Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

October 23, 2024

The Honorable Pamela Beidle, Chair
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Joseline A. Peña-Melnyk, Chair
Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: Health General § 15-103.5 — 2023 Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates (MSAR # 7893)

Dear Chair Beidle and Chair Peña-Melnyk:

Pursuant to Maryland Health-General §15-103.5, the Maryland Department of Health respectfully submits the required annual report that reviews the rates paid to providers under the federal Medicare fee schedule and compares the rates under the Medicare fee schedule to the fee-for-service rates paid to similar providers for the same services under the Maryland Medical Assistance Program and the rates paid to managed care organization providers for the same services under the Maryland Medical Assistance Program.

If you have any questions about this report, or would like additional information, please contact Sarah Case-Herron, Director, Office of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Hererra Scott, M.D., M.P.H
Secretary

cc:

Ryan Moran, Dr. P.H., Deputy Secretary, Health Care Financing and Medicaid
Tricia Roddy, M.H.S.A. Deputy Director, Office of Health Care Financing
Sarah Case-Herron, J.D., Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Maryland
DEPARTMENT OF HEALTH

2023 Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates

As Required by Health – General § 15-103.5

January 2023

Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates
January 2023

Annual Report on the Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates
January 2023

I. Introduction

Pursuant to SB 481 (Chapter 464 of the Acts of 2002), the Maryland Department of Health (MDH) established an annual process to set the fee-for-service (FFS) reimbursement rates for Maryland Medicaid and the Maryland Children's Health Insurance Program (CHIP) (together referred to as Maryland Medicaid) in a manner that ensures provider participation in the programs. The law further stipulates that, in developing the rate-setting process, MDH should account for community reimbursement rates and annual medical inflation or utilize the Resource-Based Relative Value Scale (RBRVS) methodology and American Dental Association Current Dental Terminology (CDT-3) codes to establish the Medicaid fee schedule. The RBRVS methodology is used by the Centers for Medicare & Medicaid Services (CMS) to establish the Medicare fee schedule.[1]

The law also directs MDH to submit an annual report to the Governor and various state House and Senate committees, including a comparison of Maryland Medicaid's FFS reimbursement rates with those of other states and a description of other measures of access and costs for Maryland's Medicaid program.

In addition, Section 15 of HB 70 (Chapter 656 of the Acts of 2009) requires MDH to review the rates paid to providers under the federal Medicare fee schedule and compare them with the FFS rates for the same services paid to providers under the Maryland Medicaid program and within managed care organizations (MCOs). On or before January 1 of each year, MDH must report this information and determine whether the FFS rates and MCO provider rates will exceed the rates paid under the Medicare fee schedule. This report satisfies these requirements for the state fiscal year (FY) 2022.

II. Background

In September 2001, in response to HB 1071 (Chapter 702 of the Acts of 2001), MDH prepared its first annual report analyzing the physician fees paid by Maryland Medicaid and CHIP. In 2002, SB 481 required the submission of this report on an annual basis. This is the 22nd annual report.

MDH uses the Medicare fee schedule as a point of reference when it changes physician fees. MDH's first annual report concluded that Maryland Medicaid's reimbursement rates in 2001 were, on average, approximately 36% of Medicare's rates. As of FY 2022, Maryland Medicaid's overall reimbursement rates were approximately 91% of Medicare's 2022 rates. This is a slightly

[1] The RBRVS methodology relates payments to resources that physicians use and the complexity of the services they provide. MDHused this methodology as a point of reference when it increased physician fees in FYs 2003 and 2006 through 2009, and subsequently in FYs 2013 to 2017.

higher percentage of Medicare from previous years as the Medicare rates for CY 2022 were decreased from CY 2021.

Furthermore, Senate Bill 836 of the 2005 General Assembly session created the Maryland Health Care Provider Rate Stabilization Fund (the Fund), which is administered by the Maryland Insurance Administration. The Fund was established in part to increase and maintain prior increases in physician fees within the Maryland Medicaid program. The Fund's primary revenues are derived from a tax imposed on MCOs and health maintenance organizations (HMOs). The Fund maintained increases through FY 2020, but it was repealed effective July 1, 2021.[2] The premium tax payments previously comprising the Fund are deposited directly into the state's general fund going forward.

III. Physician Fee Changes in 2013 – 2022

Physician Fees Changes Due to the Affordable Care Act for CYs 2013 and 2014

There were no changes in Maryland Medicaid physician fees for the first six months of FY 2013. Under the Affordable Care Act (ACA), the federal government paid for increasing Medicaid payment rates in the Medicaid FFS program and MCOs for evaluation and management (E&M) and vaccine administration procedures provided by primary care physicians (PCPs) to 100% of the Medicare payment rates for calendar years (CYs) 2013 and 2014.

Maryland Medicaid allows patients who have medically complex conditions to select specialists to serve as their PCPs. To improve access to primary care and specialist physicians, the Maryland Medicaid fees for E&M procedures were increased for *all* providers, not just PCPs. The costs for the fee increase for physicians who did not self-attest as PCPs were financed at the regular Federal Medical Assistance Percentage (FMAP).

Physician Fees for FYs 2015 – 2021

Following the January 1, 2015 expiration of the 100% FMAP for E&M procedures provided by PCPs, Medicaid fees for these procedures were reduced to 87% of Medicare fees for April through June of 2015. Subsequently, with the support of the Governor, the Maryland General Assembly passed laws that increased Medicaid FY 2016 fees for E&M procedures to 92% of Medicare 2015 fees.

The Governor allocated approximately $5 million in state general funds in FY 2017 for increasing Medicaid fees for E&M procedures to 94% of Medicare 2016 fees, effective October 1, 2016. Moreover, updates in relative value units (RVUs) led to decreases in Medicare fees for some procedures, resulting in Maryland Medicaid fees exceeding their corresponding Medicare fees. Therefore, effective January 1, 2017, MDH reduced any Medicaid fees that exceeded their corresponding Medicare fees and increased the lowest Medicaid fees for non-E&M procedures to approximately 72% of Medicare 2017 fees.

[2] SB 192 (Section 1, Chapter 538 of the Acts of 2020).

A total of $226.5 million was distributed to the Maryland Medicaid program from the Rate Stabilization Fund in FY 2021. The Medicare fee schedule for CY 2021, released in December 2020, was significantly re-balanced to raise the reimbursement rate for a small number of E&M codes. To ensure the Medicare reimbursement costs remained neutral, the conversion factor for all Medicare rate calculations was lowered by approximately 3.75%. The Medicare conversion factor is the monetary value per RVU assigned to each procedure. The American Rescue Plan Act included provisions to maintain the conversion factor at its CY 2020 rate for CY 2021. This resulted in a considerable increase in the reimbursement rate for a small number of very high-volume E&M codes. The Maryland Medicaid reimbursement rates for all E&M codes were maintained at 93% of Medicare for FY 2021. This led to an increase in total funds of approximately $92 million, compared with the usual increase of approximately $4 to $8 million. The new rates became effective on July 1, 2021.

Physician Fees for FY 2022

A total of $208.6 million was distributed to the Maryland Medicaid program from the Rate Stabilization Fund in FY 2021. The overall weighted average FMAP for FY 2021 was approximately 68.1%, resulting in an overall state share of 31.9%.[3] With the Fund allocation of $208.6 million, the total funds allocated for maintaining physician reimbursement rates was $653.9 million in FY 2021, of which the federal share was $445.3 million.

Medicare's CY 2022 reimbursement rates decreased slightly from CY 2021, with a decrease in the conversion factor of about 0.75%. The Maryland Medicaid reimbursement rates for E&M procedures were increased from 93% of Medicare to 100% of Medicare. The increase in total funds allocated for this increase was $60 million. The new E&M rates became effective on July 1, 2022.

The American Rescue Plan Act provided qualifying states with a temporary 10% increase to the FMAP for certain Medicaid expenditures for home and community-based services (HCBS). States were required to use the federal funds attributable to the increased FMAP to implement or supplement one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. The increased FMAP began on April 1, 2021, and continued through March 31, 2022. HB 588, Maryland's FY 2022 budget bill, directed Medicaid to spend at least 75% of federal American Rescue Plan Act reinvestment dollars for a one-time-only rate increase for HCBS providers. These increases went into effect November 1, 2021, Rates were increased by 5.2% for HCBS programs, 5.4% for behavioral health services and programs, and 5.5% for programs administered by the Developmental Disabilities Administration (DDA). The DDA's rate changes included a retroactive payment as well. This retroactive payment was aligned with the

[3] The weighted average of various FMAPs includes regular Medicaid at 53.1%, enhanced CHIP funding at 81.5%, and ACA adult expansion at 91.5%.

April 1, 2021 ARPA start date.[4] This increased provider reimbursement primarily affected physicians in the psychiatry specialty and rehabilitation specialties.

IV. Maryland Medicaid Fees Compared with Medicare and Other States

Maryland's neighboring states have their own Medicaid fee schedules. For this report, The Hilltop Institute collected data on the Medicaid physician fees of Delaware, Pennsylvania, Virginia, West Virginia, and Washington, D.C., accessed the current physician fee schedules from the states' websites, and compiled data on each state's Medicaid fees.

Physician fees include three components: the physician's work, practice expenses (e.g., costs of maintaining an office), and malpractice insurance expenses. The practice expense component composes, on average, approximately 40% of the total physician fee. When physicians render services in facilities, such as hospitals and long-term care facilities, they do not incur a practice expense. Therefore, facility fees are typically lower than non-facility fees.

Maryland, Delaware, and West Virginia have separate facility and non-facility fees. Because Pennsylvania does not separate these fees, its fees are compared with Medicare non-facility fees. Hence, for Pennsylvania, the percentages of Medicare fees reported underestimate the percentages of Medicare fees for procedures performed in facilities. Virginia and Washington, D.C., have separate facility and non-facility fees for some procedures, but they did not report facility fees for some of the procedures included in the analysis. Therefore, the analysis only compares the Medicaid non-facility fees of Virginia and Washington, D.C., with the corresponding Medicare non-facility fees for the Baltimore region.

This report compares Maryland's and other states' Medicaid reimbursement rates with the Medicare fee schedule for Baltimore and surrounding counties. The average Medicare fees in Maryland are approximately 7.2% higher than Delaware's Medicare fees, 1.6% higher than Pennsylvania's (Philadelphia locality) Medicare fees, 8.8% higher than Virginia's Medicare fees, and 12% higher than West Virginia's Medicare fees. Conversely, the average Medicare fees in Maryland are approximately 6.8% lower than the average Medicare fees in Washington, D.C.

[4] In addition, MDH implemented the one-time temporary emergency 4% rate increase for all providers who render waiver services to participants of the Waiver for Children with Autism Spectrum Disorder ("Autism Waiver"), Home and Community-Based Options Waiver ("Community Options Waiver"), Medical Day Care Services Waiver ("Medical Day Care Waiver"), and Home Care for Disabled Children Under a Model Waiver ("Model Waiver"), effective for the 4 quarters of state fiscal year 2023, July 1, 2022 through June 30, 2023. Additionally, MDH implemented a one-time, one quarter emergency rate increase of 4% for providers who render waiver services to participants of the Waiver for Adults with Brain Injury ("Brain Injury Waiver"). This rate increase will be in effect during the first quarter of state fiscal year 2023, July 1, 2022 through September 30, 2022. DDA has also implemented a one-time emergency 10% provider rate increase for the third quarter of state fiscal year 2022 (January 1, 2022 - March 31, 2022). Targeted case management providers did not receive this rate increase; they will receive a one-time 10% emergency rate increase for the quarter of the approval of the State Plan Amendment that is separate from the other rate increases.

Several codes that were commonly billed within their specialties in Maryland were not covered by Medicare and were therefore excluded from the analysis. These codes were 36415 (cardiovascular surgery), 41899 (digestive system surgery), 90999 (dialysis), 94799 (pulmonary), 97155 (physical medicine), and the following codes from the osteopathy, chiropractic, and other medicine specialty: 99000, 99024, 99051, 99050, 99053, 99058, 99070, and 99072.

Table 1 compares the states' Medicaid reimbursement rates as percentages of Medicare rates by physician specialty in FY 2022. The states' average reimbursement rates as percentages of Medicare rates have remained relatively stable over the past four years. For reimbursement rates for E&M procedures, Maryland ranks highest of all states reviewed. Generally, Maryland's rates rank toward the middle of its neighboring states, although Maryland's facility reimbursement rates for neurosurgery procedures is highest among all the states. Delaware's reimbursement is highest for most specialties, and Washington, D.C.'s reimbursement rates also rank highly for most specialties. The individual state and Medicare fees for each code included in the analysis are listed in Appendix A.

Table 1. Comparison of States' Medicaid Reimbursement Rates as Percentages of Medicare Rates, by Specialty, in FY 2022

Specialty	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
1-Evaluation & Management	100%	100%	93%	93%	67%	59%	59%	42%	85%
2-Integumentary System	70%	78%	92%	92%	76%	60%	63%	26%	87%
3-Musculoskeletal System	88%	91%	92%	92%	76%	61%	64%	39%	87%
4-Respiratory System	75%	75%	92%	92%	76%	61%	64%	43%	87%
5-Cardiovascular System – Surgical	79%	90%	92%	92%	70%	60%	65%	50%	87%
6-Hemic, Lymphatic System, and Mediastinum	69%	73%	91%	91%	76%	62%	64%	43%	86%
7-Digestive System	71%	72%	91%	83%	76%	60%	59%	47%	87%
8-Urinary System and Male Genital	72%	80%	92%	92%	76%	61%	65%	45%	87%
9-Gynecology and Obstetrics	87%	92%	87%	88%	86%	76%	90%	95%	85%
10-Endocrine System	72%	72%	91%	91%	76%	64%	64%	61%	85%
11-Nervous System	85%	94%	92%	92%	76%	59%	64%	34%	88%
12-Eye Surgery	84%	86%	92%	92%	76%	62%	62%	92%	86%
13-Ear Surgery	84%	82%	91%	92%	76%	61%	63%	44%	86%
14-Radiology	77%	77%	92%	92%	80%	59%	59%	71%	88%
15-Laboratory	93%	93%	98%	98%	100%	101%	101%	96%	80%
16-Psychiatry	84%	88%	94%	94%	95%	66%	67%	32%	84%
17-Dialysis	62%	62%	93%	93%	77%	65%	65%	43%	84%
18-Gastroenterology	70%	70%	92%	92%	75%	57%	57%	54%	89%
19-Ophthalmology and Vision Care	74%	78%	93%	93%	99%	61%	64%	39%	87%
20-ENT (Otorhinolaryngology)	80%	77%	93%	93%	77%	62%	66%	30%	86%
21-Cardiovascular System – Medical	90%	90%	92%	92%	76%	59%	59%	76%	88%
22-Noninvasive Vascular Diagnostic Studies	80%	80%	92%	92%	77%	58%	58%	66%	91%
23-Pulmonary	86%	86%	76%	91%	75%	58%	58%	60%	88%
24-Allergy and Immunology	78%	82%	91%	91%	75%	56%	57%	52%	89%

Specialty	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
25-Neurology and Neuromuscular	80%	80%	92%	92%	75%	58%	58%	43%	89%
26- Central Nervous System Assessment Tests	77%	77%	91%	91%	78%	57%	57%	71%	89%
27-Chemotherapy Administration	86%	86%	91%	91%	75%	58%	58%	74%	89%
28-Special Dermatological	48%	47%	91%	91%	75%	56%	56%	21%	93%
29-Physical Medicine and Rehabilitation	75%	75%	88%	88%	72%	59%	59%	48%	82%
30-Osteopathy, Chiropractic, and Other Medicine	80%	80%	92%	92%	77%	58%	56%	128%	88%

V. Reimbursement for Oral Health Services

The Maryland Medicaid program includes dental benefits for children, pregnant women, and the Rare and Expensive Case Management (REM) adult population. In addition, starting in January 2017, individuals who were formerly in foster care continue to receive dental benefits until they are 26 years of age. MDH generally does not reimburse for adult dental services; however, some of the MCOs provide this benefit from their own funds.[5] Starting June 1, 2019, MDH began a pilot program to provide dental benefits to adults between the ages of 21 and 64 who receive full Medicaid and Medicare benefits.[6]

In FY 2015, the General Assembly allocated approximately $940,000 in state general funds ($2.15 million with matching federal funds) to increase fees for five dental procedures in January through June 2015. The annual equivalent of $4.3 million was earmarked for the five procedures for which the rates were increased.

During the 2022 Maryland Legislative Session, the Maryland SFY 2023 Operating Budget directed $19.5 million ($7.3 million General Funds) to provide a one-time increase for dental reimbursement rates, representing the largest increase since FY 2009.

Effective July 1, 2022, the Maryland Medical Assistance Program provided a rate increase of 9.4% for a set of high utilization dental codes. However, none of the five procedures included in the 2015 rate increase were included in the 2022 rate increase.

For the rate increase for FY 2022, MDH considered maintaining rates as is, distributing the funds across all Current Dental Terminology (CDT) codes, or raising certain codes with high utilization. MDH held three stakeholder advisory meetings to discuss the distribution of the $19.5 million funds in the FY 2023 Operating Budget for Medicaid dental reimbursement rate increases. Maryland Medicaid and the Hilltop Institute assessed a targeted list of Maryland CDT code rates identified in the calls for utilization amongst adults, pregnant women, and children. Four modeling scenarios were developed to compare FY 2022 CDT rates with new proposed rates for CDT codes incurred by children and adults.

[5] The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) package of benefits is required for all Medicaid participants under the age of 21 years. Although EPSDT mandates dental care coverage for children, federal law does not mandate any minimum requirements for adult dental coverage through Medicaid.

[6] For more information on the Adult Dental Pilot Program, see https://mmcp.health.maryland.gov/Documents/Overview.pdf.

To estimate rates under different modeling scenarios, projected spending by dental code for all adults and children was calculated first. To do this, estimates of the projected new adult utilization—based on data provided by one of Maryland's contractors, Optumas, as well as CY 2021 pregnant women and children dental utilization data—were used. Percent rate increases were then calculated by distributing allowable funds across the board and across the target codes. A 9.4% rate increase for high utilization dental services was the result of these efforts. See Table 2.

Table 2. Dental Payment Rates Effective July 1, 2022

CDT	Description	New Rate
D0120	Periodic Oral Evaluation – Established Patient	$31.81
D0140	Limited Oral Evaluation – Problem Focused	$47.26
D0145	Oral Evaluation, Patient Under Three Years Of Age And Counseling With Primary Caregiver	$43.76
D0150	Comprehensive Oral Evaluation – New or Established Patient	$56.34
D0220	Intraoral – Periapical First Radiographic Image	$9.85
D0230	Intraoral – Periapical Each Additional Radiographic Image	$6.56
D0272	Bitewings – Two Radiographic Images	$16.41
D0274	Bitewings – Four Radiographic Images	$24.07
D0330	Panoramic Radiographic Image	$45.95
D1110	Prophylaxis – Adult	$63.62
D1120	Prophylaxis – Child	$46.35
D2330	Resin-Based Composite – One Surface, Anterior	$91.90
D2331	Resin-Based Composite – Two Surfaces, Anterior	$111.59
D2332	Resin-Based Composite – Three Surfaces, Anterior	$136.75
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	$165.19
D2391	Resin-Based Composite – One Surface, Posterior	$101.74
D2392	Resin-Based Composite – Two Surfaces, Posterior	$131.28
D2393	Resin-Based Composite – Three Surfaces, Posterior	$164.10
D2394	Resin-Based Composite – Four or More Surfaces, Posterior	$164.10
D2740	Crown – Porcelain/Ceramic Substrate	$328.20
D2750	Crown – Porcelain Fused to High Noble Metal	$410.25
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$168.48
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$196.92
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$168.48

CDT	Description	New Rate
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$65.64
D7140	Extraction, Erupted Tooth Or Exposed Root	$112.69
D7220	Removal of Impacted Tooth – Soft Tissue	$157.54
D7230	Removal of Impacted Tooth – Partially Bony	$230.83
D7240	Removal of Impacted Tooth – Completely Bony	$303.04
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	$77.67
D9223	Deep Sedation/General Anesthesia – Each 15 Minute Increment	$77.67
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	$19.69

Table 3 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, West Virginia, Pennsylvania, and Washington, D.C. The number of claims in Maryland were used to calculate the weighted average rank of Maryland and its neighboring states' fees.

The ranking of states' weighted average dental fees are: Delaware (first), Washington, D.C. (second), Maryland (third), West Virginia (fourth), Virginia (fifth), and Pennsylvania (sixth). Despite increases in many of the reimbursement rates for the procedures in the analysis, Maryland's ranking for dental procedures remains the same as previous years. Median fees from the ADA report correspond to CY 2020, and the states' fees correspond to CY 2022.

Table 3. Comparison of Maryland Medicaid and Neighboring States' 2022 Dental Fees with Median ADA Charges in 2020

Procedure Code	Procedure Description	ADA	MD	DE	VA	WV	PA	DC
D0120	Periodic oral evaluation	$55	$32	$43	$20	$28	$20	$35
D0140	Limited oral evaluation, problem focus	$76	$43	$64	$25	$39	$55	$50
D0145	Oral evaluation, pt < 3yrs	$65	$44	$57	$20	$28	$20	$40
D0150	Comprehensive oral evaluation	$87	$56	$77	$31	$39	$20	$78
D1110	Prophylaxis – adult (12 years of age and older)	$98	$64	$76	$47	$61	$36	$78
D1120	Dental prophylaxis child	$73	$46	$56	$34	$44	$30	$47
D1206	Topical fluoride varnish	$42	$25	$34	$21	$22	$18	$29
D1351	Dental sealant per tooth	$57	$33	$46	$32	$33	$25	$38
D7140	Extraction erupted tooth	$190	$113	$186	$69	$88	$65	$110
D9248	Non-intravenous conscious sedation	$212	$187	$295	$110	$0	$184	$0
Ranking			**3**	**1**	**5**	**4**	**6**	**2**

VII. Access to Care

The Maryland Medicaid Program includes many provisions to ensure the network is capable of providing access to all participants. For example, Maryland Medicaid has several network adequacy requirements for its MCOs.[7] Medicaid requires a ratio of one PCP to every 200 participants; although, for some sites with high volumes of Medicaid patients (such as federally qualified health centers) Medicaid may approve a ratio of up to 2,000 adult participants and 1,500 children per high-volume provider. These requirements exist for each of the state's 40 local access areas. MDH also requires MCOs to provide all medically necessary specialty care, stipulating that MCOs must arrange for care with an out-of-network specialist and compensate the provider when no in-network provider exists. In addition, each MCO must have at least one in-network provider in each of the following specialty areas: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Each MCO must also have at least one in-network specialist in each of the ten regions throughout the state for the following eight core specialties: cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

MDH conducts a broad range of assessments to monitor the adequacy of FFS and MCO networks. This includes an Accessing Monitoring Review Plan, published in 2016[8] for the FFS population, and a 2019 assessment of the accuracy of provider directories published by MCOs.[9]

VIII. Plan for the Future

MDH remains dedicated to ensuring that physicians are reimbursed equitably for their services. The provision of the ACA requiring parity of reimbursement rates for E&M procedures with Medicare rates expired at the end of 2014. While the state has historically allocated funds to maintain rates at a minimum of 93% of Medicare reimbursement rates, for FY 2023, funds were allocated for E&M services to be reimbursed at 100% of Medicare. Furthermore, MDH has continued to monitor provider network adequacy to ensure that patients' access to care is not compromised. In addition, MDH will continue to monitor the effects of the COVID-19 public health emergency that began in early 2020 on Medicaid reimbursement and access to care.

Following the public health emergency, medical care that is provided at a telehealth appointment is reimbursed at the same rate as a procedure performed at an in-person appointment. In addition, federal legislation passed that increases the FMAP for various services. The Families First Coronavirus Response Act provides an increased FMAP for non-ACA expansion participants when Medicaid programs meet their maintenance of effort

[7] COMAR 10.67.05.05-.08.

[8] The Maryland Department of Health. (2016, September 22). *Access monitoring review plan for the state of Maryland*. https://mmcp.health.maryland.gov/Pages/Fee-For-Service-Access-Monitoring-Review-Plan.aspx.

[9] The Maryland Department of Health. (2019*). CY 2019 network adequacy validation report accessing accuracy of MCO provider directories*. https://mmcp.health.maryland.gov/healthchoice/Documents/2019%20Network%20Adequacy%20Validation%20Report.pdf

requirements, ensuring current enrollees have continuous Medicaid coverage. This increased FMAP has continued through FY 2022 and is expected to end sometime in FY 2023.

Senate Bill 150 requires the Maryland Medicaid program to provide dental services to all Medicaid participants over the age of 21 who receive full Medicaid benefits. This benefit will go into effect on January 1, 2023. MDH will continue to monitor reimbursement rates and access to care as these benefits are expanded.

Appendix A. Ranking of State Reimbursement Rates by Procedure Code

Table A compares Maryland's FY 2022 Medicaid fees with the corresponding Medicare 2022 reimbursement rates for the Baltimore region, as well as neighboring states' Medicaid fees, for a sample of approximately 250 high-volume procedures in various specialty groups. In this table, procedure fees are rounded to the nearest dollar amount, and the last row of each section provides each state's weighted average Medicaid fees for the surveyed procedures as a percentage of Medicare fees in the Baltimore region. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentages of Medicare fees reported in this table correspond to the appropriate Medicare non-facility and facility fees. More specifically, Medicaid non-facility fees are compared with Medicare non-facility fees, and Medicaid facility fees, reported for Maryland and West Virginia, are compared with Medicare facility fees.

Table A. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Fees, FY 2022

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Evaluation & Management												
99309	Nursing fac care subseq	$96	$96	$96	$96	$90	$90	$66	$65	$65	$51	$82
99212	Office o/p est sf 10-19 min	$62	$39	$62	$39	$57	$36	$42	$31	$19	$26	$53
99215	Office o/p est hi 40-54 min	$196	$156	$196	$156	$181	$145	$132	$103	$81	$78	$167
99204	Office o/p new mod 45-59 min	$182	$146	$182	$146	$168	$135	$123	$116	$94	$90	$155
99203	Office o/p new low 30-44 min	$122	$90	$122	$90	$113	$83	$82	$75	$55	$54	$105
99283	Emergency dept visit	$78	$78	$78	$78	$72	$72	$49	$48	$48	$35	$64
99285	Emergency dept visit	$190	$190	$190	$190	$176	$176	$120	$129	$129	$50	$157
99233	Subsequent hospital care	$109	$109	$109	$109	$101	$101	$74	$75	$75	$81	$91
99284	Emergency dept visit	$131	$131	$131	$131	$121	$121	$83	$89	$89	$50	$108
99232	Subsequent hospital care	$76	$76	$76	$76	$70	$70	$52	$52	$52	$56	$64
99213	Office o/p est low 20-29 min	$99	$72	$99	$72	$91	$67	$67	$52	$37	$35	$85
99214	Office o/p est mod 30-39 min	$139	$105	$139	$105	$128	$98	$94	$76	$57	$54	$119
Weighted Average % of Medicare Fees				**100%**	**100%**	**93%**	**67%**	**67%**	**59%**	**59%**	**42%**	**85%**
Ranking				**1**	**1**	**4**	**6**	**6**	**8**	**7**	**9**	**5**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Integumentary System/General Surgery												
17250	Chem caut of granltj tissue	$101	$41	$63	$30	$92	$38	$76	$59	$26	$26	$89
11720	Debride nail 1-5	$36	$16	$25	$12	$33	$15	$27	$22	$11	$16	$31
12011	Rpr f/e/e/n/l/m 2.5 cm/<	$126	$61	$113	$61	$115	$55	$95	$76	$40	$32	$110
11102	Tangntl bx skin single les	$115	$41	$87	$35	$105	$38	$87	$67	$26	$32	$101
11900	Inject skin lesions </w 7	$63	$32	$44	$25	$58	$29	$48	$38	$20	$0	$55
11056	Trim skin lesions 2 to 4	$93	$24	$46	$24	$85	$22	$70	$54	$16	$30	$82
11043	Deb musc/fascia 20 sq cm/<	$259	$168	$187	$129	$237	$153	$196	$159	$108	$33	$224
12001	Rpr s/n/ax/gen/trnk 2.5cm/<	$106	$50	$88	$43	$96	$45	$79	$63	$32	$25	$92
10060	Drainage of skin abscess	$138	$115	$93	$77	$127	$106	$105	$83	$70	$24	$120
11721	Debride nail 6 or more	$48	$26	$35	$21	$45	$24	$37	$30	$17	$20	$42
11042	Deb subq tissue 20 sq cm/<	$145	$65	$93	$49	$133	$60	$110	$86	$42	$33	$128
17110	Destruct b9 lesion 1-14	$127	$73	$89	$56	$116	$67	$96	$74	$44	$49	$112
Weighted Average % of Medicare Fees				**70%**	**78%**	**92%**	**92%**	**76%**	**60%**	**63%**	**26%**	**87%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Musculoskeletal System												
27096	Inject sacroiliac joint	$181	$89	$169	$66	$167	$82	$138	$108	$57	$61	$159
29075	Application of forearm cast	$96	$68	$80	$58	$87	$62	$72	$58	$42	$46	$83
29581	Apply multlay comprs lwr leg	$100	$29	$69	$14	$92	$27	$75	$58	$19	$25	$88
29540	Strapping of ankle and/or ft	$30	$19	$28	$19	$28	$18	$23	$19	$13	$20	$26
20605	Drain/inj joint/bursa w/o us	$61	$40	$55	$40	$55	$37	$46	$37	$26	$22	$52
29515	Application lower leg splint	$78	$54	$65	$47	$71	$49	$59	$47	$34	$35	$68
20552	Inj trigger point 1/2 muscl	$59	$41	$50	$33	$54	$38	$45	$37	$27	$31	$0
20553	Inject trigger points 3/>	$68	$47	$55	$37	$63	$43	$52	$42	$30	$34	$59
20611	Drain/inj joint/bursa w/us	$110	$64	$98	$64	$101	$59	$84	$67	$42	$50	$96
29125	Apply forearm splint	$72	$44	$61	$39	$66	$40	$54	$43	$27	$26	$63
20550	Inj tendon sheath/ligament	$63	$43	$56	$39	$58	$39	$48	$39	$28	$32	$55
20610	Drain/inj joint/bursa w/o us	$72	$49	$66	$48	$66	$45	$54	$44	$32	$24	$62
Weighted Average % of Medicare Fees				**88%**	**91%**	**92%**	**92%**	**76%**	**61%**	**64%**	**39%**	**87%**
Ranking				**4**	**3**	**2**	**1**	**6**	**8**	**7**	**9**	**5**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Respiratory System												
30300	Remove nasal foreign body	$239	$139	$161	$88	$219	$127	$180	$139	$83	$23	$212
32551	Insertion of chest tube	$172	$172	$128	$128	$156	$156	$131	$113	$113	$133	$143
30140	Resect inferior turbinate	$333	$194	$315	$194	$305	$178	$252	$201	$124	$259	$289
31624	Dx bronchoscope/lavage	$287	$144	$241	$108	$264	$133	$218	$173	$94	$135	$250
31622	Dx bronchoscope/wash	$277	$142	$236	$108	$254	$131	$210	$168	$92	$134	$241
30520	Repair of nasal septum	$761	$761	$493	$493	$697	$697	$576	$461	$461	$416	$661
31237	Nasal/sinus endoscopy surg	$286	$174	$232	$136	$262	$160	$216	$173	$111	$160	$249
31579	Laryngoscopy telescopic	$222	$130	$167	$104	$203	$119	$168	$133	$82	$75	$193
32555	Aspirate pleura w/ imaging	$363	$118	$287	$94	$333	$109	$274	$213	$77	$89	$319
31575	Diagnostic laryngoscopy	$145	$73	$91	$57	$133	$67	$109	$85	$46	$69	$127
31500	Insert emergency airway	$154	$154	$112	$112	$141	$141	$118	$102	$102	$72	$128
31231	Nasal endoscopy dx	$213	$69	$167	$57	$195	$64	$161	$124	$44	$59	$188
Weighted Average % of Medicare Fees				**75%**	**75%**	**92%**	**92%**	**76%**	**61%**	**64%**	**43%**	**87%**
Ranking				**6**	**5**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Cardiovascular System -- Surgery												
36410	Non-routine bl draw 3/> yrs	$19	$10	$14	$7	$18	$9	$15	$12	$6	$0	$17
36591	Draw blood off venous device	$30	$30	$19	$19	$27	$27	$0	$17	$17	$0	$27
36556	Insert non-tunnel cv cath	$244	$91	$194	$91	$224	$84	$184	$145	$60	$113	$214
36620	Insertion catheter artery	$47	$47	$40	$40	$44	$44	$37	$31	$31	$48	$39
Weighted Average % of Medicare Fees				**79%**	**90%**	**92%**	**92%**	**70%**	**60%**	**65%**	**50%**	**87%**
Ranking				**5**	**3**	**2**	**1**	**6**	**8**	**7**	**9**	**4**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Hemic, Lymphatic System, and Mediastinum												
39501	Repair diaphragm laceration	$954	$954	$685	$685	$861	$861	$720	$611	$611	$743	$803
38571	Laparoscopy lymphadenectomy	$720	$720	$582	$582	$661	$661	$551	$464	$464	$633	$607
38724	Removal of lymph nodes neck	$1,597	$1,597	$1,160	$1,160	$1,461	$1,461	$1,217	$1,018	$1,018	$844	$1,352
38500	Biopsy/removal lymph nodes	$382	$286	$266	$205	$346	$259	$287	$234	$181	$114	$329
38510	Biopsy/removal lymph nodes	$594	$465	$337	$337	$541	$422	$449	$368	$296	$136	$510
38221	Dx bone marrow biopsies	$181	$76	$136	$59	$166	$71	$137	$107	$49	$70	$159
38220	Dx bone marrow aspirations	$174	$73	$134	$49	$160	$68	$132	$103	$47	$55	$153
38792	Ra tracer id of sentinl node	$92	$36	$32	$32	$85	$33	$70	$55	$24	$0	$81
38900	Io map of sent lymph node	$153	$153	$113	$113	$138	$138	$116	$100	$100	$110	$128
38505	Needle biopsy lymph nodes	$199	$92	$101	$57	$183	$85	$151	$119	$59	$67	$175
38525	Biopsy/removal lymph nodes	$496	$496	$353	$353	$447	$447	$373	$313	$313	$156	$420
38222	Dx bone marrow bx & aspir	$196	$82	$149	$67	$180	$76	$148	$116	$53	$63	$172
Weighted Average % of Medicare Fees				**69%**	**73%**	**91%**	**91%**	**76%**	**62%**	**64%**	**43%**	**86%**
Ranking				**6**	**5**	**1**	**2**	**4**	**8**	**7**	**9**	**3**
Digestive System												
46600	Diagnostic anoscopy spx	$138	$45	$71	$33	$126	$41	$104	$80	$28	$20	$123
43775	Lap sleeve gastrectomy	$1,243	$1,243	$969	$969	$1,117	$1,117	$937	$810	$810	$1,034	$1,036
42820	Remove tonsils and adenoids	$321	$321	$231	$231	$294	$294	$244	$201	$201	$184	$274
44970	Laparoscopy appendectomy	$678	$678	$486	$486	$611	$611	$511	$432	$432	$444	$572
43235	Egd diagnostic brush wash	$342	$342	$229	$104	$313	$122	$258	$201	$85	$125	$301
47562	Laparoscopic cholecystectomy	$744	$744	$532	$532	$670	$670	$561	$475	$475	$589	$628
49083	Abd paracentesis w/imaging	$337	$337	$267	$91	$309	$106	$255	$198	$74	$84	$297
45385	Colonoscopy w/lesion removal	$518	$276	$400	$221	$475	$254	$392	$312	$178	$268	$451
45378	Diagnostic colonoscopy	$387	$200	$299	$155	$355	$184	$293	$232	$129	$181	$337
45380	Colonoscopy and biopsy	$499	$217	$357	$186	$458	$200	$377	$296	$139	$225	$438
43239	Egd biopsy single/multiple	$438	$150	$274	$123	$401	$138	$330	$256	$96	$149	$386
Weighted Average % of Medicare Fees				**71%**	**72%**	**91%**	**83%**	**76%**	**60%**	**59%**	**47%**	**87%**
Ranking				**6**	**5**	**1**	**3**	**4**	**7**	**8**	**9**	**2**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Urinary System and Male Genital												
51700	Irrigation of bladder	$86	$33	$70	$33	$79	$31	$65	$51	$22	$29	$75
55700	Biopsy of prostate	$270	$140	$198	$104	$248	$129	$205	$163	$91	$90	$235
51784	Anal/urinary muscle study	$71	$71	$68	$68	$65	$65	$54	$44	$44	$96	$61
51701	Insert bladder catheter	$50	$28	$47	$28	$46	$26	$38	$30	$18	$25	$43
52332	Cystoscopy and treatment	$460	$167	$393	$124	$421	$154	$347	$271	$108	$144	$405
52310	Cystoscopy and treatment	$360	$162	$205	$121	$330	$149	$272	$215	$105	$129	$315
51741	Electro-uroflowmetry first	$15	$15	$15	$15	$14	$14	$12	$10	$10	$24	$13
52356	Cysto/uretero w/lithotripsy	$445	$445	$337	$337	$410	$410	$342	$290	$290	$333	$373
54161	Circum 28 days or older	$214	$214	$157	$157	$197	$197	$164	$137	$137	$128	$182
51798	Us urine capacity measure	$12	$12	$12	$12	$11	$11	$9	$7	$7	$14	$0
52000	Cystoscopy	$275	$87	$144	$87	$252	$80	$207	$161	$57	$75	$243
54150	Circumcision w/regionl block	$165	$105	$145	$78	$151	$97	$125	$102	$69	$79	$142
Weighted Average % of Medicare Fees				**72%**	**80%**	**92%**	**92%**	**76%**	**61%**	**65%**	**45%**	**87%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Gynecology and Obstetrics												
58661	Laparoscopy remove adnexa	$722	$722	$620	$620	$659	$659	$631	$263	$263	$565	$609
58100	Biopsy of uterus lining	$115	$70	$109	$70	$105	$64	$100	$71	$71	$51	$99
59410	Obstetrical care	$1,183	$1,183	$942	$942	$1,062	$1,062	$1,022	$1,005	$1,005	$1,200	$989
58558	Hysteroscopy biopsy	$1,572	$253	$1,092	$253	$1,436	$231	$1,353	$897	$897	$239	$1,403
57454	Bx/curett of cervix w/scope	$190	$147	$152	$133	$173	$134	$165	$118	$118	$106	$162
58301	Remove intrauterine device	$124	$73	$95	$66	$114	$67	$108	$76	$76	$17	$108
59430	Care after delivery	$299	$201	$149	$125	$270	$180	$258	$243	$243	$0	$256
58300	Insert intrauterine device	$125	$55	$76	$51	$115	$115	$109	$75	$75	$17	$110
59514	Cesarean delivery only	$1,014	$1,014	$993	$993	$802	$802	$873	$866	$866	$1,200	$844
59409	Obstetrical care	$894	$894	$860	$860	$802	$802	$773	$764	$764	$1,200	$746
59025	Fetal non-stress test	$54	$54	$46	$46	$49	$49	$46	$33	$33	$18	$46
Weighted Average % of Medicare Fees				**87%**	**92%**	**87%**	**88%**	**86%**	**76%**	**90%**	**95%**	**85%**
Ranking				**6**	**2**	**5**	**4**	**7**	**9**	**3**	**1**	**8**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Endocrine System												
60260	Repeat thyroid surgery	$1,208	$1,208	$875	$875	$1,098	$1,098	$917	$774	$774	$375	$1,019
60271	Removal of thyroid	$1,171	$1,171	$847	$847	$1,064	$1,064	$888	$750	$750	$925	$988
60512	Autotransplant parathyroid	$267	$267	$195	$195	$242	$242	$202	$174	$174	$217	$223
60252	Removal of thyroid	$1,469	$1,469	$1,059	$1,059	$1,333	$1,333	$1,113	$941	$941	$826	$1,239
60280	Remove thyroid duct lesion	$504	$504	$354	$354	$461	$461	$383	$314	$314	$304	$432
60500	Explore parathyroid glands	$1,082	$1,082	$775	$775	$980	$980	$818	$690	$690	$705	$914
60100	Biopsy of thyroid	$120	$82	$89	$63	$111	$76	$92	$75	$54	$66	$103
60220	Partial removal of thyroid	$786	$786	$565	$565	$715	$715	$596	$500	$500	$521	$666
60240	Removal of thyroid	$1,021	$1,021	$737	$737	$927	$927	$774	$653	$653	$591	$862
Weighted Average % of Medicare Fees				**72%**	**72%**	**91%**	**91%**	**76%**	**64%**	**64%**	**61%**	**85%**
Ranking				**6**	**5**	**1**	**2**	**4**	**8**	**7**	**9**	**3**
Neurosurgery												
64415	Njx aa&/strd brach plexus	$125	$67	$124	$67	$115	$63	$95	$76	$44	$35	$108
64447	Njx aa&/strd femoral nerve	$98	$57	$94	$57	$90	$52	$75	$60	$37	$61	$85
64450	Njx aa&/strd other pn/branch	$85	$46	$85	$46	$78	$42	$64	$51	$30	$21	$74
64636	Destroy l/s facet jnt addl	$279	$64	$188	$64	$256	$59	$210	$161	$41	$48	$0
64495	Inj paravert f jnt l/s 3 lev	$100	$56	$88	$55	$92	$52	$76	$61	$36	$42	$87
64635	Destroy lumb/sac facet jnt	$502	$208	$453	$208	$461	$192	$380	$296	$133	$179	$0
62321	Njx interlaminar crv/thrc	$297	$116	$246	$109	$273	$107	$225	$176	$75	$89	$262
64494	Inj paravert f jnt l/s 2 lev	$101	$55	$87	$54	$93	$51	$77	$61	$36	$42	$88
64484	Njx aa&/strd tfrm epi l/s ea	$126	$56	$95	$55	$116	$51	$96	$75	$36	$60	$110
62323	Njx interlaminar lmbr/sac	$293	$108	$242	$99	$269	$99	$222	$173	$69	$81	$258
64493	Inj paravert f jnt l/s 1 lev	$195	$97	$170	$94	$180	$90	$148	$117	$62	$72	$171
64483	Njx aa&/strd tfrm epi l/s 1	$279	$121	$238	$101	$256	$111	$211	$165	$77	$95	$245
Weighted Average % of Medicare Fees				**85%**	**94%**	**92%**	**92%**	**76%**	**59%**	**64%**	**34%**	**88%**
Ranking				**5**	**1**	**3**	**2**	**6**	**8**	**7**	**9**	**4**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Eye Surgery												
67800	Remove eyelid lesion	$140	$110	$100	$81	$129	$101	$107	$85	$68	$41	$122
67210	Treatment of retinal lesion	$557	$535	$430	$413	$514	$494	$425	$343	$330	$375	$482
67113	Repair retinal detach cplx	$1,424	$1,424	$1,062	$1,062	$1,316	$1,316	$1,090	$889	$889	$1,086	$1,222
66761	Revision of iris	$327	$254	$285	$253	$302	$235	$249	$197	$157	$181	$285
65855	Trabeculoplasty laser surg	$267	$220	$227	$195	$246	$203	$204	$164	$138	$237	$231
66821	After cataract laser surgery	$364	$337	$260	$246	$335	$311	$277	$220	$205	$217	$317
68761	Close tear duct opening	$162	$127	$117	$94	$149	$117	$123	$97	$78	$63	$142
67311	Revise eye muscle	$520	$520	$520	$470	$480	$480	$397	$319	$319	$468	$449
66982	Xcapsl ctrc rmvl cplx wo ecp	$799	$799	$678	$678	$739	$739	$612	$497	$497	$697	$687
67228	Treatment x10sv retinopathy	$367	$325	$333	$300	$338	$300	$280	$226	$203	$490	$316
66984	Xcapsl ctrc rmvl w/o ecp	$584	$584	$503	$503	$540	$540	$447	$362	$362	$603	$502
67028	Injection eye drug	$123	$98	$99	$98	$113	$91	$94	$75	$62	$106	$106
Weighted Average % of Medicare Fees				**84%**	**86%**	**92%**	**92%**	**76%**	**62%**	**62%**	**92%**	**86%**
Ranking				**6**	**4**	**2**	**1**	**7**	**9**	**8**	**3**	**5**
Ear Surgery												
69424	Remove ventilating tube	$146	$66	$115	$55	$134	$61	$110	$86	$41	$54	$129
69205	Clear outer ear canal	$105	$105	$91	$91	$96	$96	$79	$65	$65	$89	$90
69436	Create eardrum opening	$176	$176	$149	$149	$162	$162	$134	$109	$109	$99	$152
69200	Clear outer ear canal	$89	$52	$82	$49	$82	$47	$68	$54	$33	$30	$78
69209	Remove impacted ear wax uni	$17	$17	$11	$11	$16	$16	$13	$10	$10	$10	$15
69210	Remove impacted ear wax uni	$52	$36	$44	$29	$48	$33	$40	$32	$23	$20	$45
Weighted Average % of Medicare Fees				**84%**	**82%**	**91%**	**92%**	**76%**	**61%**	**63%**	**44%**	**86%**
Ranking				**4**	**5**	**2**	**1**	**6**	**8**	**7**	**9**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Radiology												
76817	Transvaginal us obstetric	$104	$104	$78	$78	$96	$96	$91	$62	$62	$88	$92
73610	X-ray exam of ankle	$41	$41	$25	$25	$38	$38	$31	$24	$24	$27	$37
76816	Ob us follow-up per fetus	$123	$123	$93	$93	$113	$113	$107	$73	$73	$72	$108
76856	Us exam pelvic complete	$120	$120	$88	$88	$110	$110	$104	$70	$70	$77	$106
76820	Umbilical artery echo	$50	$50	$50	$50	$46	$46	$44	$30	$30	$46	$44
76830	Transvaginal us non-ob	$136	$136	$98	$98	$125	$125	$118	$79	$79	$77	$120
77067	Scr mammo bi incl cad	$144	$144	$108	$108	$132	$132	$125	$84	$84	$105	$127
73630	X-ray exam of foot	$39	$39	$24	$24	$36	$36	$29	$22	$22	$19	$34
74177	Ct abd & pelv w/contrast	$362	$362	$287	$287	$332	$332	$273	$210	$210	$263	$321
70450	Ct head/brain w/o dye	$122	$122	$114	$114	$113	$113	$93	$72	$72	$117	$108
71046	X-ray exam chest 2 views	$38	$38	$27	$27	$34	$34	$28	$22	$22	$24	$33
71045	X-ray exam chest 1 view	$29	$29	$17	$17	$27	$27	$22	$17	$17	$15	$25
Weighted Average % of Medicare Fees				**77%**	**77%**	**92%**	**92%**	**80%**	**59%**	**59%**	**71%**	**88%**
Ranking				**5**	**5**	**1**	**1**	**4**	**8**	**8**	**7**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Laboratory												
85027	Complete cbc automated	$6	$6	$6	$6	$6	$6	$6	$6	$6	$8	$5
82306	Vitamin d 25 hydroxy	$30	$30	$29	$29	$29	$29	$30	$30	$30	$41	$24
87086	Urine culture/colony count	$8	$8	$8	$8	$8	$8	$8	$9	$9	$8	$6
87491	Chlmyd trach dna amp probe	$35	$35	$34	$34	$34	$34	$35	$39	$39	$23	$28
87591	N.gonorrhoeae dna amp prob	$35	$35	$34	$34	$34	$34	$35	$39	$39	$23	$28
84443	Assay thyroid stim hormone	$17	$17	$17	$17	$16	$16	$17	$17	$17	$23	$13
81001	Urinalysis auto w/scope	$3	$3	$3	$3	$3	$3	$3	$3	$3	$3	$3
83036	Glycosylated hemoglobin test	$10	$10	$10	$10	$10	$10	$10	$10	$10	$7	$8
80307	Drug test prsmv chem anlyzr	$62	$62	$49	$49	$61	$61	$62	$58	$58	$64	$50
80061	Lipid panel	$13	$13	$13	$13	$13	$13	$13	$13	$13	$14	$11
80053	Comprehen metabolic panel	$11	$11	$10	$10	$10	$10	$11	$11	$11	$12	$8
85025	Complete cbc w/auto diff wbc	$8	$8	$8	$8	$8	$8	$8	$8	$8	$6	$6
Weighted Average % of Medicare Fees				**93%**	**93%**	**98%**	**98%**	**100%**	**101%**	**101%**	**96%**	**80%**
Ranking				**7**	**7**	**4**	**4**	**3**	**1**	**1**	**6**	**9**
Psychiatry												
90853	Group psychotherapy	$29	$25	$24	$24	$24	$27	$27	$19	$17	$4	$24
90837	Psytx w pt 60 minutes	$158	$139	$133	$133	$131	$149	$151	$104	$93	$52	$133
90832	Psytx w pt 30 minutes	$82	$72	$67	$67	$68	$77	$78	$54	$48	$26	$69
90847	Family psytx w/pt 50 min	$106	$106	$106	$58	$100	$100	$102	$72	$71	$13	$88
90834	Psytx w pt 45 minutes	$108	$95	$88	$88	$89	$101	$103	$71	$64	$39	$90
Weighted Average % of Medicare Fees				**84%**	**88%**	**94%**	**94%**	**95%**	**66%**	**67%**	**32%**	**84%**
Ranking				**5**	**4**	**3**	**2**	**1**	**8**	**7**	**9**	**6**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Dialysis												
90961	Esrd srv 2-3 vsts p mo 20+	$318	$318	$184	$184	$296	$296	$246	$205	$205	$0	$269
90945	Dialysis one evaluation	$92	$92	$66	$66	$86	$86	$71	$59	$59	$35	$78
90960	Esrd srv 4 visits p mo 20+	$383	$383	$219	$219	$357	$357	$296	$247	$247	$0	$324
90935	Hemodialysis one evaluation	$77	$77	$56	$56	$72	$72	$60	$50	$50	$35	$65
Weighted Average % of Medicare Fees				**62%**	**62%**	**93%**	**93%**	**77%**	**65%**	**65%**	**43%**	**84%**
Ranking				**7**	**7**	**1**	**1**	**4**	**5**	**6**	**9**	**3**
Gastroenterology												
91037	Esoph imped function test	$193	$193	$127	$127	$177	$177	$146	$112	$112	$114	$171
91035	G-esoph reflx tst w/electrod	$542	$542	$384	$384	$496	$496	$407	$309	$309	$351	$484
91120	Rectal sensation test	$600	$600	$341	$341	$550	$550	$451	$339	$339	$337	$0
91065	Breath hydrogen/methane test	$103	$103	$60	$60	$94	$94	$77	$58	$58	$17	$92
91110	Gi trc img intral esoph-ile	$880	$880	$733	$733	$807	$807	$662	$500	$500	$680	$787
91122	Anal pressure record	$309	$309	$190	$190	$284	$284	$234	$181	$181	$69	$273
91010	Esophagus motility study	$254	$254	$155	$155	$234	$234	$192	$148	$148	$28	$225
91200	Liver elastography	$34	$34	$31	$31	$31	$31	$26	$20	$20	$30	$0
Weighted Average % of Medicare Fees				**70%**	**70%**	**92%**	**92%**	**75%**	**57%**	**57%**	**54%**	**89%**
Ranking				**5**	**5**	**1**	**1**	**4**	**7**	**7**	**9**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Ophthalmology/Vision Care												
92002	Eye exam new patient	$94	$50	$64	$37	$87	$47	$93	$57	$32	$28	$82
92060	Special eye evaluation	$68	$68	$51	$51	$63	$63	$68	$41	$41	$34	$60
92133	Cmptr ophth img optic nerve	$40	$40	$37	$37	$37	$37	$40	$24	$24	$35	$35
92083	Visual field examination(s)	$69	$69	$57	$57	$63	$63	$68	$41	$41	$63	$60
92340	Fit spectacles monofocal	$38	$20	$0	$0	$0	$0	$0	$23	$13	$0	$33
92250	Eye exam with photos	$41	$41	$41	$41	$37	$37	$40	$24	$24	$53	$35
92134	Cptr ophth dx img post segmt	$44	$44	$37	$37	$41	$41	$44	$27	$27	$35	$38
92012	Eye exam establish patient	$98	$54	$67	$41	$90	$51	$97	$59	$35	$29	$85
92004	Eye exam new patient	$163	$101	$117	$77	$151	$95	$162	$99	$65	$59	$141
92015	Determine refractive state	$21	$21	$19	$15	$20	$19	$21	$14	$14	$5	$18
92014	Eye exam&tx estab pt 1/>vst	$138	$82	$97	$62	$128	$76	$137	$84	$52	$45	$120
Weighted Average % of Medicare Fees				**74%**	**78%**	**93%**	**93%**	**99%**	**61%**	**64%**	**39%**	**87%**
Ranking				**6**	**5**	**3**	**2**	**1**	**8**	**7**	**9**	**4**
ENT (Otorhinolaryngology)												
92526	Oral function therapy	$92	$92	$81	$67	$86	$86	$71	$58	$58	$48	$79
92552	Pure tone audiometry air	$38	$38	$25	$25	$34	$34	$28	$21	$20	$8	$34
92551	Pure tone hearing test air	$13	$13	$10	$10	$12	$12	$10	$7	$7	$8	$12
92508	Speech/hearing therapy	$26	$26	$26	$26	$24	$24	$20	$16	$17	$10	$22
92507	Speech/hearing therapy	$83	$83	$64	$61	$77	$77	$64	$53	$56	$22	$71
Weighted Average % of Medicare Fees				**80%**	**77%**	**93%**	**93%**	**77%**	**62%**	**66%**	**30%**	**86%**
Ranking				**4**	**5**	**1**	**1**	**6**	**8**	**7**	**9**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Cardiovascular System – Medical												
93015	Cardiovascular stress test	$78	$78	$77	$77	$72	$72	$59	$47	$47	$90	$68
93303	Echo transthoracic	$251	$251	$188	$188	$231	$231	$190	$146	$146	$157	$222
93320	Doppler echo exam heart	$57	$57	$53	$53	$53	$53	$43	$34	$34	$61	$50
93325	Doppler color flow add-on	$27	$27	$25	$25	$25	$25	$20	$15	$15	$19	$24
93306	Tte w/doppler complete	$222	$222	$206	$206	$204	$204	$168	$131	$131	$141	$195
93000	Electrocardiogram complete	$16	$16	$16	$16	$14	$14	$12	$10	$10	$19	$14
93005	Electrocardiogram tracing	$7	$7	$7	$7	$6	$6	$5	$4	$4	$10	$6
93010	Electrocardiogram report	$9	$9	$7	$7	$8	$8	$7	$6	$6	$8	$7
Weighted Average % of Medicare Fees				**90%**	**90%**	**92%**	**92%**	**76%**	**59%**	**59%**	**76%**	**88%**
Ranking				**3**	**3**	**1**	**1**	**7**	**8**	**8**	**6**	**5**
Noninvasive Vascular Tests												
93925	Lower extremity study	$275	$275	$208	$208	$252	$252	$207	$157	$157	$147	$246
93922	Upr/l xtremity art 2 levels	$93	$93	$93	$93	$85	$85	$70	$53	$53	$49	$83
93880	Extracranial bilat study	$217	$217	$162	$162	$199	$199	$163	$125	$125	$148	$193
93975	Vascular study	$302	$302	$225	$225	$276	$276	$227	$174	$174	$182	$268
93970	Extremity study	$214	$214	$158	$158	$195	$195	$161	$123	$123	$114	$190
93971	Extremity study	$136	$136	$96	$96	$124	$124	$102	$78	$78	$100	$121
93976	Vascular study	$163	$163	$161	$161	$150	$150	$135	$95	$95	$131	$159
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**77%**	**58%**	**58%**	**66%**	**91%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Pulmonary System												
94664	Evaluate pt use of inhaler	$19	$19	$14	$14	$17	$17	$14	$11	$11	$12	$17
94727	Pulm function test by gas	$48	$48	$36	$36	$45	$45	$37	$28	$28	$32	$43
94004	Vent mgmt nf per day	$52	$52	$38	$38	$0	$0	$40	$34	$34	$80	$43
94060	Evaluation of wheezing	$43	$43	$43	$43	$40	$40	$33	$25	$25	$19	$38
94729	Co/membane diffuse capacity	$65	$65	$46	$46	$60	$60	$49	$37	$37	$40	$58
94010	Breathing capacity test	$30	$30	$29	$29	$27	$27	$22	$17	$17	$15	$26
94640	Airway inhalation treatment	$13	$13	$13	$13	$11	$11	$9	$7	$7	$0	$11
94760	Measure blood oxygen level	$3	$3	$3	$3	$2	$2	$2	$1	$1	$2	$2
Weighted Average % of Medicare Fees				**86%**	**86%**	**76%**	**91%**	**75%**	**58%**	**58%**	**60%**	**88%**
Ranking				**3**	**3**	**5**	**1**	**6**	**8**	**8**	**7**	**2**
Allergy/Immunology												
95251	Cont gluc mntr analysis i&r	$37	$37	$34	$34	$35	$35	$29	$24	$24	$29	$31
95165	Antigen therapy services	$17	$3	$10	$2	$16	$3	$13	$10	$2	$8	$15
95004	Percut allergy skin tests	$5	$5	$5	$5	$4	$4	$3	$3	$3	$2	$4
95115	Immunotherapy one injection	$11	$11	$9	$9	$10	$10	$8	$6	$6	$4	$10
95117	Immunotherapy injections	$13	$13	$10	$10	$12	$12	$10	$7	$7	$7	$12
Weighted Average % of Medicare Fees				**78%**	**82%**	**91%**	**91%**	**75%**	**56%**	**57%**	**52%**	**89%**
Ranking				**5**	**4**	**1**	**2**	**6**	**8**	**7**	**9**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Neurology/Neuromuscular System												
95885	Musc tst done w/nerv tst lim	$72	$72	$48	$48	$66	$66	$54	$42	$42	$42	$64
95913	Nrv cndj test 13/> studies	$320	$320	$258	$258	$296	$296	$245	$195	$195	$231	$277
95930	Visual ep test cns w/i&r	$73	$73	$73	$73	$67	$67	$55	$42	$42	$74	$65
95910	Nrv cndj test 7-8 studies	$198	$198	$157	$157	$183	$183	$151	$120	$120	$140	$172
95923	Autonomic nrv syst funj test	$140	$140	$112	$112	$129	$129	$106	$83	$83	$0	$124
95911	Nrv cndj test 9-10 studies	$238	$238	$186	$186	$220	$220	$182	$145	$145	$170	$207
95811	Polysom 6/>yrs cpap 4/> parm	$707	$707	$691	$691	$648	$648	$532	$407	$407	$648	$629
95806	Sleep study unatt&resp efft	$101	$101	$101	$101	$93	$93	$77	$61	$61	$0	$88
95816	Eeg awake and drowsy	$428	$428	$289	$289	$392	$392	$322	$244	$244	$23	$383
95810	Polysom 6/> yrs 4/> param	$677	$677	$628	$628	$621	$621	$510	$389	$389	$347	$603
95819	Eeg awake and asleep	$503	$503	$333	$333	$460	$460	$378	$285	$285	$23	$450
95886	Musc test done w/n test comp	$111	$111	$72	$72	$103	$103	$85	$66	$66	$66	$98
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**75%**	**58%**	**58%**	**43%**	**89%**
Ranking				**4**	**4**	**1**	**1**	**6**	**7**	**7**	**9**	**3**
CNS Assessment Tests												
96159	Hlth bhv ivntj indiv ea addl	$24	$21	$15	$13	$23	$20	$19	$16	$14	$20	$20
96161	Caregiver health risk assmt	$3	$3	$3	$3	$3	$3	$2	$2	$2	$3	$3
96160	Pt-focused hlth risk assmt	$3	$3	$3	$3	$3	$3	$2	$2	$2	$3	$0
96127	Brief emotional/behav assmt	$5	$5	$5	$5	$5	$5	$5	$3	$3	$4	$5
96110	Developmental screen w/score	$12	$12	$9	$9	$11	$11	$9	$7	$7	$7	$11
Weighted Average % of Medicare Fees				**77%**	**77%**	**91%**	**91%**	**78%**	**57%**	**57%**	**71%**	**89%**
Ranking				**6**	**5**	**1**	**2**	**4**	**9**	**8**	**7**	**3**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Chemotherapy Administration												
96366	Ther/proph/diag iv inf addon	$23	$23	$18	$18	$21	$21	$18	$14	$14	$12	$20
96417	Chemo iv infus each addl seq	$75	$75	$62	$62	$68	$68	$56	$43	$43	$62	$66
96360	Hydration iv infusion init	$38	$38	$38	$38	$35	$35	$29	$22	$22	$32	$34
96415	Chemo iv infusion addl hr	$32	$32	$28	$28	$30	$30	$24	$19	$19	$28	$29
96361	Hydrate iv infusion add-on	$14	$14	$14	$14	$13	$13	$11	$8	$8	$9	$13
96367	Tx/proph/dg addl seq iv inf	$33	$33	$29	$29	$31	$31	$25	$19	$19	$19	$30
96374	Ther/proph/diag inj iv push	$44	$44	$44	$44	$40	$40	$33	$25	$25	$31	$39
96375	Tx/pro/dx inj new drug addon	$18	$18	$18	$18	$16	$16	$13	$10	$10	$13	$16
96365	Ther/proph/diag iv inf init	$76	$76	$57	$57	$69	$69	$57	$43	$43	$39	$67
96413	Chemo iv infusion 1 hr	$154	$154	$126	$126	$140	$140	$115	$87	$87	$125	$137
96372	Ther/proph/diag inj sc/im	$16	$16	$15	$15	$14	$14	$12	$10	$10	$13	$14
Weighted Average % of Medicare Fees				**86%**	**86%**	**91%**	**91%**	**75%**	**58%**	**58%**	**74%**	**89%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**
Special Dermatological Procedures												
96567	Pdt dstr prmlg les skn	$163	$163	$109	$109	$149	$149	$122	$90	$90	$0	$0
96921	Laser tx skin 250-500 sq cm	$191	$77	$136	$60	$176	$72	$145	$113	$49	$59	$0
96920	Laser tx skin < 250 sq cm	$175	$68	$124	$53	$161	$64	$133	$103	$44	$59	$0
96900	Ultraviolet light therapy	$27	$27	$17	$17	$25	$25	$20	$15	$15	$0	$24
96910	Photochemotherapy with uv-b	$133	$133	$57	$57	$121	$121	$99	$74	$74	$20	$120
Weighted Average % of Medicare Fees				**48%**	**47%**	**91%**	**91%**	**75%**	**56%**	**56%**	**21%**	**93%**
Ranking				**7**	**8**	**2**	**3**	**4**	**6**	**5**	**9**	**1**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Physical Medicine/Rehabilitation/Therapy												
97012	Mechanical traction therapy	$15	$15	$13	$13	$14	$14	$12	$10	$10	$13	$13
97016	Vasopneumatic device therapy	$13	$13	$13	$13	$12	$12	$10	$8	$8	$13	$11
97161	Pt eval low complex 20 min	$109	$109	$69	$69	$101	$101	$84	$68	$68	$64	$94
97150	Group therapeutic procedures	$19	$19	$18	$18	$18	$18	$15	$12	$12	$7	$16
97014	Electric stimulation therapy	$14	$14	$13	$13	$13	$13	$11	$8	$8	$17	$12
97010	Hot or cold packs therapy	$7	$7	$5	$5	$6	$6	$5	$4	$4	$17	$6
97112	Neuromuscular reeducation	$37	$37	$27	$27	$35	$35	$29	$23	$23	$17	$32
97140	Manual therapy 1/> regions	$29	$29	$23	$23	$27	$27	$23	$18	$18	$21	$25
97530	Therapeutic activities	$41	$41	$31	$31	$38	$38	$30	$25	$25	$13	$35
97110	Therapeutic exercises	$32	$32	$29	$29	$30	$30	$25	$20	$20	$8	$28
Weighted Average % of Medicare Fees				**75%**	**75%**	**88%**	**88%**	**72%**	**59%**	**59%**	**48%**	**82%**
Ranking				**4**	**4**	**1**	**1**	**6**	**7**	**7**	**9**	**3**
Osteopathy, Chiropractic, and Other Medicine												
99174	Ocular instrumnt screen bil	$7	$7	$6	$6	$6	$6	$6	$4	$4	$8	$6
98967	Hc pro phone call 11-20 min	$26	$23	$0	$0	$24	$22	$20	$20	$15	$9	$21
99152	Mod sed same phys/qhp 5/>yrs	$57	$14	$45	$11	$52	$13	$43	$34	$9	$10	$0
99177	Ocular instrumnt screen bil	$5	$5	$5	$5	$0	$0	$5	$3	$3	$15	$5
99173	Visual acuity screen	$3	$3	$3	$3	$0	$0	$2	$2	$2	$6	$3
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**77%**	**58%**	**56%**	**128%**	**88%**
Ranking				**6**	**5**	**3**	**2**	**7**	**8**	**9**	**1**	**4**

MC: Medicare Part B; NF: non-facility (e.g., office); FA: facility (e.g., hospital); N/A: data not available or not applicable.