spending. The model heavily leverages the Merit-Based Incentive Payment System (MIPS) infrastructure and will use quality, cost, improvement activities, and promoting interoperability as the categories measured for performance. However, CMS outlines specific measures for each of these categories under each condition cohort. Payment adjustments will begin in 2029 (based on performance in 2027), ranging from -9% to +9%, scaling up to ±12% by 2033.

The intent of the ASM model is to hold individual specialists accountable for care costs for patients to whom they provide longitudinal care. CMS expresses that it also seeks to leverage the model to promote improved upstream management of care as part of this effort to reduce costs, through engaging in health-related social needs screening and improving care coordination, particularly with primary care.

The AOA opposed mandatory participation and offered several recommendations to CMS on how to refine and improve the model. While ASM aligns with many elements of MIPS, it differs in key areas, including scoring, payment methodology, and flexibilities physicians receive to better manage care. A key concern AOA expressed was that ASM would retain 15% of the negative payment adjustments as savings to the Medicare program, rather than distributing all funds to participants. Overall, physicians may be more likely to receive a negative adjustment or reduced payment as compared to MIPS.

Physicians identified in the following specialties who have historically treated at least 20 patients for heart failure or low back pain over a 12-month period would be subject to this mandatory model**:**

- Anesthesiology
- Cardiology
- Pain management
- Interventional pain management
- Neurosurgery
- Orthopedic surgery
- Physical medicine and rehabilitation

Eligible providers will be identified with specialty codes in alignment with any of the specialties listed above on the plurality of their Medicare Part B claims. CMS will stratify Medicare core-based statistical areas (CBSAs) based on spending on the episodes under the model and randomly select 40% of CBSAs within each stratum for participation.

AOA expressed concern regarding how rural and underserved areas will be impacted under this model. CMS has finalized that it will be offering a practice scoring adjustment for small practices to support their ability to successfully perform.

Medicare Diabetes Prevention Program (MDPP)

CMS finalized policy to extend flexibilities established during the COVID-19 public health emergency permitting asynchronous delivery of MDPP sessions through Dec. 31, 2029. Under this approach, sessions must be furnished in a manner consistent with the Diabetes Prevention Recognition Program (DPRP) Standards for online sessions with emails and text messages counting toward the requirement for live coach interaction if there is bi-directional communication between the coach and participant. These extensions will allow patients to receive virtual counseling with the intention of increasing adherence to preventive care services. CMS also created a new HCPCS code (G9871) and established payment for online MDPP sessions. CMS intends to evaluate the effectiveness of asynchronous delivery compared with in-person and synchronous distance learning.

Policies to improve care for chronic illness and behavioral health needs

CMS finalized changes to Healthcare Common Procedure Coding System (HCPCS) code G0136, revising the code to align with the administration's approach to addressing upstream drivers of chronic disease. This code will now account for assessment of physical activity and nutrition. CMS had previously created this G-code to account for administration of an evidence-based social determinant of health risk assessment. However, the administration's shift in approach to addressing upstream drivers of health led CMS to recharacterize this code.

HCPCS code G0136 is payable when both physical activity and nutrition risk assessment are performed, or when either a physical activity or risk assessment is performed if there is a clinical scenario where only one is reasonable and necessary. CMS provides the following example: if a beneficiary has recently started a new diet but their physical activity levels have not been assessed, only a physical activity risk assessment may be reasonable and necessary.

G0136 may be billed with E/M, psychiatric diagnosis evaluation, health behavior assessment intervention services and annual wellness visits. The code may only be billed and paid once every six months per beneficiary. The code carries a work RVU of 0.18.

Code	Descriptor	Work RVU
G0136	Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months.	0.18

Quality Payment Program Provisions

Overview

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 Advanced Alternative Payment Model (AAPM) tracks. This section outlines key changes related to performance under MIPS and AAPMs.

Performance threshold

Reflecting successful advocacy from AOA, CMS decided to maintain the Merit-Based Incentive Payment System (MIPS) performance threshold of 75 points for performance year 2026 through performance year 2028. This policy is intended to promote stability within the MIPS program. The 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 during the COVID-19 public health emergency and again in 2024 due to the Change Healthcare cyberattack. Many of these practices are just resuming full participation in MIPS, and MIPS performance data is likely skewed by the large number of practices that have sought exemption over the last several years.

Traditional MIPS

Quality Performance Category

CMS has finalized changes to both the measure set and scoring under the MIPS quality category. MIPS participants should reference CMS' 2026 QPP fact sheet for additional details on the removal of 10 quality measures, addition of five new measures and substantive changes to 30 existing measures.

In CY 2025, CMS finalized policy modifying the methodology it utilizes for scoring topped-out measures from a single benchmark methodology that caps the total number of points that can be earned at seven to instead lift the cap and apply a flat benchmarking methodology to a subset of topped-out measures. For CY 2026, 19 quality measures, which belong to specialty sets and MVPs with limited measure choice and a high proportion of topped-out measures, will have the new methodology applied. CMS is also updating the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures. Under this approach, CMS would tie the median score to a point value derived from the performance threshold and assign points above and below the median based on a standard deviation.

Last, in order to expand participation and response rates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey, CMS will begin permitting a web-based survey mode.

Cost Performance Category

CMS is finalizing its proposal to create a two-year informational-only period for new MIPS cost measures. If a physician is attributed a cost measure during its informational-only feedback period, CMS would calculate a measure score, provide the score and MIPS performance feedback, but not count performance on the measures towards a physician's overall score. The AOA supported this proposal and has repeatedly urged CMS to improve feedback and information-sharing with MIPS participants. This change will help practices develop performance improvement strategies to succeed under new cost measures before having the measures count towards their final MIPS score.

CMS is also finalizing its proposal to modify the total per capita cost (TPCC) measure candidate event and attribution criteria. Under the new methodology, CMS will (1) exclude candidate events initiated by an advanced care practitioner Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria; (2) require the second service used to initiate a second candidate event to be an E/M service or other related primary care service provided within 90 days of the initial candidate event service by a TIN-NPI within the same TIN; and (3) require the second service used to initiate a candidate event be provided by a TIN-NPI that has not been excluded from the measure based on specialty exclusion criteria.

Improvement Activities Performance Category

CMS finalized revisions to the improvement activities (IA) inventory, adding three new activities, modifying seven existing activities and removing eight activities. New IAs include (1) Improving Detection of Cognitive Impairment in Primary Care, (2) Integrating Oral Health Care in Primary Care, and (3) Patient Safety in Use of Artificial Intelligence. Additionally, CMS has replaced the Achieving Health Equity subcategory for improvement activities with a new Advancing Health and Wellness Subcategory.

Promoting Interoperability Performance Category

CMS finalized several key changes to the promoting interoperability category, including updates to existing requirements, establishing new attestation requirements and creating a new bonus measure. Changes include the following:

- Establishing a second attestation requirement under the Security Risk Analysis measure requiring clinicians to attest to having conducted security risk management as required under the risk management component of the HIPAA Security Rule in addition to the existing measure requirement
- Updating the High Priority Practices SAFER Guide Measure by requiring use of the 2025 SAFER Guides
- Establishing a new Public Health Reporting Using TEFCA optional bonus measure under the Public Health and Clinical Data Exchange Objective, intended to promote data-sharing under the Trusted Exchange Framework and Common Agreement (TEFCA)
- Establishing a new measure suppression policy and suppressing the Electronic Case Reporting Measure (reporting is still required although all participants will receive full scores)

MIPS Value Pathways (MVPs)

CMS made substantial changes to the MIPS Value Pathways to support more meaningful participation. First, CMS finalized six new MVPs for the following specialties: diagnostic radiology, interventional radiology, neuropsychology, pathology, vascular surgery and podiatry. Second, CMS has revised the format of each MVP to categorize quality measures by clinical conditions or episodes of care, intended to help physicians select the most clinically relevant measures. Third, CMS has made modifications to MVP group reporting and attestations. Beginning in 2026, MIPS eligible clinicians in multispecialty groups will be required to divide into and report as a subgroup or report as an individual to report an MVP. In the CY 2026 rule, CMS finalized further policy to (1) permit the MVP group reporting option for multispecialty groups with a small practice designation; and (2) modify the MVP group registration process to add the self-attestation requirement for identifying group specialty composition.

CMS reiterates in the rule its intent to sunset traditional MIPS and fully transition to MVP reporting.

APM Performance Pathway (APP)

In CY 2025, CMS finalized its proposal to create a new APM Performance Pathway (APP) Plus measure set that will be required for Medicare Shared Savings Program ACO participants to report. CMS had finalized policy to phase in the measure set through CY 2028. Under the CY26 rule, CMS continues the phase in of this measure set with two additional measures: (1) *colorectal cancer screening*; and (2) *Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*. CMS is also removing one measure from the set: *screening for social drivers of health*. These changes also better align the APP Plus measure set with the MIPS measure inventory.

Advanced Alternative Payment Model (AAPM) Pathway

CMS is adding an individual-level QP determination calculation for all clinicians participating in an Advanced APM in addition to determinations at the APM entity level. This change is intended to support participation in APMs, particularly by specialists, as QP thresholds increase.

Medicare Shared Savings Program Provisions

CMS has finalized several substantive changes to the Medicare Shared Savings Program (MSSP), including the following:

- For agreements beginning on or after Jan. 1, 2027, CMS is modifying requirements for MSSP eligibility to support participation by less-experienced ACOs that do not have history of participation in Medicare programs. Inexperienced ACOs will be permitted to participate under a one-sided model for up to five performance years under a single agreement under the MSSP BASIC track. However, these ACOs will be required to progress faster to higher levels of risk and potential reward under a two-sided model by their second or subsequent agreement period.
- Beginning in performance year 2025 and subsequent years, CMS has updated the extreme and uncontrollable circumstances policies to account for cyberattacks.
- CMS will provide flexibility in instances where an ACO participant or SNF affiliate experiences a change of ownership, enabling organizations that undergo a change in ownership (CHOW) to continue participating without interruption. ACOs must submit a change request and update their ACO participant list outside of the annual charge request cycle when an ACO participant undergoes a CHOW, and ACOs will be required to report changes which occur during the performance year to the ACO's SNF affiliate list if a SNF affiliate undergoes a CHOW resulting in a new TIN.
- CMS is also finalizing quality reporting changes, including updates to the APP Plus measure set outlined previously in this document.

Questions?

If you have any questions regarding the contents of this document, please reach out to Gabriel Miller, AOA Senior Director of Regulatory Affairs, at gmiller@osteopathic.org.

Appendices

Appendix A: Medicare payment calculation formula

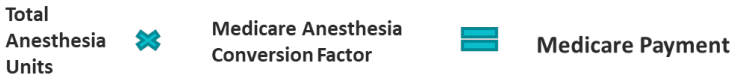
Step 1: Calculate Total RVUs

Step 2: Calculate Final Medicare Payment

Appendix B: Medicare anesthesia payment calculation

Step 1: Calculate Total Anesthesia Units

Step 2: Calculate Final Medicare Payment



Appendix C: Additions to the Medicare telehealth service list

Code	Descriptor
90849	Multiple-Family Group Psychotherapy
G0473	Face-to-face behavioral counseling for obesity, group (2 to 10), 30 minutes
G0545	Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases consultant, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, or subsequent)

92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
92623	(Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)

Appendix D: Work RVUs for new and revised codes

This table, which can be found on pages 362-385 of the final rule, lists all new and revised codes for which CMS has adopted changes. For specific details regarding any coding or value changes, please refer to the rule or contact the AOA.

Work RVUs noted as "B" are part of a bundled payment and non-payable as separate codes, in alignment with OPPS to not pay separately for each step used to manufacture a drug or biological.

Work RVUs noted as "C" indicate contractor-priced code. Contractors establish RVUs and payment amounts for these services.

Work RVUs noted as "D" indicate that the code is deleted and will not be available beginning in 2026.

Work RVUs noted as "I" indicate CMS has determined the service is not valid for Medicare payment purposes, as CMS believes there is another code for reporting and payment of that service.

Work RVUs noted as "N" indicate a non-covered service.

Work RVUs noted as "X" indicate a non-payable service that is used for tracking purposes only.

Code	Short descriptor	Current work RVUs	New work RVUs
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia	C	2.70
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	C	2.43
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	C	1.05
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	C	0.00
27458	Osteotomy(ies), femur, unilateral, with insertion of an externally controlled intramedullary lengthening device, including iliotibial band release when performed, imaging, alignment assessments,	NEW	26.65

	computations of adjustment schedules, and management of the intramedullary lengthening device		
27465	Osteoplasty, femur; shortening	18.60	21.13
27466	Osteoplasty, femur; lengthening	17.28	22.65
27713	Osteotomy(ies), tibia, including fibula when performed, unilateral, with insertion of an externally controlled intramedullary lengthening device, including imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	NEW	28.00
27715	Osteoplasty, tibia and fibula, lengthening or shortening	15.50	22.50
28750	Arthrodesis, great toe; metatarsophalangeal joint	8.57	8.75
28755	Arthrodesis, great toe; interphalangeal joint	4.88	7.50
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	14.00	10.25
33880	Endovascular repair of thoracic aorta, including preprocedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation; by deployment of an aorto-aortic tube endograft covering the left subclavian artery and all aortic tube endograft extension(s) proximally in the aortic arch and ascending aorta and distally to the celiac artery, when performed	34.58	27.00
33881	Endovascular repair of thoracic aorta, including preprocedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation; by deployment of an aorto-aortic tube endograft not involving coverage of the left subclavian artery origin and all endograft extension(s) placed from the level of the left subclavian carotid artery to the celiac artery	29.58	22.53
33882	Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stentgraft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation	NEW	35.00
33883	Delayed placement of proximal extension prosthesis(es) not involving coverage of the left subclavian artery origin, after endovascular repair of the thoracic aorta, including pre-procedure sizing and device selection, nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed	21.09	19.91
33886	Delayed placement of distal extension prosthesis(es) from the level of the left subclavian artery to the celiac artery, after endovascular repair	18.09	19.91

	of descending thoracic aorta, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation		
35602	Bypass graft, with other than vein; carotidcontralateral carotid	NEW	23.53
37254	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	NEW	7.30
37255	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	3.00
37256	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	NEW	10.75
37257	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (list separately in addition to code for primary procedure)	NEW	3.89
37258	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	NEW	8.75
37259	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral;	NEW	4.00

	straightforward lesion, each additional vessel (list separately in addition to code for primary procedure)		
37260	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	12.69
37261	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (list separately in addition to code for primary procedure)	NEW	4.25
37262	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (list separately in addition to code for primary procedure)	NEW	3.00
37263	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	NEW	7.75
37264	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (list separately in addition to code for primary procedure)	NEW	3.00
37265	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	NEW	10.50
37266	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all	NEW	4.00

	maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)		
37267	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	NEW	8.75
37268	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	3.73
37269	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	14.75
37270	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	5.00
37271	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy	NEW	9.00

	and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel		
37272	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	4.00
37273	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	12.63
37274	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	5.50
37275	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	NEW	11.00
37276	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	4.25

37277	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	15.00
37278	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	6.00
37279	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	NEW	4.00
37280	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	NEW	9.80
37281	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	3.00
37282	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	NEW	12.31

37283	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	4.26
37284	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	NEW	10.00
37285	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	3.34
37286	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	13.46
37287	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	5.00
37288	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological	NEW	13.50

	supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel		
37289	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	4.75
37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	17.00
37291	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	6.50
37292	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	NEW	15.00
37293	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral;	NEW	6.50

	straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)		
37294	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	NEW	18.00
37295	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	8.16
37296	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	NEW	11.00
37297	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	NEW	4.00
37298	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	NEW	13.70
37299	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and	NEW	5.00

	radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)		
43889	Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed	NEW	12.56
47384	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	NEW	9.41
52500	Transurethral resection of bladder neck (separate procedure)	8.14	6.00
52597	Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed	NEW	10.25
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	13.16	10.00
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	6.55	6.55
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	12.15	10.05
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	14.56	13.00
55705	Biopsy, prostate, any approach, nonimaging-guided	4.61	1.93
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	6.28	4.27
55707	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])	NEW	2.63
55708	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance, first targeted lesion	NEW	3.39
55709	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant, ultrasound-localized discrete lesion[s])	NEW	3.23
55710	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion-guidance biopsy, first targeted lesion	NEW	3.81
55711	Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion	NEW	2.61

55712	Biopsy, prostate, transperineal, MRI-ultrasound fusion guided, targeted lesion(s) only, first targeted lesion	NEW	3.10
55713	Biopsy, prostate, in-bore CT- or MRI-guided (ie, sextant), with biopsy of additional targeted lesion(s), first targeted lesion	NEW	4.00
55714	Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion	NEW	3.62
55715	Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided targeted lesion (List separately in addition to code for primary procedure)	NEW	1.05
55840	Prostatectomy, retropubic radical, with or without nerve sparing;	21.36	21.36
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	21.36	21.36
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	25.18	25.18
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed;	22.46	22.46
55867	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed	19.53	19.53
55868	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with lymph node biopsy(ies) (limited pelvic lymphadenectomy)	NEW	22.46
55869	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	NEW	27.41
55877	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	NEW	13.50
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; central nervous system (intracranial, spinal cord)	20.12	20.00
61626	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), including all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention, percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	16.60	15.31
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed	18.95	18.95

62330	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; one interspace, lumbar	NEW	8.00
62331	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (ie, CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)	NEW	4.25
63032	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure)	NEW	2.50
64567	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	NEW	1.50
64654	Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (ie, total system), and intraoperative interrogation and programming	NEW	11.00
64655	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only	NEW	11.30
64656	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only	NEW	8.01
64657	Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator	NEW	12.13
64658	Removal of baroreflex activation therapy (BAT) modulation system; lead only	NEW	8.95
64659	Removal of baroreflex activation therapy (BAT) modulation system; pulse generator only	NEW	8.23
64728	Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance	NEW	2.70
70471	Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing	NEW	2.50
70472	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)	NEW	0.77
70473	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy	NEW	1.00
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75	1.75

70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75	1.75
75577	Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional	NEW	0.85
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	1.31	2.25
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	1.65	1.85
76872	Ultrasound, transrectal;	0.69	0.67
77417	Therapeutic radiology port image(s)	0.00	B
77436	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting	NEW	0.77
77437	Surface radiation therapy; superficial, delivery, ≤150 kV, per fraction (eg, electronic brachytherapy)	NEW	0.00
77438	Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction	NEW	0.00
77439	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (List separately in addition to code for primary procedure)	NEW	0.30
90480	Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; first or only component of each vaccine administered	X	X
90481	Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; each additional component administered (List separately in addition to code for primary procedure)	NEW	X
90832	Psychotherapy, 30 minutes with patient	1.86	1.94
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.64	1.71
90834	Psychotherapy, 45 minutes with patient	2.45	2.56
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	2.08	2.17
90837	Psychotherapy, 60 minutes with patient	3.63	3.78
90839	Psychotherapy for crisis; first 60 minutes	3.43	3.58
90840	Psychotherapy for crisis; each additional 30 minutes	1.64	1.71
90845	Psychoanalysis	2.30	2.40
90846	Family psychotherapy (without the patient present), 50 minutes	2.63	2.74
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	2.74	2.86

90849	Multiple-family group psychotherapy	0.65	0.67
90853	Group psychotherapy (other than of a multiple-family group)	0.65	0.67
91124	Rectal sensation, tone, and compliance study (eg, barostat)	NEW	3.05
91125	Anorectal manometry, with rectal sensation and rectal balloon expulsion test, when performed	NEW	2.70
92920	Percutaneous transluminal coronary angioplasty, single major coronary artery and/or its branch(es)	9.85	8.35
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)	11.74	10.13
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments	10.96	10.00
92930	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch	NEW	12.00
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed, single major coronary artery and/or its branch(es)	12.29	11.94
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed, single major coronary artery and/or its branches	10.95	11.30
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single major coronary artery and/or its branches or single bypass graft and/or its subtended branches	12.31	12.72
92943	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach	12.31	13.69
92945	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches	NEW	15.00
92973	Percutaneous transluminal coronary mechanical aspiration thrombectomy (List separately in addition to code for primary procedure)	3.28	1.75

93145	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); without programming	NEW	0.65
93146	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming, including optimization of tolerated therapeutic level setting	NEW	0.90
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	0.00	0.00
93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; initial vessel (List separately in addition to code for primary procedure)	1.38	1.80
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, when performed; each additional vessel (List separately in addition to code for primary procedure)	1.00	1.44
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	0.85	0.85
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	2.30	2.40
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	1.59	1.66
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	0.55	0.57
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	0.23	0.24
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	0.11	0.11
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	1.70	1.77
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	0.60	0.63

96380	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional	0.24	0.28
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection	0.17	0.17
97007	Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education	NEW	0.00
97008	Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period	NEW	0.00
97009	Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure)	NEW	0.00
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment	0.00	0.00
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 16-30 days in a 30-day period	0.00	0.00
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 16-30 days in a 30-day period	0.00	0.00
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period	C	C
98979	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 10 minutes	NEW	0.31
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0.62	0.62
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least 1 real-time interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	0.61	0.61
98984	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, 2-15 days in a 30-day period	NEW	0.00
98985	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data	NEW	0.00

	access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period		
98986	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period	NEW	C
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	1.10	1.10
99445	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30- day period	NEW	0.00
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); initial set-up and patient education on use of equipment	0.00	0.00
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30- day period	0.00	0.00
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 20 minutes	0.61	0.61
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	0.61	0.61
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes	NEW	0.31
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	0.00	0.00
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30- day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	0.18	0.18

G0568	Initial psychiatric collaborative care management, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies (list separately in addition to the Advanced Primary Care Management code).	NEW	1.88
G0569	Subsequent psychiatric collaborative care management, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment (list separately in addition to Advanced Primary Care Management code).	NEW	2.05
G0570	Care management services for behavioral health conditions, 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 (list separately in addition to Advanced Primary Care Management code)	NEW	0.93

G0571	Intraoperative nerve(s) cryoablation for post-surgical pain relief	NEW	1.39