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CY 2022 Medicare Physician Fee Schedule Proposed Rule
Major Provisions

On July 13, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule for the 2022 Medicare Physician Fee Schedule (MPFS): https://www.govinfo.gov/content/pkg/FR-2021-07-23/pdf/2021-14973.pdf. Comments are due no later than September 13, 2021. We anticipate that the final rule will be published in early November 2021 and will become effective for services provided starting on January 1, 2022.

This document provides ASH Members with a summary of the major provisions of the MPFS proposed rule impacting Hematologists/Oncologists, including charts showing physician work relative value units and national average Medicare payment rates for Hem/Onc and evaluation and management (E/M) services.

Proposed Conversion Factor

CMS is proposing a conversion factor (CF) of $33.58 in CY 2022, which is a decrease of 3.75% from the CY 2021 CF of $34.89. The conversion factor is used to convert the physician fee schedule relative value units for physician work, practice expense, and malpractice expense into Medicare's payment rates. The decrease in the CF for CY 2022 is due to the fact that Congress mandated a 3.75% increase in the 2021 CF to hold physicians harmless from the required budget neutrality adjustment that was occurring due to the changes in E/M and other services' coding values in 2021. The American Medical Association (AMA) and other medical societies will be advocating for Congress to prevent the 3.75% reduction in the CF from occurring in 2022.

Proposed Rule Impact on Hematology and Hematology/Oncology and E/M Services

Attached to this summary is a specialty impact chart provided by the AMA that reflects the impact on specialties for the provisions in the proposed rule, including the proposed CF reduction. Also, attached are the specialty specific charts for Hematology and Hematology/Oncology and E/M Services.

The CY 2022 PFS proposed rule presents a series of standard technical proposals involving practice expense, including the implementation of the fourth year of the market-based supply and equipment pricing update, changes to the practice expense for many services associated with the proposed update to clinical labor pricing, and standard rate-setting refinements.

The specialty impact chart is showing an overall decrease in payment for Hematology services of 5.1% and Hematology/Oncology services of 5.8%. If Congress acts to restore the 3.75% decrease in the CF, the specialty will experience a minimal decrease in payment due to the rule in CY 2022.
The most significant impact on payment is for office-based Hematology/Oncology services where proposed reductions range from 10% – 18%. This is largely due to the changes proposed in the labor component used to calculate the Practice Expense RVUs. Reductions in hospital-based services and

E/M services are also proposed, but these are largely due to the 3.75% reduction in the CF, which Congress may act to reinstate.

Chronic Pain Management Services: CMS is seeking comments on whether to create separate coding and payment for medically necessary chronic pain management and opioid reduction services, particularly whether the costs would be best captured through an add-on or stand-alone code, in what healthcare settings and stages in treatment these transitions typically occur, and what types of practitioners can furnish these services.

Evaluation and Management

Split or Shared Visits
CMS is proposing changes in the reporting of split or shared services, which are services furnished in a facility setting by a physician and a non-physician provider (NPP) in the same group. CMS is proposing to allow physicians and NPPs to bill for split (or shared) visits for both new and established patients and for critical care and certain Skilled Nursing Facility /Nursing Facility (SNF/NF) E/M visits. CMS is proposing that the provider who performs the substantive portion (more than half of the total time) of the split visit would bill for the visit. The total time for the service would equal the sum of the distinct time spent by each provider. CMS references CPT E/M Guidelines in listing the activities that can count toward total time for purposes of determining the substantive portion. For visits that are not critical care services, CMS is proposing the same listing of activities that can count when time is used to select E/M visit level, regardless of whether direct patient contact is involved.

Critical Care Services
CMS is proposing to allow that more than one provider can furnish critical care services using the split/shared services rules as described above. CMS is also proposing that no other E/M service may be provided on the same day as the critical care service to the same patient and that critical care visits cannot be reported during the same time period as a procedure with a global surgical period.
Teaching Physicians Reporting of E/M Services

CMS is proposing that when total time is used to determine the office/outpatient E/M visit level, the time that the teaching physician is present can be included in determining what level code to report. After the COVID-19 public health emergency (PHE), CMS proposes that teaching physician presence requirements can be met through audio/video real-time communication technology only in residency training sites located outside of metropolitan statistical areas (MSAs) and must otherwise be in-person. While the PHE is in effect, the time of the teaching physician when they are present through audio/video real-time communications technology may also be included in the total time considered for visit level selection.

Direct Supervision Requirements

CMS is soliciting comment on whether the temporary flexibility during the PHE for direct supervision requirements to be met through virtual presence using real-time audio/visual technology should be further extended or be made permanent.

Telehealth

During the COVID-19 PHE CMS has waived the geographic and site of service originating site restrictions for Medicare telehealth services, allowing Medicare beneficiaries to receive care from their homes. These flexibilities remain in effect as long as the PHE declaration is in place, which is expected to continue through CY 2021. CMS does not propose to permanently waive these restrictions in the MPFS because the agency states that it lacks authority to make this adjustment. Without this change in requirements, physicians will not be able to use the office/outpatient E/M codes to provide telehealth services to patients in their homes beyond the PHE. CMS does make an exception to this rule for the diagnosis, evaluation, and treatment of a patient with a mental health disorder and will allow for audio-only telehealth mental health services.

In last year's final rule, CMS referred to three different categories for telehealth codes: Category 1, which represents services that are similar to professional consultation, office visits, and office psychiatry services that are currently on the Medicare telehealth services list, Category 2, which includes services that are not similar to those on the current Medicare telehealth services list, and a new Category 3 to represent services added to the telehealth list on a temporary basis, where CMS is interested in gathering data and additional information on whether these should be made permanent. In this rule, CMS is proposing to allow the services temporarily added to the telehealth services list in the CY2021 MPFS to remain on the list through Dec. 31, 2023. This will enable CMS to collect data to determine whether these services should be permanently added to the telehealth list following the COVID-19 PHE.

Virtual Check-In Service – CMS is proposing to permanently adopt coding and payment for HCPCS code G2252 (brief communication technology-based service, such as virtual check-in service) as described in the CY 2021 PFS final rule. The service can be provided by any form of telehealth communication technology, including audio-only.

Medicare Part B Drugs

CMS is proposing to require drug manufacturers to report each quarter's average sales price (ASP) data for all national drug codes (NDCs) under the same U.S. Food and Drug Administration approval application for Part B drugs regardless of whether they have Medicaid drug rebate agreements. CMS proposes to include any item, service, supply, or product payable under Part B as a drug or biological in existing drug pricing reporting requirements and will include drug repackagers in this requirement. Prior to this rule only manufacturers with Medicaid agreements had to report this data to CMS.

E-Prescribing for Part D Drugs

Due to the pandemic, CMS is proposing to delay the e-prescribing compliance date from Jan. 1, 2022, to Jan. 1, 2023. Violators will receive a letter from CMS asking why they are not in compliance. At this time, CMS is not proposing payment penalties but will reevaluate in future rulemaking. CMS also proposes to extend the compliance deadline for Part D controlled substance prescriptions written for beneficiaries in long-term care facilities (excluding residents of nursing facilities covered under Part A) from Jan. 1, 2022, to Jan. 1, 2025.

Physician Assistant (PA) Services

By law, effective Jan. 1, 2022, PAs are authorized to bill the Medicare program and be paid directly for their services, including incident to services. They may also reassign their billing rights and choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, as nurse practitioners do. CMS is proposing to implement these policies in this rule.

Open Payments Program and Physician Self-Referral Law

CMS additionally proposes changes in these two important areas. First, CMS provides details on data reporting requirements related to the Open Payments Program which publicly posts information about the financial relationships between the pharmaceutical and medical device industry and providers. More information can be found at pages 39333-39337 of the proposed rule on the Open Payment Program. Second, CMS updates the Physician Self-Referral Law, also known as the "Stark Law," which restricts a physician from making referrals to an entity for certain healthcare services if the physician has a financial relationship with the entity. More information on the Physician Self-Referral Law is provided on pages 39319-39326 of the proposed rule. ASH recommends that its members seek input from their institutions and/or legal counsel regarding participation in these programs.

Excerpt from the American Medical Association (AMA) Summary Quality Payment Program (QPP)

MIPS Value Pathways (MVPs) and Subgroups

In response to concerns raised by the AMA and the Federation that MIPS is overly burdensome and not clinically relevant, MVPs are intended to hold physicians accountable for cost, quality and use of technology around a condition or episode of care. CMS proposes an initial set of MVPs and detailed scoring and registration policies for individual clinicians, groups, and subgroups interested in participating in this voluntary option beginning in 2023. The proposed MVPs include Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia.

The proposed MVP scoring methodology responds to some of the recommendations made to CMS by the AMA after significant consultation with specialty and state medical societies, such as fewer check-the-box reporting requirements. Specifically, CMS proposes to require MVP participants select four, rather than six, quality measures; two medium-weighted or one high-weighted improvement activity; and be scored on only the cost measures included in the MVP. Unfortunately, however, CMS maintains many of the same traditional MIPS reporting and scoring requirements, including requiring reporting on the same Promoting Interoperability measures required under traditional MIPS. Additionally, CMS proposes to require MVP participants to select one population health measure to be scored on.

CMS proposes to establish a subgroup reporting option for MVP participation by a subset of clinicians in a multispecialty group. To form a subgroup, interested clinicians must identify the MVP the

subgroup will report on, identify the clinicians in the subgroup by TIN/NPI, and provide a plain language name for the subgroup for purposes of public reporting. Registration for both MVPs and subgroups would take place between April 1 and Nov. 30 of the performance period. Subgroups would be scored at the subgroup level on Quality, Cost, and Improvement Activities and would receive the group's Promoting Interoperability score. CMS proposes to use performance period benchmarks, or a different baseline period, such as calendar year 2019, for scoring quality measures in the 2022 performance period.

CMS also requests comment on moving to mandatory subgroup reporting beginning in 2025 for multispecialty groups interested in MVP participation and potentially phasing out traditional MIPS after the 2027 performance year, and mandating MVP participation for all MIPS clinicians beginning in 2028.

Quality Performance Category

As required by statue, CMS proposes to reduce the weight of Quality Performance Category from 40 percent to 30 percent of the final MIPS score in 2022 and beyond. CMS proposes to update quality measure scoring to remove end-to-end electronic reporting and high-priority measure bonus points as well as the 3-point floor for scoring measures (with some exceptions for small practices). In addition, extend the CMS Web Interface as a quality reporting option for registered groups, virtual groups, or other APM Entities for the 2022 performance period, as well as update the quality measure inventory (a total of 195 proposed for the 2022 performance period). Lastly, increase the data completeness requirement to 80 percent beginning with the 2023 performance period.

Cost Performance Category

As required by statute, CMS proposes to increase the weight of the Cost Performance Category from 20 to 30 percent of the final MIPS score in 2022 and beyond. CMS proposes to add five new episode-based cost measures, including the first chronic condition cost measures. The proposed measures include Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease, and Diabetes. Measure specifications can be downloaded here. CMS also proposes a new process for stakeholders to develop cost measures for MIPS beginning in 2022 for earliest adoption in MIPS in 2024. Finally, CMS proposes criteria for determining whether a cost measure change is considered substantive and thus must be proposed through notice-and-comment rulemaking before it is implemented in MIPS.

Improvement Activities Category

CMS included several new proposals for the Improvement Activities (IA) Performance Category for the 2022 performance year and beyond. Most substantively, it included a proposal around group reporting requirements to address subgroup participation. Essentially, each IA for which groups and virtual groups attest to performing must be performed by at least 50 percent of the NPIs that are billing under the group's TIN or virtual group's TINs or that are part of the subgroup, as applicable. The NPIs must perform the same activity during any continuous 90-day period within the same performance year. If, for example, out of a group of 100 Eligible Clinicians, 30 of them choose to form a subgroup, 15 Eligible Clinicians in the subgroup must perform the IA, and 35 (50 percent of the group's remaining 70 Eligible Clinicians) must perform an IA on behalf of the larger group to receive credit. Additionally, CMS revised the timeframe for IAs nominated during a public health

emergency; revised the required criteria for IA nominations received through the Annual Call for Activities; and added seven new IAs, modified 15 existing IAs, and removed six existing IAs. It also proposed a process to suspend IAs that raise possible safety concerns or become obsolete from the program when this occurrence happens outside of the rulemaking process.

Promoting Interoperability Category

CMS included several new proposals for the Promoting Interoperability (PI) Category for the 2022 performance year. Most notably, CMS is proposing that physicians meet the requirements of two new measures. For the first new measure, CMS is proposing that physicians must report "yes" to being in active engagement with a public health agency to a) electronically submit case reporting of reportable conditions, and b) submit and receive immunization data. Unless an exclusion can be used, physicians who fail to report "yes" on either (a) or (b) would score zero for the PI category. For the second new measure, CMS is proposing to require that physicians attest "yes" to having conducted an annual self-assessment of the high priority practices listed in ONC's SAFER Guides. CMS is also proposing to require that physicians make patient health information available indefinitely starting with encounters on or after January 1, 2016. CMS is proposing to reduce the required attestation statements physicians must make related to actions taken that limit or restrict the compatibility or interoperability of EHRs. CMS is proposing to temporarily not require an application from physicians and small practices seeking to qualify for the small practice hardship exception and reweighting. Instead, the exception would be applied automatically. Lastly, CMS includes three requests for information regarding technical standards and additional PI considerations.

Advanced Alternative Payment Models (Advanced APMs)

CMS notes that during the 2019 Qualifying APM Participant (QP) performance period, 195,564 eligible clinicians earned QP status and 27,995 earned partial QP status. These QPs received a five percent lump sum incentive payment in 2021. For the 2022 QP performance period, CMS estimates that between 225,000 and 290,000 eligible clinicians will become QPs, be excluded from MIPS, and qualify for the lump sum APM incentive payment in 2024. Each year that the QP incentive payments have been made, there have been thousands of physicians who CMS has had difficulty locating to make their payments, although the number declined from more than 20,000 in 2019 to fewer than 10,000 in 2021. CMS now proposes some changes in how it accesses the TIN information for QPs to increase the likelihood of paying incentive payments in a timely manner. Advanced APMs for 2022 are: Bundled Payments for Care Improvement Advanced; Comprehensive Care for Joint Replacement; Global and Professional Direct Contracting; Kidney Care Choices; Maryland Total Cost of Care; Medicare Shared Savings Program; Oncology Care Model; Primary Care First; Radiation Oncology model; and Vermont All-Payer ACO Model.

Other MIPS Policies

CMS proposes to increase the 2022 MIPS threshold to 75 points and the exceptional performance threshold to 89 points.

MIPS Threshold Score

As required by statute, beginning with the 2022 performance year/2024 payment year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. CMS proposes to increase the MIPS performance threshold, which must be achieved to avoid a penalty, from 60 to 75 points based on the mean final score from the 2017 performance period/2019 MIPS payment year.

Exceptional Performance Threshold

For the 2024 MIPS payment year, the additional performance threshold must be set at either 1) the 25th percentile of the range of possible final scores above the performance threshold, or 2) the 25th percentile of the actual final scores for MIPS eligible clinicians with final scores at or above the performance threshold with respect to a prior period. CMS proposes to increase the additional performance threshold from 85 to 89 points.

Projected 2022 MIPS Participation and 2024 Payment Adjustments

CMS estimates approximately 809,625 clinicians will be MIPS eligible in 2022. Due to the expiration of the MIPS transition policies and CMS proposals to fully implement the program as required by statute, CMS estimates the overall proportion of clinicians who will avoid a MIPS penalty and/or earn an incentive payment decreases from 91.7 percent to 67.5 percent. The mean final score would be 75.86 and the median would be 80.30. The maximum positive payment adjustment, including the exceptional bonus, is estimated to be 14 percent, while the maximum penalty is 9 percent. Under statute, the 2022 performance period is the last year that an exceptional performance bonus from a $500 million pool that is not tied to budget neutrality is available. Payment adjustments stemming from the 2022 performance period will be applied to 2024 Medicare payments.

2022 Proposed Physician Fee Schedule (CMS–1751–P)										
Payment Rates for Medicare Physician Services - Hematology/Oncology										
CPT Code	**Descriptor**	**2022**	**NON-FACILITY (OFFICE)**				**FACILITY (HOSPITAL)**			
			2022		**2021**	**% payment change 2021 to 2022**	**2022**		**2021**	**% payment change 2021 to 2022**
		Work RVUs	**Total RVUs**	**Payment CF=$33.5848**	**Payment CF=$34.8931**		**Total RVUs**	**Payment CF=$33.5848**	**Payment CF=$34.8931**	
20939	Bone marrow aspir bone grfg	1.16	NA	N/A	NA	NA	2.04	$68.51	$71.53	-4.2%
36430	Blood transfusion service	0.00	1.29	$43.32	$37.68	15.0%	NA	N/A	NA	NA
36511	Apheresis wbc	2.00	NA	N/A	NA	NA	3.17	$106.46	$111.66	-4.7%
36512	Apheresis rbc	2.00	NA	N/A	NA	NA	3.10	$104.11	$109.22	-4.7%
36513	Apheresis platelets	2.00	NA	N/A	NA	NA	3.09	$103.78	$110.26	-5.9%
36514	Apheresis plasma	1.81	16.01	$537.69	$661.92	-18.8%	2.73	$91.69	$95.96	-4.4%
36516	Apheresis, selective	1.56	48.23	$1,619.79	$2,041.60	-20.7%	2.56	$85.98	$86.19	-0.2%
36522	Photopheresis	1.75	41.03	$1,377.98	$1,767.68	-22.0%	2.82	$94.71	$99.45	-4.8%
38205	Harvest allogenic stem cells	1.50	NA	N/A	NA	NA	2.49	$83.63	$86.19	-3.0%
38206	Harvest auto stem cells	1.50	NA	N/A	NA	NA	2.47	$82.95	$86.19	-3.7%
38220	Bone marrow aspiration	1.20	4.62	$155.16	$172.37	-10.0%	1.98	$66.50	$70.83	-6.1%
38221	Bone marrow biopsy	1.28	4.78	$160.54	$165.39	-2.9%	2.07	$69.52	$70.83	-1.9%
38222	Dx bone marrow bx & aspir	1.44	5.24	$175.98	$181.44	-3.0%	2.23	$74.89	$78.16	-4.2%
38230	Bone marrow collection	3.50	NA	N/A	NA	NA	5.93	$199.16	$209.01	-4.7%
38232	Bone marrow harvest autolog	3.50	NA	N/A	NA	NA	5.80	$194.79	$203.78	-4.4%
38240	Bone marrow/stem transplant	4.00	NA	N/A	NA	NA	7.08	$237.78	$242.51	-1.9%
38241	Bone marrow/stem transplant	3.00	NA	N/A	NA	NA	5.23	$175.65	$180.05	-2.4%
38242	Lymphocyte infuse transplant	2.11	NA	N/A	NA	NA	3.70	$124.26	$129.45	-4.0%
88184	Flowcytometry/ tc, 1 marker	0.00	2.03	$68.18	$69.79	-2.3%	NA	N/A	NA	NA
88185	Flowcytometry/ tc, add-on	0.00	0.58	$19.48	$23.03	-15.4%	NA	N/A	NA	NA
88187	Flowcytometry/read, 2-8	0.74	1.04	$34.93	$36.64	-4.7%	1.04	$34.93	$36.64	-4.7%
88188	Flowcytometry/read, 9-15	1.20	1.81	$60.79	$62.81	-3.2%	1.81	$60.79	$62.81	-3.2%
88189	Flowcytometry/read, 16 & <	1.70	2.43	$81.61	$85.14	-4.1%	2.43	$81.61	$85.14	-4.1%
96360	Hydration iv infusion, init	0.17	0.91	$30.56	$36.29	-15.8%	NA	N/A	NA	NA
96361	Hydrate iv infusion, add- on	0.09	0.36	$12.09	$13.96	-13.4%	NA	N/A	NA	NA
96365	Ther/ proph/ diag iv inf, init	0.21	1.86	$62.47	$73.62	-15.2%	NA	N/A	NA	NA
96366	Ther/ proph/ dg iv inf, add- on	0.18	0.60	$20.15	$22.33	-9.8%	NA	N/A	NA	NA
96367	Tx/ proph/ dg addl seq iv inf	0.19	0.82	$27.54	$32.10	-14.2%	NA	N/A	NA	NA
96368	Ther/ diag concurrent inf	0.17	0.57	$19.14	$21.28	-10.1%	NA	N/A	NA	NA
96372	Ther/ proph/ diag inj, sc/ im	0.17	0.43	$14.44	$14.31	0.9%	NA	N/A	NA	NA
96373	Ther/ proph/ diag inj, ia	0.17	0.56	$18.81	$18.49	1.7%	NA	N/A	NA	NA
96374	Ther/ proph/ diag inj, iv push	0.18	1.06	$35.60	$41.87	-15.0%	NA	N/A	NA	NA
96375	Ther/ proph/ diag inj add- on	0.10	0.45	$15.11	$17.10	-11.6%	NA	N/A	NA	NA
96377	Applicaton on-body injector	0.17	0.54	$18.14	$20.24	-10.4%	NA	N/A	NA	NA

96401	Chemotherapy, sc/im	0.21	2.07	$69.52	$82.35	-15.6%	NA	N/A	NA	NA
96402	Chemo hormon antineopl sq/ im	0.19	1.07	$35.94	$33.15	8.4%	NA	N/A	NA	NA
96405	Intralesional chemo admin	0.52	2.34	$78.59	$87.58	-10.3%	0.83	$27.88	$29.31	-4.9%
96406	Intralesional chemo admin	0.80	3.67	$123.26	$136.08	-9.4%	1.31	$44.00	$45.36	-3.0%
96409	Chemo, iv push, sngl drug	0.24	2.88	$96.72	$113.40	-14.7%	NA	N/A	NA	NA
96411	Chemo, iv push, addl drug	0.20	1.57	$52.73	$62.11	-15.1%	NA	N/A	NA	NA
96413	Chemo, iv infusion, 1 hr	0.28	3.69	$123.93	$148.30	-16.4%	NA	N/A	NA	NA
96415	Chemo, iv infusion, addl hr	0.19	0.81	$27.20	$31.40	-13.4%	NA	N/A	NA	NA
96416	Chemo prolong infuse w/ pump	0.21	3.62	$121.58	$147.25	-17.4%	NA	N/A	NA	NA
96417	Chemo iv infus each addl seq	0.21	1.82	$61.12	$71.88	-15.0%	NA	N/A	NA	NA
96420	Chemotherapy, push technique	0.17	2.94	$98.74	$115.50	-14.5%	NA	N/A	NA	NA
96422	Chemotherapy,infusion method	0.17	4.48	$150.46	$180.05	-16.4%	NA	N/A	NA	NA
96423	Chemo, infuse method add-on	0.17	2.12	$71.20	$82.70	-13.9%	NA	N/A	NA	NA
96425	Chemotherapy,infusion method	0.17	4.84	$162.55	$192.96	-15.8%	NA	N/A	NA	NA
96440	Chemotherapy, intracavitary	2.12	24.35	$817.79	$995.85	-17.9%	3.69	$123.93	$125.62	-1.3%
96446	Chemotx admn prtl cavity	0.37	5.38	$180.69	$215.64	-16.2%	0.77	$25.86	$25.82	0.2%
96450	Chemotherapy, into CNS	1.53	4.76	$159.86	$182.49	-12.4%	2.25	$75.57	$78.86	-4.2%
96521	Port pump refill & main	0.21	3.74	$125.61	$152.83	-17.8%	NA	N/A	N/A	N/A
96522	Refill/ maint pump/ resvr syst	0.21	3.33	$111.84	$130.85	-14.5%	NA	N/A	N/A	N/A
96523	Irrig drug delivery device	0.04	0.72	$24.18	$28.96	-16.5%	NA	N/A	N/A	N/A
96542	Chemotherapy injection	0.75	3.64	$122.25	$140.27	-12.8%	1.23	$41.31	$42.22	-2.2%

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		Work RVUs	Total RVUs	Payment CF=$33.5848	Payment CF=$34.8931		Total RVUs	Payment CF=$33.5848	Payment CF=$34.8931	
99202	Office o/p new sf 15-29 min	0.93	2.18	$73.21	$73.97	-1.0%	1.41	$47.35	$49.90	-5.1%
99203	Office o/p new low 30-44 min	1.60	3.35	$112.51	$113.75	-1.1%	2.42	$81.28	$84.44	-3.7%
99204	Office o/p new mod 45-59 min	2.60	4.96	$166.58	$169.93	-2.0%	3.90	$130.98	$137.48	-4.7%
99205	Office o/p new hi 60-74 min	3.50	6.60	$221.66	$224.36	-1.2%	5.34	$179.34	$186.68	-3.9%
99211	Office o/p est minimal prob	0.18	0.69	$23.17	$23.03	0.6%	0.26	$8.73	$9.07	-3.7%
99212	Office o/p est sf 10-19 min	0.70	1.70	$57.09	$56.88	0.4%	1.05	$35.26	$36.29	-2.8%
99213	Office o/p est low 20-29 min	1.30	2.71	$91.01	$92.47	-1.6%	1.94	$65.15	$68.04	-4.2%
99214	Office o/p est mod 30-39 min	1.92	3.84	$128.97	$131.20	-1.7%	2.84	$95.38	$100.49	-5.1%
99215	Office o/p est hi 40-54 min	2.80	5.39	$181.02	$183.19	-1.2%	4.22	$141.73	$147.95	-4.2%
99221	Initial hospital care	1.92	NA	N/A	NA	NA	2.88	$96.72	$101.19	-4.4%
99222	Initial hospital care	2.61	NA	N/A	NA	NA	3.87	$129.97	$136.08	-4.5%
99223	Initial hospital care	3.86	NA	N/A	NA	NA	5.71	$191.77	$200.29	-4.3%
99231	Subsequent hospital care	0.76	NA	N/A	NA	NA	1.12	$37.61	$38.38	-2.0%
99232	Subsequent hospital care	1.39	NA	N/A	NA	NA	2.05	$68.85	$71.88	-4.2%
99233	Subsequent hospital care	2.00	NA	N/A	NA	NA	2.92	$98.07	$103.28	-5.1%
99291	Critical care first hour	4.50	8.14	$273.38	$282.98	-3.4%	6.29	$211.25	$220.87	-4.4%
99292	Critical care addl 30 min	2.25	3.56	$119.56	$123.87	-3.5%	3.16	$106.13	$110.96	-4.4%
99421	Ol dig e/m svc 5-10 min	0.25	0.45	$15.11	$15.00	0.7%	0.38	$12.76	$12.91	-1.1%
99422	Ol dig e/m svc 11-20 min	0.50	0.88	$29.55	$30.01	-1.5%	0.74	$24.85	$26.17	-5.0%
99423	Ol dig e/m svc 21+ min	0.80	1.42	$47.69	$47.45	0.5%	1.20	$40.30	$41.17	-2.1%
99446	Interprof phone/online 5-10	0.35	0.52	$17.46	$18.84	-7.3%	0.52	$17.46	$18.84	-7.3%
99447	Interprof phone/online 11-20	0.70	1.05	$35.26	$33.85	4.2%	1.05	$35.26	$33.85	4.2%
99448	Interprof phone/online 21-30	1.05	1.58	$53.06	$53.74	-1.2%	1.58	$53.06	$53.74	-1.2%
99449	Interprof phone/online 31/>	1.40	2.12	$71.20	$73.28	-2.8%	2.12	$71.20	$73.28	-2.8%
99451	Ntrprof ph1/ntrnet/ehr 5/>	0.70	1.05	$35.26	$36.29	-2.8%	1.05	$35.26	$36.29	-2.8%
99452	Ntrprof ph1/ntrnet/ehr rfrl	0.70	1.06	$35.60	$36.64	-2.8%	1.06	$35.60	$36.64	-2.8%
99453	Rem mntr physiol param setup	0.00	0.66	$22.17	$19.19	15.5%	NA	N/A	NA	NA
99454	Rem mntr physiol param dev	0.00	1.47	$49.37	$63.16	-21.8%	NA	N/A	NA	NA
99457	Rem physiol mntr 20 min mo	0.61	1.54	$51.72	$50.94	1.5%	0.90	$30.23	$31.75	-4.8%
99458	Rem physiol mntr ea addl 20	0.61	1.22	$40.97	$41.17	-0.5%	0.90	$30.23	$31.75	-4.8%
99471	Ped critical care initial	15.98	NA	N/A	NA	NA	22.75	$764.05	$792.07	-3.5%

99472	Ped critical care subsq	7.99	NA	N/A	NA	NA	11.60	$389.58	$403.36	-3.4%
99487	Cmplx chron care w/o pt vsit	1.81	4.12	$138.37	$91.77	50.8%	2.65	$89.00	$51.29	73.5%
99489	Cmplx chron care addl 30 min	1.00	2.14	$71.87	$43.97	63.5%	1.47	$49.37	$25.82	91.2%
99490	Chron care mgmt srvc 20 min	1.00	1.89	$63.48	$41.17	54.2%	1.48	$49.71	$31.75	56.5%
99491	Chrnc care mgmt svc 30 min	1.50	2.51	$84.30	$82.35	2.4%	2.22	$74.56	$82.35	-9.5%
99495	Trans care mgmt 14 day disch	2.78	6.27	$210.58	$207.96	1.3%	4.12	$138.37	$145.16	-4.7%
99496	Trans care mgmt 7 day disch	3.79	8.49	$285.13	$281.59	1.3%	5.60	$188.07	$197.49	-4.8%
G0396	Alcohol/subs interv 15-30mn	0.65	1.04	$34.93	$36.29	-3.7%	0.95	$31.91	$33.15	-3.7%
G0397	Alcohol/subs interv >30 min	1.30	1.98	$66.50	$67.69	-1.8%	1.90	$63.81	$64.55	-1.1%
G0506	Comp asses care plan ccm svc	0.87	1.88	$63.14	$61.76	2.2%	1.30	$43.66	$45.01	-3.0%