CY2025 Medicare Physician Fee Schedule

Key Takeaways for Physicians

American Osteopathic Association

511 2nd St NE
Washington, DC 20002
(312) 202-8000
osteopathic.org

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Executive Summary

On November 1, the Centers for Medicare & Medicaid Services (CMS) issued the CY2025 Medicare Physician Fee Schedule final rule which includes updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program (MSSP). Most significantly, CMS has reduced the CY2025 conversion factor by 2.83 percent from $33.288 to $32.347. The anesthesia conversion factor will also decrease from $20.774 to $20.318. These reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address through legislation.

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

- CMS continues to support payment for comprehensive primary care, and has created several new opportunities for payment, including enabling the G2211 evaluation/management care complexity add-on code to be billed with Medicare preventive services, as well as the creation of new Advanced Primary Care Management (APCM) codes;
- Recognizing telehealth services remain a critical way for patients to access care, CMS has finalized a range of policies promoting access to telehealth, pending Congressional extension of COVID-19 era statutory flexibilities, including continuing payment for telehealth services at parity with in-person services, paying for audio-only services, and finalizing additional flexibilities; and
- CMS continues to expand payment for vital mental and behavioral health services, including payment changes for opioid treatment programs, standalone G codes and payment for safety planning interventions and follow-up services post-discharge for a crisis encounter.

Changes related to surgical care include new requirements for reporting transfer of care modifiers – raising concerns for future changes to surgical payment. CMS also created a new code to capture the time and resources spent providing post-operative care within a 90-day global period by a physician who did not perform the surgical procedure.

The rule also contains a range of changes to the QPP and MSSP. Overall, CMS has made modifications to measure lists across the Merit Based Incentive Payment System (MIPS) performance categories and made substantial changes to the MIPS value pathways. Additionally, following AOA advocacy CMS will maintain the MIPS performance threshold, upon which payment adjustments are determined, at 75 points. AOA expressed concern that raising the performance threshold would disadvantage small and independent practices, especially those 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 by 2029, remains a concern.

Physician Fee Schedule Provisions

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

Conversion Factor and Rate Setting

CMS has reduced the CY2025 conversion factor by 2.83 percent from $33.288 to $32.347. The anesthesia conversion factor will also decrease from $20.774 to $20.318. For physician services (excluding anesthesia), total payment is calculated by first determining the total relative value units (RVUs) for a given services (comprised of three components: physician work, practice expense (PE), and liability insurance) and multiplying the total RVUs by the conversion factor. The formulas used to calculate final payment for Medicare services can be found in Appendices A and B of this document.

The conversion factor reductions, which apply to services across the fee schedule, are the result of statutorily mandated reductions, which the AOA has been fighting to address. Statutory requirements prevent CMS from providing positive payment adjustment under the physician fee schedule without a corresponding negative reduction – changes to the fee schedule must be applied in a budget neutral manner. This means that any changes to RVUs may not result in a net increase in Medicare expenditures when accounting for anticipated utilization. The driver of the 2.83 percent conversion factor reduction is the expiration of the short-term increase to the conversion factor enacted by Congress in FY2024 to mitigate physician payment cuts.

These payment cuts come amid rising costs of practicing medicine, the combination of which is unsustainable in the long term. Between 2000 and 2024, practice costs as measured by the Medicare Economic Index increased 48 percent, and in 2025, CMS expects costs will further increase by 3.5 percent. The AOA is continuously working with lawmakers to express the urgent need to reform physician payment and avert the payment reductions that will take effect in 2025.

Telehealth Services Provisions

The final rule reflects a commitment by CMS to ensuring continued access to telehealth services, recognizing the important role they play in supporting longitudinal care, and enabling patients to see a physician when they otherwise may not be able to. However, CMS does not have the authority to extend all telehealth flexibilities, such as waiving statutory restrictions on geography, site of service, and practitioner type, which existed during the COVID-19 Public Health Emergency (PHE) and will be rescinded effective January 1, 2025, without Congressional action. Absent Congressional action by the end of 2024, Medicare beneficiaries will need to be in a rural area and a medical facility to receive non-behavioral health services via telehealth.

Telehealth Services List and Payment Rates

The Medicare Telehealth Services List is separated into two categories, permanent and provisional. CMS has added caregiver training service codes (CPT codes 97550-97552, 96202, 96203, HCPCS codes GCTD1-GCTD3, GCTB1, GCTB2) on a provisional basis and added individual counseling for preexposure prophylaxis (PrEP) (HCPCS codes G0011 and G0013) with a permanent status. The full code descriptions are available in Appendix C.

CMS noted that the agency will not be making determinations on whether to recategorize any provisional codes as permanent until CMS can complete a comprehensive analysis of all such provisional codes, which they expect to address in future rulemaking.

Payment and Coding for Telemedicine Evaluation and Management Services

CMS will continue to pay for telehealth services at parity with in-person services. The agency recognized that work, practice expense, and malpractice costs for most telehealth services, particularly for E/M services, remain the same regardless of whether a service was provided in-person or via telehealth. E/M services are selected on the basis of time or medical decision making. As a result, CMS has continued payment parity between telehealth and in-person services.

Providers should use existing office/outpatient E/M codes with the appropriate POS code to identify the location of the beneficiary and, when applicable, the appropriate modifier to identify the service as being furnished via audio-only communication technology.

With the recognition that telehealth and in-person care require the same level of resources, CMS does not feel telehealth-specific codes are required when the code describes services that would otherwise be furnished in person. While CMS has recognized newly created CPT telehealth E/M codes, CMS is assigning codes 98000-98015 a Procedure Status indicator of “I”, meaning that there is a more specific code that should be used for purposes of Medicare and these codes will not be paid separately. The AOA opposed this approach, as it may result in a bifurcation of payment where private payers adopt the more specific CPT codes for payment despite CMS paying for telehealth E/M services through existing office/outpatient (O/O) E/M codes appended with the appropriate modifiers. Practices should confirm with private payers how they will continue to pay for telehealth E/M services.

Given the similarity between the newly created CPT code 98016 for virtual check-ins and HCPCS code G2012, CMS determined G2012 will be deleted and replaced with 98016 with the RUC-recommended RVU of 0.30.

CPT code 98016
Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
RVU of 0.30

Audio-Only Communication Technology

CMS revised the definition of "interactive telecommunications system" to include two-way, real-time audio-only services when the following conditions are met:

1. the beneficiary is in their home, and
2. the patient is either not capable or does not consent to use video technology.

CMS stated that this audio-only flexibility was finalized to support patient-centered care and decision-making, so the distant site physician or practitioner must still be technically capable of using an interactive telecommunications system that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

Modifiers must be appended to the claim to verify conditions have been met. These are CPT modifier "93" and, for Rural Health Clinics (RHCs) and Federally Qualified Heath Centers (FQHCs), Medicare modifier "FQ" (Medicare telehealth service was furnished using audio-only communication technology). Practitioners have the option to use the "FQ" or the "93" modifiers or both where appropriate and true, since they are identical in meaning. Place of services (POS) code 10 will continue to be required, as with all telehealth services, to indicate a telehealth service was provided in a patient's home.

Distant Site Requirements

CMS will continue to permit the distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through the end of CY2025. This ensures the privacy and safety of physicians who may conduct telehealth visits from their home.

Definition of "Direct Supervision" for Audio/Video Telecommunication

CMS will continue to define direct supervision in a manner that allows the requirement to be satisfied via the "virtual presence" and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications. CMS has extended this policy through 2025 to ensure continuity in light of how many practices have restructured following flexibilities granted during the PHE, and it will re-evaluate this policy in future rulemaking based on availability of additional data regarding patient safety.

CMS has permanently adopted a definition of direct supervision that 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).

AOA expressed concern that long-term extension of this flexibility and 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.

Supervision of Residents in Teaching Settings

CMS finalized policy that would continue to allow teaching physicians to have a virtual presence in all teaching settings in clinical instances when the service is furnished virtually (i.e., a three-way telehealth visit, with all parties in separate locations). This will extend the policy through the end of CY2025.

Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS finalized policy continuing to suspend frequency limitations for Medicare telehealth subsequent care services in inpatient settings, nursing facility settings, and critical care consultations, on a temporary basis, for CY2025. This will allow the agency more time to continue to collect data on these services and "determine how practice patterns are evolving and what changes, if any, to frequency limitations should be made on a permanent basis." Frequency limitations will continue to be suspended for the following codes:

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

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

Evaluation and Management Visits

Office/Outpatient Evaluation and Management Visit Complexity Add-On

CMS is finalizing policy to permit the G2211 add-on code to be billed with preventive services furnished on the same date as an O/O E/M service. In the CY2024 Medicare Physician Fee Schedule Final rule, CMS implemented a new O/O E/M visit complexity add-on code, G2211. The O/O E/M visit complexity add-on reflects the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M office visit services that enable them to build longitudinal relationships with all patients (not only those patients who have a chronic condition or single high-risk disease) and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time. The code is intended to be used widely across O/O E/M visits.

Generally, G2211 cannot be billed when an E/M is appended with a modifier-25 for a minor procedure on the same date. However, to better align payment for the G2211 add-on code with how primary care is delivered, CMS has finalized its proposal to allow payment for G2211 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. This change will support improved payment for the time and effort by physicians to build longitudinal care relationships with patients, including when their care is focused on prevention and promoting wellness. Additional resources from AOA on G2211 can be found here.

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-On for Infectious Diseases (HCPCS code G0545)

CMS has established a new add-on code, G0545, to describe the intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease that is performed by a physician with specialized training in infectious diseases. The full code descriptor can be found below.

HCPCS Code G0545
Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and/or 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, subsequent or discharge),
Work RVU of 0.89

Enhanced Care Management: Advanced Primary Care Management (APCM) Services

CMS has finalized its proposal to establish and pay for three new HCPCS codes for advanced primary care management (APCM) services. CMS states that these new codes are part of the agency's long-term effort to support payment for primary care services, recognizing the importance of primary care to promoting population health as "long-term relationship with a primary care provider leads to reduced emergency department (ED) visits, improved care coordination, and increased patient satisfaction."

CMS elaborates that implementing advanced primary care, which supports whole-person care and coordination across the healthcare system, is important to improving the well-being of patients and communities. However, it "involves 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."

The three new APCM codes are intended to describe APCM services furnished per calendar month following an initial qualifying visit. Physicians who bill APCM services must intend to be responsible for the patient's primary care and serve as the continuing focal point for all needed health care services.

The codes are stratified into three level-based patient characteristics that are broadly indicative of patient complexity and the consequent resource intensity involved in the provision of these services. The three codes are outlined below:

Table 1. Newly Created Advanced Primary Care Management Codes

Code	Service	CMS Work RVU	Total Non-Facility Payment
G0556	Advanced primary care management services for patients with one or fewer chronic conditions ("level 1")	0.25	$15
G0557	Advanced primary care management services for patients with two or more chronic conditions ("level 2")	0.77	$50
G0558	Advanced primary care management services furnished to patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries ("level 3")	1.67	$110

When determining whether to bill APCM codes, it is important to consider the following:

- What services are considered duplicative and may not be billed with APCM;
- Which duplicative services are likely to be rendered and what total payment would be;
- Whether the documentation burden, through elimination of time-based requirements, is meaningfully different.

The value of billing APCM instead of other "duplicative services" that may not be billed concurrently should be considered based on the above.

APCM Service Elements and Practice Level Capabilities

In order to bill APCM services, at least one of the service elements described in the code descriptor must be furnished to a patient in the calendar month and the practice must also have certain characteristics and capabilities that CMS defines as "inherent to, and necessarily present when a practitioner is providing covered services using an advanced primary care delivery model." CMS finalized the following service elements and practice-level capability requirements for APCM to be billed:

1. **Consent:** Informing the patient of the availability of the service, including cost-sharing obligations, and obtain consent;
2. **Initiation:** Initiation during a qualifying visit for new patients;
3. **24/7 Access to Care and Care Continuity:** Providing 24/7 access to a member of the care team and ensuring that patient information is available to members of the team for continuity of care;
4. **Comprehensive Care Management:** Overall comprehensive care management, which includes systematic needs assessment; systems-based approach to ensuring receipt of services; and medication reconciliation, management, and oversight of self-management;
5. **Patient Centered Comprehensive Care Plan:** Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan which is available within and outside the billing practice as appropriate;
6. **Management of Care Transitions:** Coordinating care transitions between providers and settings, including timely follow up following emergency department visits and hospital discharges, ensuring timely exchange of electronic health information, and ensuring

timely communication with patients and caregivers following certain episodes or health events;

7. **Practitioner, Home-, and Community-Based Care Coordination:** coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and ensuring appropriate communication and documentation;
8. **Enhanced Communication Opportunities**: Making available patient-initiated digital communication and providing additional ways for patients to communicate with their physician or care team through asynchronous methods (e.g. e-visits, patient portals, remote evaluation of patient recorded information);
9. **Patient Population-Level Management:** Analyzing patient population data to identify gaps in care, offer additional interventions, or risk stratify populations to target services; and
10. **Performance Measurement:** Being assessed on primary care quality, total cost of care, and meaningful use of certified electronic health record technology (CEHRT) through participation in the Value in Primary Care MVP, participating in an MSSP Accountable Care Organization (ACO), or participating in an applicable advanced-Alternative Payment Model (APM).

While APCM services closely resemble Chronic Care Management (CCM) and Principal Care Management (PCM) services, and contain many of the same elements, the key differentiating factors are:

1. APCM codes are not time based, and only the service element(s) provided in a month must be documented; and
2. Practices must have certain additional capabilities in order to bill APCM relative to other care management services.

As described below, APCM may not be billed with other care management services.

Duplicative Services and Concurrent Billing Restrictions

CMS considers APCM to be a bundle of services that reflect the broader efforts practices engage in to provide comprehensive care to a patient through advanced primary care. As such, CMS has finalized policy to prohibit billing of APCM with any of the following codes which would be considered duplicative in a calendar month in which APCM is billed:

- Chronic Care Management (CCM): CPT Codes 99487, 99489, 99490, 99491, 99439, 99437)
- Principal Care Management (PCM): CPT Codes 99424, 99425, 99426, 99427
- Transitional Care Management (TCM): CPT Codes 99495, 99496
- Interprofessional Internet Consultation: CPT Codes 99446, 99447, 99448, 99449, 99451, 99452
- Remote Evaluation of Patient Videos/Images: HCPCS Code G2250
- Virtual Check-in Codes: HCPCS Codes G2251, G2252
- Online Digital E/M: CPT Codes 98970, 98971, 98972, 99421, 99422, 99423

Cardiovascular Risk Assessment and Risk Management

CMS finalized its proposal to create two new G-codes for cardiovascular (CV) risk assessment and risk management. This policy builds on the success of the CMS Innovation Center's Million Hearts® Cardiovascular Disease (CVD) Risk Reduction model, which was designed to decrease the incidence of first-time heart attacks and strokes among medium and high-risk Medicare beneficiaries over five years and reduce Medicare spending on cardiovascular events. The model coupled payment for risk assessment and corresponding risk management for patients with CV disease risk.

The two finalized HCPCS codes are outlined in the table below.

Code	Short Descriptor	CMS Work RVU
G0537	Administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment for patients with ASCVD risk factors, 5-15 minutes, not more often than every 12 months per practitioner	0.18
G0538	Atherosclerotic Cardiovascular Disease (ASCVD) risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at intermediate, medium, or high risk for CVD as previously determined by the ASCVD risk assessment; ASCVD-Specific care plan established, implemented, revised, or monitored that addresses risk factors and risk enhancers and must incorporate shared decision making between the practitioner and the patient; clinical staff time directed by physician or other qualified health care professional; per calendar month	0.18

ASCVD will be a designated care management service, patient consent must be obtained, and the service may be billed more than once per calendar month. Risk management services may include blood pressure management, cholesterol management, smoking cessation, and other elements.

Strategies for Improving Global Surgery Payment Accuracy

Transfer of Care Modifiers

CMS expressed concern that global surgical payments are not valued appropriately, and the agency is seeking a way to potentially revalue global surgical packages that support patient-centered care. In an attempt to improve the accuracy of valuation and payment for global packages to practitioners providing preoperative, surgery, and post-operative care to Medicare beneficiaries, CMS will now require that a modifier (modifier -54) be applied for all 90-day global surgical packages where a practitioner only intends to perform the procedure and does not intend to provide the post-operative care. This includes formal, documented transfers of care (current policy) and informal, non-documented but expected transfers of care. It is important to note that appending claims with modifier -54 would adjust the portion of the payment received to reflect that the proceduralist did not provide postoperative care. Practitioners other than the proceduralist and, if applicable, those outside the proceduralist's group practice (practitioners "receiving" the patient), can continue to separately bill for post-operative services without the need to report a modifier.

Post-Operative Care Services Add-On Code

CMS will establish a new add-on code, G0559, that would account for resources involved in post-operative care for a global package provided by a physician who was not involved in furnishing the surgical procedure and does not benefit from the global surgical payment, such as a patient's primary care provider. Documentation in the medical record must justify use of the add-on code and that the E/M visit was, as clinically understood by the reporting practitioner, related to a post-operative visit furnished during the 90-day post-operative period.

G0559: Post-Operative Care Services Add-On Code
Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: • Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation. • Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). • Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. • Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established).
RVU of 0.16

Advancing Access to Behavioral Health Services

Safety Planning Interventions

CMS created 2 new HCPCS codes to better support efforts by physicians to address risk of suicidality and overdose among patients in crisis across settings. CMS finalized add-on G-code, G0560, that would be billed when safety planning interventions are personally performed by the billing practitioner in a variety of settings. These interventions involve a patient working with a clinician to develop a personalized list of coping and response strategies and sources of support that the person can use in the event of experiencing thoughts of harm to themselves or others. The service can be billed as a standalone service, or with an E/M or psychotherapy service, and has a work RVU of 1.09.

CMS also finalized a monthly billing code, G0544, to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a behavioral health or other crisis encounter, as a bundled service describing four calls in a month, each lasting between 10-20 minutes. G0544 has a work RVU of 1.00.

The code descriptors for these services can be found in Appendix D.

Digital Mental Health Treatment Services

CMS is finalizing payment for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. The payment encompasses software devices cleared by FDA to treat or alleviate mental health conditions. The 3 HCPCS codes created would cover device supply (G0552), first 20 minutes of monthly treatment management services (G0553), and each additional 20 minutes of monthly treatment management services (G0554).

The code descriptors and work RVUs for these services can be found in Appendix D.

Opioid Treatment Programs (OTP)

CMS finalized several policies expanding access to opioid use disorder (OUD) treatment through OTPs. The agency will make permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, as long as all other applicable requirements are met. Additionally, the agency will allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

CMS has also updated payment for intake activities furnished by OTPs to include payment for social determinants of health risk assessments to adequately reflect additional effort for OTPs to identify a patient's unmet health-related social needs or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD. Finally, CMS also finalized its proposal to pay for OTPs to provide new medications to patients, including a new nalmefene hydrochloride product, Opvee®, and a new injectable buprenorphine product, Brixadi®.

Medicare Part B Payment for Preventive Services

Hepatitis B Vaccine Cost and Administration

Medicare Part B pays for the hepatitis B vaccine for individuals who are at high or intermediate risk of contracting hepatitis. Based on ACIP recommendations and research, CMS concluded that anyone who is not fully vaccinated for hepatitis B to be at intermediate risk of contracting the hepatitis B virus. The Department of Health and Human Services Secretary has the statutory authority to determine who is at high or intermediate risk of contracting hepatitis B for coverage of the hepatitis B vaccine. As such, CMS changed the definition of "intermediate risk" to include any person who has not yet received the hepatitis B vaccine or whose vaccination history is unknown. With this change, a physician's assessment of the patient's risk is no longer needed, so a doctor's order will no longer be necessary for the administration of a hepatitis B vaccine under Part B starting in CY2025.

CMS aligned payment for hepatitis B vaccinations in RHCs and FQHCs with payment for pneumococcal, influenza, and COVID-19 vaccinations in those settings.

Proposed Fee Schedule for Drugs Covered as Additional Preventive Services

In light of recent development of preventive physician administered drugs, such as injectable PrEP, CMS finalized a fee schedule for drugs covered as additional preventive services (DCAPS) as follows:

- Use existing Part B drug pricing mechanisms to maintain consistency across Part B including DCAPS;
- Determine payment limit for a DCAPS drug using Average Sales Price (ASP) methodology or alternative pricing mechanism if ASP data is not available for a particular drug; and
- Update the fee schedule quarterly.

Exact details on coding and corresponding crosswalks will be included in the published DCAPS fee schedule once DCAPS drugs are finalized for coverage via the national coverage determination (NCD) process. Payment to RHCs and FQHCs for DCAPS drugs, including their supply and administration, is separate from, the RHC All-Inclusive Rate (AIR) and FQHC prospective payment system (PPS). DCAPS drugs and their supplying and administration fees, when provided by RHCs and FQHCs, will be reported on the uniform billing (UB) 04.

Pre-Exposure Prophylaxis (PrEP) for HIV

CMS is finalizing national rates for 3 HCPCS codes created in 2024 following a national coverage determination for PrEP for HIV prevention. The three new services, which CMS will cover as preventive, include one code for PrEP injection administration and 2 codes for counseling. The values for these codes can be found in Appendix D. CMS is also including PrEP under the newly created fee schedule of drugs covered as preventive services.

Expanded Colorectal Cancer Screening

CMS has finalized its proposal to update and expand coverage for colorectal cancer (CRC) screening by (1) removing coverage for the barium enema procedure for CRC screening; (2) adding coverage of the computed tomography colonography (CTC) procedure for CRC screening; and (3) expanding Medicare's approach to a "Complete CRC Screening" to include a covered blood-based biomarker test alongside a covered non-invasive stool-based test. Such services would be considered preventive and thus would not be subject to beneficiary coinsurance.

Federally Qualified Health Centers and Rural Health Clinics

The MPFS final rule makes several policy updates for federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) outlined below. The 2025 productivity adjusted FQHC market basket update for payment to FQHCs is 3.4 percent.

RHC Conditions for Certification and FQHC Conditions for Coverage

CMS has finalized policy to remove productivity standards that evaluate the total hours of an RHC's operation and whether a majority of those hours involve primary care services. These have historically limited RHC payment rates and placed unnecessary burdens on physicians at RHCs. While no longer enforcing this standard, CMS proposes to establish regulation that

RHCs must provide primary care services. CMS is not implementing parallel requirements for FQHCs as these settings already have safeguards within HRSA regulations ensuring they provide comprehensive services.

Care Management Services

Beginning in 2025, FQHCs and RHCs will be required to individually bill care management services rather than billing G0511, as is current practice. Since 2016, RHCs and FQHCs have been able to bill for Chronic Care Management services through a consolidated care management code (G0511). However, this single code represents 22 care management services, which presents serious billing and reimbursement issues. CMS proposes allowing these entities to bill individual care management codes, including the newly proposed APCM services. This will ensure more accurate coding and payment and will enable FQHCs and RHCs to bill time-based add-on codes, which may provide meaningful payment considering the patient population of these sites. RHCs and FQHCs will have a six-month period to come into compliance.

Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-In of Payment Reductions

Beginning in 2026, absent action by Congress, CMS will move forward with implementation of phased-in payment reductions and reporting requirements for clinical diagnostic laboratory tests as required under the *Protecting Access to Medicare Act (PAMA).* These changes have been delayed through congressional intervention since 2021.

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.

Physicians participating in MIPS are measured under 4 performance categories:

- Cost (30 percent of final score)
- Quality (30 percent of final score)
- Promoting Interoperability (25 percent of final score)
- Improvement Activities (15 percent of final score)

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

MIPS Performance Threshold

CMS finalized its proposal to maintain the MIPS performance threshold at 75 points for the 2025 performance year, marking a significant advocacy win for the AOA. In 2024, AOA expressed concern to CMS regarding a previous proposal to raise the performance threshold at a moment where CMS did not have accurate data on performance due to the COVID-19 PHE. In addition to seeking extreme and uncontrollable circumstance (EUC) exemptions from MIPS due to the PHE in 2024, practices have been faced with yet another challenge in 2024 as a result of the Change Healthcare cyberattack that disrupted practices across the country. Maintaining the performance threshold at 75 points will provide stability and an easy transition to physicians recovering from practice disruptions and enable CMS to collect performance data over a longer period of time.

Traditional MIPS

Quality Performance Category

CMS has finalized a measure set inventory of 195 measures, of which 192 are available in traditional MIPS and 3 are only available for physicians participating in MIPS Value Pathways (MVPs). Among the 195 measures in the quality measure inventory, 7 are newly finalized and 10 have been removed. Substantive changes were made to 66 measures. The above changes can be found in the final rule, as well as in CMS' QPP fact sheet. CMS has finalized 2 key overall changes impacting scoring in this category.

First, CMS finalized its proposal to modify 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. This proposal only applies to topped out measures that are (1) part of a specialty measures set with limited measure choice and a high proportion of topped out measures, and (2) in areas that lack measure development, which precludes meaningful participation in MIPS. Measures subject to this methodology can be found in the QPP fact sheet.

Second, CMS finalized its proposal to maintain the data completeness criteria threshold of at least 75 percent for the CY2027 and CY2028 performance periods/2029 and 2030 MIPS payment years. Meeting the data completeness threshold means the following:

An individual MIPS eligible clinician, group, virtual group, or APM Entity submitting measure data on:

1. qualified clinical data registry (QCDR) measures, MIPS clinical quality measures (CQMs), or eCQMs must submit data on at least a specific percent of their patients that meet the measure's denominator criteria, regardless of payer; or
2. Medicare Part B claims measures must submit data on at least a specified percent of their Medicare Part B patients seen during the corresponding performance period.

An APM Entity, specifically a Shared Savings ACO that meets the reporting requirements under the APP, submitting quality measure data on Medicare CQMs must submit data on:

1. at least a specified percent of the APM Entity's applicable beneficiaries eligible for the Medicare CQM who meet the measure's denominator criteria.

Cost Performance Category

CMS finalized three key changes to the cost category. First, CMS will add six new episode-based cost measures in 2025 which include Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, Rheumatoid Arthritis, and Respiratory Infection Hospitalization. The measures will be implemented at the group (TIN) and clinician (TIN/NPI) level with a 20-episode case minimum.

Second, in response to concerns about cost performance category scoring having a negative impact on physicians' final scores, CMS is modifying the methodology for scoring cost measures beginning with the 2024 performance period/2026 payment year. Specifically, 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, CMS is finalizing a new cost measure exclusion policy where the agency will exclude a cost measure if the significant changes or errors affect the performance period, leading to misleading or inaccurate results. This policy will begin with the CY2024 performance period/2026 payment year.

Improvement Activities Performance Category

CMS has finalized an inventory of 104 measures in the improvement activities performance category, including 2 new activities, the removal of 4 activities, and modification of 1 activity.

CMS has finalized scoring changes that will substantially simplify scoring under this category. CMS has eliminated “high” and “medium” weighting for measures that has made reporting under this category unnecessarily complex. Instead, the agency will simply require MIPS eligible clinicians to report two improvement activities to receive full credit. This is a substantial shift from prior policy where the number of measures physicians needed to report depended on the weighting of the measures reported.

Promoting Interoperability Performance Category

Key changes in the promoting interoperability (PI) category relate to data submission, which is described later in this document. In the final rule, CMS highlights its intentions to use the PI category to further advance the use of Fast Healthcare Interoperability Resources (FHIR) application programming interfaces and promote cybersecurity best practices.

MIPS Value Pathways

MVP Scoring

CMS finalized proposals to update the scoring of population health measures in MVPs by using the highest score of all available population health measures, and to remove the requirement for MVP Participants to select a population health measure at the time of MVP registration.

To align MVP scoring with changes made in this rule for traditional MIPS, CMS modified the improvement activities performance category in MVP scoring policies to remove references to high- and medium-weighted activities. Because of this change, CMS made changes to require MVP participants to report one activity to achieve a full score in the improvement activities performance category. Prior to this change, MVP participants were required to report one high-weighted activity or two medium weighted activities to receive a full score.

New MIPS Value Pathways

CMS finalized 6 new MVPs to promote broader participation across specialties. The new MVPs include:

- Complete Ophthalmologic Care
- Dermatological Care
- Gastroenterology Care
- Optimal Care for Patients with Urologic Conditions
- Pulmonology Care
- Surgical Care

Currently, participation in MVPs is optional. However, CMS has stated that its goal is to fully shift participation into MVPs or Alternative Payment Models (APMs) and ultimately sunset traditional MIPS. CMS stated in the proposed rule that they anticipate they may be ready to fully transition to MVPs by the CY2029 performance period/2031 MIPS payment year, but the agency stated in the final rule that no official timeline has been established and must still establish a comprehensive range of participation options across specialties.

MVP Reporting

CMS will move forward with its policy beginning in the 2026 performance year/2028 payment year, requiring multispecialty groups who chose to participate in an MVP (rather than traditional MIPS) to report at the subgroup, individual, or (if applicable) APM entity level, rather than at the group level.

APM Performance Pathway Plus Quality Measure Set

CMS finalized its proposal to create a new APM Performance Pathway (APP) Plus measure set which participants in Medicare Shared Savings Program ACO participants will be required to report. The measure set will be optional for MIPS eligible clinicians, groups, and APM Entities participating in MIPS APMs.

The APP Plus measure set is comprised of 6 current APP quality measures and 5 universal foundation measures. In CY2025, participants would only report 6 measures with the set incrementally expanding through CY2028. CMS states that the creation of the APP Plus measure set supports the agency's goal of streamlining and aligning quality measures across programs. However, the new requirement to report these measures will likely create additional administrative burden for Advanced APM participants.

The table in Appendix E outlines the APP Plus Measure set, including the timeline along which new measures will be added and required.

Data Submission

Individual MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities generally submit data on measures and activities for the quality, improvement activities, and promoting interoperability performance categories, and CMS considers any submission made towards scoring. To mitigate the negative scoring impact of unintentional submissions that do not contain data, CMS is finalizing policy to establish minimum criteria for qualifying data submissions.

To support data submission from multiple sources within the quality and improvement activities performance categories, CMS has finalized that for multiple data submissions received from submitters in multiple organizations (e.g., a vendor and practice), CMS will calculate a score for each submission received and assign the highest scores. However, in the case of multiple submissions from the same organization, CMS will score the most recent submission. CMS is finalizing a similar policy for the promoting interoperability category, assigning the highest of the scores calculated when multiple submissions are received.

Medicare Shared Savings Program Provisions

Health Equity Benchmark Adjustment

CMS has finalized its proposal to adjust an ACO's historical benchmark based on the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) or dually eligible for Medicare and Medicaid. CMS' stated goal is to incentivize practices serving higher proportions of beneficiaries from underserved communities to enter and remain in the program.

Prepaid Shared Savings

CMS has finalized its proposal to establish a new "prepaid shared savings" option in which eligible ACOs with a history of shared savings can be approved for advance shared savings they can use to invest in enhanced care services, care coordination, or infrastructure. The payments would be distributed on a quarterly basis and recouped from shared savings. CMS will require that 50 percent of the prepaid shared savings be spent on direct beneficiary services.

APM Performance Pathway (APP)

CMS is moving forward with two key changes to the APM performance pathway. First, CMS is requiring that MSSP ACOs in the APP report all measures under the newly created APP Plus measure set. Details regarding this measure set can be found in the QPP section of this document on page 39. Second, CMS is moving forward with sunset of the Web Interface and removal of the MIPS clinical quality measure (CQM) reporting option for ACOs.

Questions?

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

Appendices

Appendix A: Medicare Payment Calculation Formula

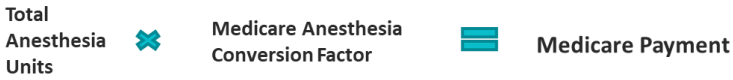
Step 1: Calculate Total RVUs

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 Services List

Code	Descriptor	Finalized Status
	PrEP for HIV	
G0011	Individual counseling for preexposure prophylaxis (PrEP) by physician or QHP to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes	Permanent
G0013	Individual counseling for preexposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence	Permanent

Caregiver Training		
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	Provisional
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service)	Provisional
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	Provisional
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes	Provisional
96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)	Provisional
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes	Provisional
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use G0542 in conjunction with G0541)	Provisional

G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers	Provisional
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes	Provisional
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes	Provisional
Safety Planning Interventions		
G0560	Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe; (List separately in addition to an E/M visit or psychotherapy)	Permanent

Appendix D: Work RVUs for New and Revised Codes

This table, which can be found on pages 344-362 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.

Code	Short Descriptor	Current Work RVUs	New Work RVUs
15011	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	New	C
15012	Harvest of skin for skin cell suspension autograft; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)	New	C
15013	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin	New	C
15014	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure)	New	C
15015	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less	New	C
15016	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	New	C
15017	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less	New	C
15018	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	New	C
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	8.08	9.00
25447	Arthroplasty, intercarpal or carpometacarpal joints; interposition (e.g., tendon)	11.14	10.50
25448	Arthroplasty, intercarpal or carpometacarpal joints; suspension, including transfer or transplant of tendon, with interposition, when performed	New	11.85
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	6.90	9.00
36514	Therapeutic apheresis; for plasma pheresis	1.81	1.81
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	1.56	1.56
36522	Photopheresis, extracorporeal	1.75	1.75
38225	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	New	B
38226	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)	New	B

38227	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration	New	B
38228	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	New	3.00
49186	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less	New	22.00
49187	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm	New	28.65
49188	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 10.1 to 20 cm	New	34.00
49189	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm	New	40.00
49190	Excision or destruction, open, intra-abdominal (i.e., peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm	New	50.00
51721	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed	New	4.05
53865	Cystourethroscopy with insertion of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate	New	3.10
53866	Catheterization with removal of temporary device for ischemic remodeling (i.e., pressure necrosis) of bladder neck and prostate	New	1.48
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation	New	9.80
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed	New	11.50
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	0.79	1.20
60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	New	5.75
60661	Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)	New	4.25
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target,	New	18.95

	intracranial, including stereotactic navigation and frame placement, when performed		
64466	Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	New	1.50
64467	Thoracic fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed	New	1.74
64468	Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed	New	1.67
64469	Thoracic fascial plane block, bilateral; by continuous infusion(s), including imaging guidance, when performed	New	1.83
64473	Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	New	1.34
64474	Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed	New	1.67
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	1.20
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	1.48	1.39
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.60	1.40
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	1.80	1.75
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5.10	5.10
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	3.79	3.79
66680	Repair of iris, ciliary body (as for iridodialysis)	6.39	7.97
66682	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (e.g., McCannel suture)	7.33	8.74
66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed	New	10.67
76014	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes	New	0.00
76015	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30	New	0.00

	minutes (List separately in addition to code for primary procedure)		
76016	MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR examination, analysis of risk vs clinical benefit of performing MR examination, and determination of MR equipment, accessory equipment, and expertise required to perform examination, with written report	New	0.60
76017	MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or other qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies, with written report	New	0.76
76018	MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room, with written report	New	0.75
76019	MR safety implant positioning and/or immobilization under supervision of physician or other qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room, with written report	New	0.60
76981	Ultrasound, elastography; parenchyma (e.g., organ)	0.59	0.59
76982	Ultrasound, elastography; first target lesion	0.59	0.59
76983	Ultrasound, elastography; each additional target lesion	0.50	0.47
77012	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation	1.50	1.50
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose	X	X
90832	Psychotherapy, 30 minutes with patient	1.78	1.86
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	1.57	1.64
90834	Psychotherapy, 45 minutes with patient	2.35	2.45
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	1.99	2.08
90837	Psychotherapy, 60 minutes with patient	3.47	3.63
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	2.62	2.74
90839	Psychotherapy for crisis; first 60 minutes	3.28	3.43

90840	Psychotherapy for crisis; each additional 30 minutes	1.57	1.64
90845	Psychoanalysis	2.20	2.30
90846	Family psychotherapy (without the patient present), 50 minutes	2.51	2.63
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	2.62	2.74
90849	Multiple-family group psychotherapy	0.62	0.65
90853	Group psychotherapy (other than of a multiple-family group)	0.62	0.65
92132	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral	0.30	0.29
92133	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	0.40	0.31
92134	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina	0.45	0.32
92137	Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography	New	0.64
93886	Transcranial Doppler study of the intracranial arteries; complete study	0.91	0.90
93888	Transcranial Doppler study of the intracranial arteries; limited study	0.50	0.73
93892	Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection	1.15	1.15
93893	Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection	1.15	1.15
93896	Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)	New	0.81
93897	Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)	New	0.73
93898	Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)	New	0.85
96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter	New	0.00
96156	Health behavior assessment, or re-assessment (i.e., health focused clinical interview, behavioral observations, clinical decision making)	2.20	2.30
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	1.52	1.59
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	0.52	0.55
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	0.22	0.23

96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	0.10	0.11
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	1.62	1.70
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	0.58	0.60
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	0.24
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection	0.17	0.17
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	C	6.53
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes	C	3.00
96920	Excimer laser treatment for psoriasis; total area less than 250 sq cm	1.15	0.83
96921	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm	1.30	0.90
96922	Excimer laser treatment for psoriasis; over 500 sq cm	2.10	1.15
97012	Application of a modality to 1 or more areas; traction, mechanical	0.25	0.25
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	0.18	0.18
97016	Application of a modality to 1 or more areas; vasopneumatic devices	0.18	0.18
97018	Application of a modality to 1 or more areas; paraffin bath	0.06	0.06
97022	Application of a modality to 1 or more areas; whirlpool	0.17	0.17
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	0.25	0.25
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	0.26	0.26
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	0.21	0.21
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	0.21	0.21
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	0.45	0.45
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	0.50	0.50
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	0.48	0.48
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	0.45	0.45

97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	0.43	0.43
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	0.44	0.44
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	0.48	0.48
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	0.45	0.45
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	0.48	0.48
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes	0.48	0.48
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	0.60	0.61
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	0.50	0.46
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	0.65	0.74
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)	0.55	0.47
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion	New	0.30
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	C	0.21
G0168	Wound closure utilizing tissue adhesive(s) only	0.31	0.31
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	0.18	0.18
G0442	Annual alcohol misuse screening, 5 to 15 minutes	0.18	0.18

G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	0.45	0.60
G0444	Annual depression screening, 5 to 15 minutes	0.18	0.18
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	0.45	0.60
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	0.45	0.60
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	0.45	0.60
G0465	Autologous platelet rich plasma (prp) or other blood derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	C	1.83
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)	1.82	1.82
G0517	Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	2.10	2.10
G0518	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	3.55	3.55
G0537	Administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment, 5-15 minutes, not more often than every 12 months	New	0.18
G0538	Atherosclerotic Cardiovascular Disease (ASCVD) risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at intermediate, medium, or high risk for CVD as previously determined by the ASCVD risk assessment; ASCVD-Specific care plan established, implemented, revised, or monitored that addresses risk factors and risk enhancers and must incorporate shared decision-making between the practitioner and the patient; clinical staff time directed by physician or other qualified health care professional; per calendar month	New	0.18
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes	New	1.00
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes	New	0.54
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes	New	1.00

G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	New	0.54
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers	New	0.23
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month.	New	1.00
G0545	Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and/or 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, subsequent or discharge)	New	0.89
G0546	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review	New	0.35
G0547	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review	New	0.70
G0548	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review	New	1.05
G0549	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's	New	1.40

	treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review		
G0550	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time	New	0.70
G0551	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes	New	0.70
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	New	C
G0553	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the DMHT device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	New	0.62
G0554	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the DMHT device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month. (List separately in addition to HCPCS code G0553)	New	0.61
G0555	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring	New	C
G0556	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: ● Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.	New	0.25

	++ Document in patient's medical record that consent was obtained. ● Initiation during a qualifying visit for new patients or patients not seen within 3 years; ● Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; ● Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; ● Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; ● Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management. ● Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; ● Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ● Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; ● Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other		

	communication technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits). ● Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; ● Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; ● Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology.		
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: ● Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ Document in patient's medical record that consent was obtained. ● Initiation during a qualifying visit for new patients or patients not seen within 3 years; ● Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; ● Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; ● Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; ● Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management.	New	0.77

	● Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; ● Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ● Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; ● Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits). ● Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; ● Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; ● Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology		
G0558	Advanced primary care management services for a patient that is a Qualified Medicare Beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all	New	1.67

	primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: ● Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ Document in patient's medical record that consent was obtained. ● Initiation during a qualifying visit for new patients or patients not seen within 3 years; ● Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; ● Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; ● Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; ● Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management. ● Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; ● Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. ● Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial		

	strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; ● Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits). ● Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; ● Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; ● Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology		
G0559	Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90- day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: ++ Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation. ++ Research the procedure to determine expected postoperative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). ++ Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. ++ Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established	New	0.16
G0560	Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky	New	1.09

	substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe		
G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (List separately in addition to 69433)	New	C
G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	New	C
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	New	C
G0564	Creation of subcutaneous pocket with insertion of 365-day implantable interstitial glucose sensor, including system activation and patient training	New	C
G0565	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365-day implantable sensor, including system activation	New	C

Appendix E: APP Plus Quality Measure Set

Year Required	Measure #	Measure Title	Collection Type	Submitter Type
Beginning CY 2025	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2025	134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2025	236	Controlling High Blood Pressure	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2025	321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary

Beginning CY 2025	479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible MIPS Clinician Groups	Administrative Claims	N/A
Beginning CY 2025	112	Breast Cancer Screening	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2026	484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A
Beginning CY 2026	113	Colorectal Cancer Screening	eCQM/MIPS CQM/Part B Claims (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2027	305	Initiation and Engagement of Substance Use Disorder Treatment	eCQM (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2028	487	Screening for Social Drivers of Health	eCQM/MIPS CQM (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary
Beginning CY 2028	493	Adult Immunization Status	eCQM/MIPS CQM (all APP reporters) Medicare CQM (SSP ACOs only)	MIPS Eligible Clinician Representative of a Practice APM Entity Third Party Intermediary