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PBN Perspectives

CMS' push for 'equity' won't change providers' lives today, but may soon

The term "health equity" is turning up frequently in CMS rulemaking. Its impact is mostly seen far upstream of medical practice work, but experts see a growing role for it in the value-based future, where equitable health treatment can pay off for both patients and providers.

If you read through the proposed 2020 Medicare physician fee schedule released July 13, you may have noticed multiple mentions of health equity as one of CMS' goals (*PBN 7/26/21*). For example, the rule solicits comments as to whether "services driven by or supported by innovative technology such as software algorithms and/or AI [are] associated with improvements in the quality of care or improvements in health equity."

CMS also asks for comments "on addressing health disparities and promoting health equity" in the Shared Savings accountable care organization (ACO) program, and mentions that its proposed all-payer electronic clinical quality measures (eCQM) and MIPS clinical quality measures (MIPS CQM) for the program "will help to address health disparities and promote health equity by promoting a single standard of care across all patients receiving care from practices participating in Shared Savings Program ACOs regardless of location or racial/ethnic group."

Equity may expand reporting

"Payers will be put in a position to address gaps in health care equity" in Shared Savings, says Dave Halpert, chief, client team at Roji Health Intelligence in Chicago, "and if they're really serious about it, they're not going to be able to do it by allowing ACOs to continue reporting on a relatively small sample of Medicare-only patients."

Get the skinny on the proposed PFS

With the proposed 2022 Medicare physician fee schedule out July 13, get an early look at the coming changes. Sign up for the Aug. 25 webinar **2022 Proposed Physician Fee Schedule: Get an Early Fix on Critical Updates** and you'll discover new revenue opportunities, payment and policy changes, and critical coding and billing updates on pace to impact your practice starting Jan. 1, 2022. Learn more: https://codingbooks.com/ympda082521.

Also, CMS proposes to include in 2022 an Achieving Health Equity Improvement Activity subcategory for MIPS, with “Create and Implement an Anti-Racism Plan” and “Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols” activities. The first activity is based on CMS’ Disparities Impact Statement and would include a “clinic-wide review of existing tools and policies” to “identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps” (*see resources, below*).

The second activity calls for “identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status … for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.” Providers still have several other improvement activities to choose from.

Equity is also mentioned as a factor in CMS’ decisions on the Medicare Diabetes Prevention Program and audio-only telehealth.

“Over the past year, the public health emergency has highlighted the disparities in the U.S. health care system, while at the same time demonstrating the positive impact of innovative policies to reduce these disparities,” said CMS Administrator Chiquita Brooks-LaSure in a press release related to the proposed rule. “CMS aims to take the lessons learned during this time and move forward toward a system where no patient is left out and everyone has access to comprehensive quality health services.”

Equity vs. equality

CMS takes its definition of “equity” from Executive Order (EO) 13985, issued by President Biden on Jan. 25, 2021. In that EO, equity is defined as “the consistent and systematic fair, just and impartial treatment of all individuals, including individuals who belong to underserved communities who have been denied such treatment, such as Black, Latino and Indigenous and Native American persons, Asian Americans, Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.”

The Jan. 25 EO is also mentioned in the recent Surprise Billing rule (*PBN 7/19/21*).

This “consistent and systematic fair, just and impartial treatment” may sound like a description of “equality,” especially considering that its opposite, inequality, is one of the adverse effects that equity is supposed to address. But experts say there’s a significant difference.

Amanda Simmons, executive vice president at Integrated Health Partners, a subsidiary of Health Care Partners of California (HCP) of Southern California in San Diego, notes that equality has been a mandate

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for government health care services since the mid-20th century, when President Harry Truman said the nation must "strive to make good health equally available to all citizens," as seen in major health-related legislative achievements such as Medicare and, later, the Affordable Care Act.

Providers will also be familiar with HHS-driven interventions to ensure equality of access by the Office for Minority Health (OMH), which takes the lead role on language and interpretation requirements for providers under the Civil Rights Act (*PBN 9/27/13*), and the Office for Civil Rights (OCR), better known for HIPAA enforcement authority but which also addresses discrimination in health care encounters involving racial minorities, the hearing-impaired, and gay and transgender patients, among others (*PBN 7/13/20*, *9/22/20*, *11/16/20*).

But equity means "moving to a patient-centric approach allowing [providers] to achieve the best health possible for each individual based on their individual situations," including social and other factors that may impact their care access, Simmons says.

Charles E. Binkley, M.D., director of bioethics for the Markkula Center of Santa Clara University in California and formerly a practicing surgeon, thinks of equity as not only "making sure that there is equal access [to care]" but also making sure that "there are not biases that favor certain patients and disfavor others in terms of access to that care."

Binkley offers an example from his own field of cancer surgery. "We know that Black patients do less well than white patients for almost every type of organ-specific cancer," he says. "And we also know that for many of those cancer types, Black patients aren't offered curative surgery as often as white patients — and often, even when they are offered curative surgery, they do less well. So the question then becomes: Is this something intrinsic to Black patients that puts them at higher risk? Or do they receive less high-quality care?"

How to boost equity

The most obvious interventions to achieve equity at present are metrics that take into account a patient's added challenges. Nicole Howard, chief advancement officer at Health Center Partners, mentions analysis of social determinants of health (SDOH) and their impact on a patient's health outcomes as a growing part of the equity mix.

In June 2021, the CDC released a series of new SDOH Z-codes that cover socioeconomic and psychosocial circumstances (**Z55-Z65**) (*PBN 7/19/21*). Among these codes is **Z59** (Problems related to housing and economic circumstances), which includes secondary codes including **Z59.0** (Homelessness), **Z59.1** (Inadequate housing) and **Z59.2** (Discord with neighbors, lodgers and landlord), among others. There are also codes for other housing issues, nutrition issues, problems with socialization, food insecurity — all of which can impact the patient's ability to accept, tolerate and recover from treatment.

Howard says HCP's member community health centers use SDOH "to analyze patient behaviors, needs and outcomes," and use that analysis in care planning and patient goal-setting, involving community-based organizations in care plans and strategy development.

There's also a role for risk adjustment in improving health equity. Binkley mentions a recent JAMA analysis of CMS' comprehensive care for joint replacement (CJR) bundle. The study authors report that CMS has included risk adjustment scoring for dual eligibility for Medicare and Medicaid for the CJR bundle, a status associated with lower-income patients, which the authors call "an important step that will give 'credit' to hospitals, to a certain extent, for caring for patients who are clinically and socially complex and recognize the higher resources needed for treating these patients."

Proactive approaches

Beyond these coding and payment considerations, you'll find some models currently in operation that actively make adjustments for equity purposes in real time.

Anna Mangum, MSW, MPH, deputy director for programs with the National Association of Social Workers (NASW) in Washington, D.C., points to integrated care organizations that employ clinical teams, including clinical social workers (CSW) who can assess the patient's equity shortfalls and create plans to address them.

This can be helpful not only in helping patients meet care needs, but also in revealing those needs; patients with "access-related challenges, displacement and life-long trauma" may have difficulty asking for or accepting help in the first place, Mangum says.

In such cases, a combination of counseling and "health-related coaching" — that is, interventions "aimed at enhancing health literacy, increasing knowledge about how the care team and PCP can be helpful to the patient, and building skills on how and when to communicate symptoms and side effects to their providers" — can get the patient to open up to care, Mangum says.

Kurt Waltenbaugh, CEO of Carrot Health, a health data solutions company in Minneapolis, says that population health data can help identify patients who need this kind of treatment. He describes a Carrot client project to reach patients whose SDOH status puts them at heightened risk of COVID-19 infection.

The client's previous outreach had been "largely dependent on the availability of self-reported data via survey response," Waltenbaugh says. "Because lower income and minority members were less likely to provide self-reported information through surveys, these members were previously contacted at a disproportionately lower rate, resulting in a lower level of program engagement." Carrot used proprietary tools to risk-stratify the client's patient population by social determinants and create appropriate messages to engage them.

Companies like these are at the cutting edge of equity now, well ahead of what CMS is requiring of providers — but it shows what may, in the near future, become standard procedure. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCES

- CMS Disparities Impact Statement: *www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf*
- JAMA Viewpoint article, "The Triple Aim for Payment Reform in Joint Replacement Surgery: Quality, Spending, and Disparity Reduction," July 23: *https://jamanetwork.com/journals/jama/fullarticle/2782537?resultClick=1*

Coding

CMS plans tougher critical care rules along with new split/shared policy

If you enjoyed the twists and turns of CMS' proposed split/shared policy, don't miss similar turbulence in the proposed guidelines for critical care services (**99291-99292**) that also are part of the proposed 2022 Medicare physician fee schedule.

Earlier in 2021, CMS withdrew its guidelines for critical care services in CMS Internet-only Manual 100-04, chapter 12, §30.6.12 at the same time it withdrew the guidelines for split/shared visits (*PBN 6/7/21*).

CMS intends to "adopt the CPT prefatory language as the definition of critical care services," and would lift its ban on split/shared billing for critical care services, according to the proposed rule.

This could allow more practices to provide critical care services, says Melissa Billman, director of billing services with CE Medical Group in Murray, Utah.

The split/shared critical care policy would resemble CMS' proposed split/shared policy (*PBN 7/26/21*):

- The physician and the qualified health care professional (QHP) from the same practice would add up the time they spend on certain activities.
- The practitioner who spends more than half of the time providing critical care services for the date of service would bill the service.
- Time would be based on a different listing of qualifying activities for split, or shared, critical care.

"These qualifying activities are described in prefatory language on pp. 31-32 of the CPT Codebook," CMS says in the proposed rule.

Example: "Critical care involves high complexity decision-making to assess, manipulate and support vital system function(s)," the manual states. Activities include those performed on the floor, such as "time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care."

In addition, CMS intends to clarify its guidelines for concurrent care by providers of different specialties.

(*continued on p. 6*)

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Benchmark of the week

Proposed cuts hit 38 of 40 high-utilization procedures, visits in CY2022

Last year saw plenty of double-digit cuts in the "selected procedures" that CMS traditionally calls out to show the impact of the proposed physician fee schedule (PFS) on a suite of Medicare's most frequently used codes (PBN 8/24/20).

The CY 2022 chart doesn't look as foreboding, but pay cuts are still expected across a range of services as a result of the nearly 4% cut to the Medicare PFS conversion factor. As you can see from the chart of high-utilization services, the proposed allowable fees for 38 of 40 high-utilization services are reduced from their 2021 versions. Only two services, **93015** (Cardiovascular stress test), which gets a 6% boost, and **17000** (Destruction premalignant lesion), with a 2% increase, are in the black. Other high-use codes, including E/M office visit codes **99203, 99213** and **99214**, are in the red.

History suggests that the 2022 final version of the selected procedures chart will not look much better than this proposed rule version. The proposed rate cuts for 2021 looked only slightly different in the 2021 final rule, after the across-the-board conversion factor cut was reduced from 11% to 10.2% (PBN 12/21/20). Industry groups are already on CMS' case about the proposed 2022 conversion factor, but the federal budget neutrality mandate suggests there isn't much room for improvement (PBN 7/26/21). – *Roy Edroso* (redroso@decisionhealth.com)

Impact on CY 2022 Payment for Selected Procedures

Code	MOD	Short descriptor	Facility			Non Facility		
			CY 2021[1]	CY 2022[2]	% Change	CY 2021[1]	CY 2022[2]	% Change
11721		Debride nail 6 or more	$24.43	$23.51	-4%	$45.36	$44.00	-3%
17000		Destruct premalg lesion	$54.43	$55.41	2%	$67.34	$68.18	1%
27130		Total hip arthroplasty	$1,322.45	$1,278.24	-3%	NA	NA	NA
27244		Treat thigh fracture	$1,263.48	$1,224.84	-3%	NA	NA	NA
27447		Total knee arthroplasty	$1,320.70	$1,276.89	-3%	NA	NA	NA
33533		Cabg arterial single	$1,908.30	$1,858.58	-3%	NA	NA	NA
35301		Rechanneling of artery	$1,150.77	$1,122.40	-3%	NA	NA	NA
43239		Egd biopsy single/multiple	$140.27	$137.36	-2%	$400.92	$360.70	-10%
66821		After cataract laser surgery	$315.08	$305.29	-3%	$339.51	$326.11	-4%
66984		Xcapsl ctrc rmvl w/o ecp	$548.17	$530.98	-3%	NA	NA	NA
67210		Treatment of retinal lesion	$501.41	$487.32	-3%	$522.35	$502.09	-4%
77427		Radiation tx management x5	$191.91	$190.43	-1%	$191.91	$190.43	-1%
88305	26	Tissue exam by pathologist	$37.68	$35.94	-5%	$37.68	$35.94	-5%
90471		Immunization admin	NA	NA	NA	$17.10	$16.46	-4%
90935		Hemodialysis one evaluation	$73.28	$70.53	-4%	NA	NA	NA
92012		Eye exam establish patient	$51.64	$48.70	-6%	$91.07	$88.33	-3%
92014		Eye exam&tx estab pt 1/>vst	$77.81	$74.22	-5%	$128.41	$125.27	-2%
93000		Electrocardiogram complete	NA	NA	NA	$15.00	$14.78	-2%
93010		Electrocardiogram report	$8.37	$8.06	-4%	$8.37	$8.06	-4%
93015		Cardiovascular stress test	NA	NA	NA	$71.88	$75.90	6%
93307	26	Tte w/o doppler complete	$45.36	$42.99	-5%	$45.36	$42.99	-5%
93458	26	L hrt artery/ventricle angio	$299.38	$288.49	-4%	$299.38	$288.49	-4%
98941		Chiropract manj 3-4 regions	$34.20	$32.91	-4%	$40.48	$38.96	-4%
99203		Office o/p new low 30-44 min	$84.44	$81.28	-4%	$113.75	$112.51	-1%
99213		Office o/p est low 20-29 min	$68.04	$65.15	-4%	$92.47	$91.01	-2%
99214		Office o/p est mod 30-39 min	$100.49	$95.38	-5%	$131.20	$128.97	-2%
99222		Initial hospital care	$136.08	$129.97	-5%	NA	NA	NA
99223		Initial hospital care	$200.29	$191.77	-4%	NA	NA	NA
99231		Subsequent hospital care	$38.38	$37.61	-2%	NA	NA	NA
99232		Subsequent hospital care	$71.88	$68.85	-4%	NA	NA	NA
99233		Subsequent hospital care	$103.28	$98.07	-5%	NA	NA	NA
99236		Observ/hosp same date	$214.59	$203.86	-5%	NA	NA	NA
99239		Hospital discharge day	$106.42	$102.43	-4%	NA	NA	NA
99283		Emergency dept visit	$72.93	$70.53	-3%	NA	NA	NA
99284		Emergency dept visit	$123.87	$119.56	-4%	NA	NA	NA
99291		Critical care first hour	$220.87	$211.25	-4%	$282.98	$273.38	-3%
99292		Critical care addl 30 min	$110.96	$106.13	-4%	$123.87	$119.56	-4%
99348		Home visit est patient	NA	NA	NA	$83.74	$80.27	-4%
99350		Home visit est patient	NA	NA	NA	$178.65	$170.95	-4%
G0008		Admin influenza virus vac	NA	NA	NA	NA	NA	NA

1 Payments based on the 1/1/2021 - 12/31/2021 conversion factor of 34.8931.

2 Payments based on the 2022 conversion factor of 33.5848, which includes the budget neutrality adjustment.

Source: *Proposed 2022 Medicare physician fee schedule supplementary data files*

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(continued from p. 4)

"I do think the idea of two people billing critical care services is important," says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati. "I think you do get two specialties working on the same patient. I think that was a good thing."

Expect stricter guidelines

CMS intends to reverse some policies in its original guidelines. It plans to clamp down on other E/M services provided on the same day as a critical care service.

"No other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group," CMS states in the proposed rule.

In an acknowledged departure from the original guidelines, CMS does not intend to cover critical care services during the global period of another service. "Because critical care visits are included in some 10- and 90-day global packages, we are proposing to bundle critical care visits with procedure codes that have a global surgical period," the agency states.

Finally, it would take more time to meet the requirements for add-on code 99292 when multiple practitioners add up their time.

"Under our proposal, once the cumulative required critical care service time is met to report CPT code 99291, CPT code 99292 would not be reported by the practitioner or another practitioner in the same specialty and group unless and until an additional 30 minutes of critical care services are furnished to the same patient on the same day (114 total minutes)," CMS states.

According to the withdrawn guidelines, a critical care service "may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292."

The withdrawn guidelines stated the practitioner could report one unit of 99292 at 75 minutes and two units at 105 minutes. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

RESOURCE

- CMS Internet-only Manual 100-04, chapter 12, §30.6.12 – Withdrawn

Physician fee schedule

Enrollment fee may disappear as CMS nudges diabetes prevention, nutrition therapy services

CMS is showing interest in shoring up the underutilized Medicare Diabetes Prevention Program (MDPP) and medical nutrition therapy (MNT) services in the proposed 2022 Medicare physician fee schedule.

The agency is proposing to waive the Medicare supplier enrollment application fee for MDPP, currently $599 but waived for the COVID public health emergency (PHE), beyond the PHE as well.

CMS also proposes to reduce the program timespan, which currently involves a year of core sessions and core maintenance sessions and a second year of ongoing maintenance sessions, to one year of core sessions and core maintenance sessions. This applies for new entrants starting Jan. 1, 2022, though current participants in the ongoing maintenance phase can continue in it if they maintain their attendance and 5% weight loss numbers.

CMS will "redistribute a portion of the ongoing maintenance sessions phase performance payments to certain core and core maintenance session performance payments," the rule proposes, making the one-year program maximum $661.00 versus the current two-year $704.00 maximum.

The program had been made all-virtual for the duration of the PHE in the 2021 physician fee schedule final rule (*PBN 12/14/20*).

Nutrition changes

CMS also makes some proposed changes to services rendered by nutrition professionals, mainly to the Medicare Nutrition Therapy (MNT) service CPT codes. That includes individual, face-to-face initial assessment and intervention per 15 minutes (**97802**),

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subsequent reassessment and intervention (**97803**) and for group sessions in 30-minute increments (**97804**). MNT also has HCPCS reassessment codes: **G0270** (Individual, each 15 minutes) and **G0271** (Group, each 30 minutes).

Currently paid at 80% of the lesser of the actual charge for the services or 85% of the PFS rate, these codes are proposed to be paid at 100% percent of the lesser of the actual charges or 85% of the PFS amount.

But the payment updates are a "technical correction," reports Marsha Schofield, MS, RD, LD, FAND, senior director, governance, nutrition services coverage for the Academy of Nutrition and Dietetics in Chicago, and would not result in increased payments.

More meaningfully, CMS wants to remove the requirement that the service be referred by the beneficiary's "treating" physician — that is, the physician treating the patient's diabetes — and allow any M.D. or D.O. to order it.

"We'd like it to also include NPPs," Schofield says, but she considers it a step in the right direction.

"It may be the beneficiary's podiatrist or ophthalmologist who happens to identify the need for MNT services for diabetes, or a hospitalist or an ED physician," Schofield says. "But currently none of those physicians would meet the CMS definition of 'treating physician.'"

Also, "to improve access and utilization of the MNT benefit" for chronic kidney disease (CKD) patients, CMS proposes to make changes to its chronic renal insufficiency glomerular filtration rate (GFR) criteria for the service to take into account changes in the definition of moderate CKD. CMS also suggests it will remove the "treating" physician referral requirement for these patients.

Schofield, who has been working with her colleagues and the National Kidney Foundation to get CMS to make these changes, is pleased. "The definitions and staging of CKD have evolved since the MNT benefit was first established and the eligibility criteria have not kept up with the field," she says. "Currently, we find ourselves in a situation where the eligibility criteria for MNT for beneficiaries with CKD falls midstage for moderate kidney disease."

The rule further suggests it will allow Medicare diabetes self-management training (DSMT), which also currently must be ordered by the beneficiary's treating physician or qualified NPP, to be ordered by any physician or NPP whether treating or not. **Note**: Neither MNT nor DSMT may be performed incident-to and cannot be billed together, CMS says. The DSMT HCPCS codes are **G0108** for individual training per 30 minutes and **G0109** for group training of two or more individuals per 30 minutes.

Will it work?

The MDPP services are not racking up big numbers at present. While CMS cites a study that estimates 16.4 million people are eligible for MDPP and "over 3,600 beneficiaries" are taking part in the program, the most recent Medicare numbers for the program are weak. In 2019, MDPP's primary code, **G9890** (Bridge payment: a one-time payment for the first MDPP core session), registered only 1,431 claims, according to the latest available Medicare claims data.

MNT and DMST do much better — reaching the hundreds of thousands of claims — but have serious denial issues, particularly MNT codes, which hover in the 36% to 42% denial range (*PBN 5/3/21*). — *Roy Edroso* (*redroso@decisionhealth.com*) ■

Coding

Take a first peek at dozens of new codes slated to appear in 2022

You'll see dozens of new and revised codes in your 2022 CPT manual, according to a preview of the annual code updates contained in the proposed 2022 Medicare physician fee schedule released July 13.

The proposed rule includes a list of new services that will be covered under the Part B fee schedule in 2022, which means most new laboratory codes aren't listed in this proposed rule. CMS provides the full descriptors for the codes along with placeholder codes that will be updated in the 2022 CPT Manual.

You'll find more information about the new codes in Addendum B — Relative Value Units and Related Information Used in CY 2022 Proposed Rule, including the global periods and the relative value units that will determine the national payment. (*See the chart, p. 8, for the projected payments for covered codes.*)

Use the following overview to spot coding and revenue changes that may impact your practice. However, take note: The descriptors in your 2022 CPT manual may vary slightly from what is listed in Table 13 of the proposed rule. In addition, CMS' proposals for the new codes are not finalized. Take advantage of the comment period, ending Sept. 13, to help shape final policy and payment.

E/M services: Care management

Add-on codes will be a notable addition to chronic care and principal care management codes in 2022. Physicians and other qualified health care professionals (QHP) who report the 20-minute chronic care management (CCM) service (**99491**) will be able to bill for additional time spent on the services in 30-minute increments thanks to a new code. In addition, the E/M codes that will replace 30-minute principal care management (PCM) codes **G2064** and **G2065** will each have a primary code based on who performed the service and a 30-minute add-on code. *— Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

Editor's note: This story continues online. For additional coverage on CY2022 coding updates, including proposals to the cardiology, path/lab, medicine and other sections of the CPT manual, visit www.partbnews.com.

Projected payments for new procedures and visits in 2022

Take a look at the national payment for the new codes that will be paid under the Medicare physician fee schedule in 2022, in the non-facility (Non-Fac.) and facility (Fac.) settings, according to the proposed rule (*see story, p. 7*). Payments were calculated using the relative value units (RVU) in Addendum B to the proposed physician fee schedule and the proposed $33.5848 conversion factor.

Note that the final payments will likely look different pending changes to relative value units (RVU) and the conversion factor. The listed codes are placeholders and will not be used to report services. Full descriptors are located in Table 13 of the proposed rule.

Code	Short desciptor	Non-Fac.	Fac.
99X21	Chrnc care mgmt phys ea addl	$60.12	$49.71
99X22	Prin care mgmt phys 1st 30	$81.61	$72.88
99X23	Prin care mgmt phys ea addl	$59.45	$50.38
99X24	Prin care mgmt staff 1st 30	$63.14	$48.36
99X25	Prin care mgmt staff ea addl	$49.71	$34.93
33XXX	Tcat plmt&rmvl cepd perq	N/A	$129.97
33XX3	Open excl laa any method	N/A	$1,044.49
33XX4	Opn excl laa oth px any meth	N/A	$128.63
33XX5	Thrscp excl laa any method	N/A	$828.54
338X0	Perq trluml angp nt/recr coa	N/A	$562.21
338X1	Evasc st rpr thrc/aa acrs br	N/A	$951.46
338X2	Evasc st rpr thrc/aa x crsg	N/A	$757.00
35XX0	Ndsc hrv uxtr art 1 sgm cab	N/A	$169.27
42XXX	Dise eval slp do brth flx dx	N/A	$113.52
434XX	Transorl lwr esophgl myotomy	N/A	$792.94
617X1	Litt icr 1 traj 1 smpl les	N/A	$898.39
617X2	Litt icr mlt trj mlt/cplx ls	N/A	$1,070.68
630XX	Lam facetc&frmt arthrd lum 1	N/A	$183.37
630X1	Lam factc&frmt arthrd lum ea	N/A	$137.03
645X1	Opn mpltj hpglsl nstm ary pg	N/A	$870.18
645X2	Rev/rplct hpglsl nstm ary pg	N/A	$787.23
645X3	Rmvl hypglsl nstim ary pg	N/A	$664.98
646X0	Trml dstrj ios bvn 1st 2 l/s	N/A	$460.45
646X1	Trml dstrj ios bvn ea addl	N/A	$211.25
669X1	Xcpsl ctrc rmvl cplx insj 1+	N/A	$729.46
669X2	Xcapsl ctrc rmvl insj 1+	N/A	$565.23
68XXX	Insj rx elut implt lac canal	$37.61	$31.91
69X50	Impltj oi implt skl tc esp	N/A	$603.85
69X51	Revj/rplcmt oi implt tc esp	N/A	$603.85
69X52	Rmvl oi implt skl perq esp	N/A	$411.41
69X53	Rmvl oi implt skl tc esp	N/A	$470.19
77X01	Tbs dxa cal w/i&r fx risk	$40.30	N/A
77X02	Tbs techl prep&transmis data	$3.02	N/A
77X03	Tbs techl calculation only	$27.54	N/A
77X04	Tbs i&r fx rsk qhp	$9.74	$9.74
80XX0	Path clin consltj sf 5-20	$25.86	$21.49
80XX1	Path clin consltj mod 21-40	$51.38	$47.02
80XX2	Path clin consltj high 41-60	$91.69	$86.98
80XX3	Path clin consltj prolng svc	$40.64	N/A
9111X	Gi trc img intral colon	$780.85	N/A
93X1X-26	R hrt cath chd nml nt cnj	$185.39	$185.39
93X2X-26	R hrt cath chd abnl nt cnj	$290.51	$290.51
93X3X-26	L hrt cath chd nm/abn nt cnj	$262.30	$262.30
93X4X-26	R&l hrt cath chd nml nt cnj	$317.38	$317.38
93X5X-26	R&l hrt cath chd abnl nt cnj	$423.17	$423.17
93X6X-26	Car outp meas drg cath chd	$68.85	$68.85
933X0	3d echo img cgen hrt anomal	$54.74	$24.85
946X1	Phy/qhp op pulm rhb w/o mntr	$74.89	$19.14
946X2	Phy/qhp op pulm rhb w/mntr	$82.62	$27.20
989X1	Rem ther mntr 1st setup&edu	$22.50	N/A
989X2	Rem ther mntr dev sply resp	$45.00	N/A
989X3	Rem ther mntr dv sply mscskl	$45.00	N/A
989X4	Rem ther mntr 1st 20 min	$51.38	$30.56
989X5	Rem ther mntr ea addl 20 min	$41.31	$30.56

Sources: *Table 13 and Addendum B – Medicare proposed physician fee schedule, 2022*

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