Maryland
DEPARTMENT OF HEALTH

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

September 10, 2024

The Honorable Pamela Beidle
Chair
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 Article § 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 Health-General Article §15-103.5, the Maryland Department of Health is hereby submitting 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: Marie Grant, Assistant Secretary for Health Policy
Ryan Moran, Deputy Secretary, Health Care Financing and Medicaid
Tricia Roddy, Deputy Director, Office of Health Care Financing
Sarah Case-Herron, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Maryland

DEPARTMENT OF HEALTH

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 and Chapter 656 of the Acts of 2009

January 2024

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

Pursuant to SB 481 (Chapter 464 of the Acts of 2002), the Maryland Department of Health (the Department) 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, the Department should account for community reimbursement rates and annual medical inflation or utilize the Resource-Based Relative Value Scale (RBRVS) methodology and American Dental Association (ADA) 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 the Department 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 the Department 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, the Department 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) 2023.

II. Background

In September 2001, in response to HB 1071 (Chapter 702 of the Acts of 2001), the Department 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 23rd annual report.

The Department uses the Medicare fee schedule as a point of reference when it changes physician fees. The Department'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 2023, Maryland Medicaid's overall reimbursement rates were approximately 94% of Medicare's 2023 rates. This is a slightly higher percentage of Medicare from previous years as the Medicare rates for calendar year (CY) 2023 were decreased from CY 2022. However, Maryland

[1] The RBRVS methodology relates payments to resources that physicians use and the complexity of the services they provide. The Department used 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.

Medicaid's reimbursement of evaluation and management procedures did not decrease and is currently around 102.8 percent of Medicare.

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 were 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] Starting in FY 2022, the premium tax payments previously comprising the Fund are deposited directly into the state's general fund.

III. Physician Fee Changes in 2013 – 2023

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 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 – 2022

Following the January 1, 2015 expiration of 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, the Department 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. 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

[2] 2020 MD Laws Ch. 538.

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 Medicare 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.

Medicare's CY 2022 reimbursement rates decreased slightly from CY 2021, with a decrease in the conversion factor of about 0.75%. Effective July 1, 2022, 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 American Rescue Plan Act (ARPA) 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[3], 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 percent for HCBS programs, 5.4 percent for behavioral health services and programs, and 5.5 percent 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 April 1, 2021 ARPA start date.[4] This increased ARPA provider reimbursement primarily affected physicians in the psychiatry specialty and rehabilitation specialties.

[3] 2021 MD Laws Ch. 357.

[4] For more information see https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-announces-new-Medicaid-rate-increases.aspx. 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, the Department 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 was effective for the first quarter of state fiscal year 2023, July 1, 2022 through September 30, 2022. DDA 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.

Physician Fees for FY 2023

Medicare reimbursement rates decreased again in CY 2023, with a cut of around 2 percent in the conversion factor. Despite this reduction, the Medicaid reimbursement rates for E&M procedures were kept at its current level through FY 2024. E&M reimbursement for FY 2023 was 102.8 percent of CY 2023 Medicare.

Senate Bill 150[5] passed in 2022 requires the Maryland Medicaid program to provide dental services to all Medicaid participants over the age of 21 who receive full Medicaid benefits. The implementation of the adult dental benefit went into effect on January 1, 2023. Rates for dental services were raised 9.4% in CY 2022 for all participants. The Department increased rates again effective August 1, 2023 for some codes, and is continuing discussions with stakeholders to consider additional rate increases, dependent on funding availability. More information is available in Section V: Reimbursement for Oral Health Services below.

The overall weighted average FMAP for FY 2023 was approximately 64.3%, resulting in an overall state share of 35.7%.[6]

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.

[5] 2022 MD Laws Ch. 303.

[6] Due to the PHE unwinding, the FMAPs for FY 2023 were as follows: July 1, 2022 through March 31, 2023: ACA participants at 90%, MCHIP participants at 69.3%, other participants at 56.2%; for April 1, 2023-June 30, 2023: ACA participants at 90%, MCHIP participants at 68.5%, other participants at 55%

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, 1.8% higher than Pennsylvania's (Philadelphia locality) Medicare fees, 9.6% higher than Virginia's Medicare fees, and 11.3% higher than West Virginia's Medicare fees. Conversely, the average Medicare fees in Maryland are approximately 6.0% lower than the average Medicare fees in Washington, D.C.

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 2023. 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 2023

Specialty	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
1-Evaluation & Management	102%	102%	93%	93%	68%	66%	68%	49%	85%
2-Integumentary System	72%	80%	91%	92%	78%	62%	66%	27%	87%
3-Musculoskeletal System	89%	94%	91%	92%	78%	64%	67%	39%	86%
4-Respiratory System	77%	76%	91%	92%	78%	63%	67%	45%	86%
5-Cardiovascular System – Surgical	81%	89%	91%	92%	73%	63%	67%	58%	87%
6-Hemic, Lymphatic System, and Mediastinum	71%	75%	91%	91%	78%	65%	67%	45%	85%
7-Digestive System	74%	80%	91%	92%	78%	63%	67%	50%	86%
8-Urinary System and Male Genital	74%	81%	92%	92%	78%	64%	68%	45%	86%
9-Gynecology and Obstetrics	88%	93%	87%	88%	88%	81%	84%	95%	84%
10-Endocrine System	73%	73%	91%	91%	78%	67%	67%	65%	84%
11-Nervous System	87%	95%	92%	93%	78%	62%	67%	34%	87%
12-Eye Surgery	85%	88%	92%	92%	79%	65%	65%	94%	86%
13-Ear Surgery	85%	84%	92%	92%	78%	64%	66%	46%	86%
14-Radiology	80%	80%	92%	92%	82%	61%	61%	73%	88%
15-Laboratory	97%	97%	98%	98%	99%	100%	100%	96%	86%

16-Psychiatry	85%	94%	94%	95%	99%	69%	70%	33%	84%
17-Dialysis	63%	63%	93%	93%	80%	68%	68%	44%	84%
18-Gastroenterology	75%	75%	91%	91%	78%	60%	60%	58%	88%
19-Ophthalmology and Vision Care	75%	80%	93%	94%	79%	64%	66%	40%	87%
20-ENT (Otorhinolaryngology)	83%	80%	93%	93%	80%	65%	65%	31%	86%
21-Cardiovascular System – Medical	93%	93%	92%	92%	79%	62%	62%	79%	87%
22-Noninvasive Vascular Diagnostic Studies	83%	83%	91%	91%	80%	61%	61%	71%	90%
23-Pulmonary	87%	87%	91%	91%	78%	60%	60%	61%	88%
24-Allergy and Immunology	80%	82%	91%	91%	78%	60%	60%	53%	88%
25-Neurology and Neuromuscular	82%	82%	91%	91%	78%	61%	61%	42%	88%
26- Central Nervous System Assessment Tests	77%	78%	91%	91%	81%	61%	61%	74%	88%
27-Chemotherapy Administration	91%	91%	91%	91%	78%	61%	61%	78%	88%
28-Special Dermatological	50%	47%	90%	91%	78%	59%	59%	19%	89%
29-Physical Medicine and Rehabilitation	80%	80%	93%	93%	86%	64%	64%	48%	86%
30-Osteopathy, Chiropractic, and Other Medicine	81%	81%	91%	91%	77%	62%	63%	118 %	73%

NF: non-facility (e.g., office); FA: facility (e.g., hospital)

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. The Department generally does not reimburse for adult dental services; however, some of the MCOs provide this benefit from their own funds.[7] Starting June 1, 2019, the Department began a pilot program to provide dental benefits to adults between the ages of 21 and 64 who receive full Medicaid and Medicare benefits.[8]

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 FY 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.

[7] 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.

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

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, the Department considered maintaining rates as is, distributing the funds across all Current Dental Terminology (CDT) codes, or raising certain codes with high utilization. The Department 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.

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.

In FY 2023, additional rate increases were considered with a budget of $19.6 million. The Department considered a number of options to raise dental rates. After discussions with stakeholders, the reimbursement rates for a small number of dental codes were raised by 20% and all remaining preventative and restorative codes were raised by 5.49%. The codes eligible for the 20% increase included ten codes selected by stakeholders as most in need of increased reimbursement. See Table 3 for these updated rates. The rate increases went live on August 1, 2023. These rate increases applied to both participants covered for dental services before January 1, 2023 and those covered under the expanded dental benefit. The Department is continuing discussions with stakeholders to consider additional rate increases, dependent on funding availability.

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

CDT	Description	New Rate
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$168.48
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. Dental Payment Rates Effective August 1, 2023

CDT	Description	Current Fee	New Fee
Tier 1-20% Increase			
D1330	Oral Hygiene Instructions	$6.00	$7.20
D0220	Intraoral – Periapical First Radiographic Image	$9.85	$11.82
D1351	Sealant – Per Tooth	$33.23	$39.88
D4342	Periodontal Scaling and Root Planing – One to Three Teeth per Quadrant	$54.00	$64.80
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$65.64	$78.77
D2390	Resin-Based Composite Crown, Anterior	$75.00	$90.00
D4341	Periodontal Scaling and Root Planing – Four or More Teeth per Quadrant	$75.00	$90.00
D7140	Extraction, Erupted Tooth Or Exposed Root	$112.69	$135.23
D2740	Crown – Porcelain/Ceramic Substrate	$328.20	$393.84
D2750	Crown – Porcelain Fused to High Noble Metal	$410.25	$492.30
Tier 2-5.49% Increase			
D1110	Prophylaxis – Adult	$63.62	$67.12
D1120	Prophylaxis – Child	$46.35	$48.90
D1206	Topical Application of Fluoride Varnish	$24.92	$26.29

CDT	Description	Current Fee	New Fee
D1208	Topical Application of Fluoride – Excluding Varnish	$23.00	$24.26
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth	$33.23	$35.06
D1354	Interim Caries Arresting Medicament Application- Per Tooth	$10.00	$10.55
D1510	Space Maintainer – Fixed, Unilateral	$84.00	$88.62
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	$144.00	$151.91
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	$144.00	$151.91
D1520	Space Maintainer – Removable – Unilateral	$64.00	$67.52
D1526	Space Maintainer – Removable – Bilateral, Maxillary	$96.00	$101.28
D1527	Space Maintainer – Removable – Bilateral, Mandibular	$96.00	$101.28
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	$24.00	$25.32
D1556	Removal of fixed unilateral space maintainer- per quadrant	$25.00	$26.37
D2140	Amalgam – One Surface, Primary or Permanent	$70.00	$73.85
D2150	Amalgam – Two Surfaces, Primary or Permanent	$88.00	$92.84
D2160	Amalgam – Three Surfaces, Primary or Permanent	$104.00	$109.72
D2161	Amalgam – Four or More Surfaces, Primary or Permanent	$104.00	$109.72
D2330	Resin-Based Composite – One Surface, Anterior	$91.90	$96.95
D2331	Resin-Based Composite – Two Surfaces, Anterior	$111.59	$117.72
D2332	Resin-Based Composite – Three Surfaces, Anterior	$136.75	$144.26
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	$165.19	$174.27
D2391	Resin-Based Composite – One Surface, Posterior	$101.74	$107.33
D2392	Resin-Based Composite – Two Surfaces, Posterior	$131.28	$138.49

CDT	Description	Current Fee	New Fee
D2393	Resin-Based Composite – Three Surfaces, Posterior	$164.10	$173.12
D2394	Resin-Based Composite – Four Or More Surfaces, Posterior	$164.10	$173.12
D2721	Crown – Resin with Predominantly Base Metal	$250.00	$263.74
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$375.00	$395.61
D2752	Crown – Porcelain Fused to Noble Metal	$375.00	$395.61
D2780	Crown – ¾ Cast High Noble Metal	$292.00	$308.05
D2781	Crown – ¾ Cast Predominantly Base Metal	$292.00	$308.05
D2782	Crown – ¾ Cast Noble Metal	$292.00	$308.05
D2783	Crown – ¾ Porcelain/Ceramic	$292.00	$308.05
D2790	Crown – Full Cast High Noble Metal	$292.00	$308.05
D2791	Crown – Full Cast Predominantly Base Metal	$292.00	$308.05
D2792	Crown – Full Cast Noble Metal	$292.00	$308.05
D2794	Crown – Titanium	$292.00	$308.05
D2910	Re-cement or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration	$25.00	$26.37
D2920	Re-cement or Re-bond Crown	$25.00	$26.37
D2928	Prefabricated porcelain/ceramic crown – Permanent Tooth	$180.00	$189.89
D2929	Prefabricated Porcelain/Ceramic Crown – Primary Tooth	$154.00	$162.46
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$168.48	$177.74
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$196.92	$207.74
D2932	Prefabricated Resin Crown	$75.00	$79.12
D2933	Prefabricated Stainless Steel Crown with Resin Window	$81.00	$85.45
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$168.48	$177.74
D2940	Protective Restoration	$50.00	$52.75
D2950	Core Buildup, Including Any Pins When Required	$81.00	$85.45
D2951	Pin Retention – Per Tooth, In Addition to Restoration	$12.00	$12.66

CDT	Description	Current Fee	New Fee
D2952	Post and Core In Addition to Crown, Indirectly Fabricated	$96.00	$101.28
D2954	Prefabricated Post and Core In Addition to Crown	$70.00	$73.85
D2955	Post Removal	$25.00	$26.37
D2960	Labial Veneer (Resin Laminate) – Chairside	$81.00	$85.45
D2961	Labial Veneer (Resin Laminate) – Laboratory	$81.00	$85.45
D2962	Labial Veneer (Porcelain Laminate) – Laboratory	$108.00	$113.93
D2980	Crown Repair Necessitated by Restorative Material Failure	$93.00	$98.11

Table 4 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), Virginia (third), West Virginia (fourth), Maryland (fifth), and Pennsylvania (sixth). Last year Maryland ranked third but dropped to fifth in 2023. As the codes included in this analysis are based on utilization, the change in rankings reflects the inclusion of different codes this year as opposed to previous years. Median fees from the ADA report correspond to CY 2022, and the states' fees correspond to CY 2023.

Table 4. Comparison of Maryland Medicaid and Neighboring States' 2023 Dental Fees with Median ADA Charges in 2022

Procedure Code	Procedure Description	ADA	MD	DE	VA	WV	PA	DC
D0120	Periodic Oral Evaluation – Established Patient	$60	$32	$45	$26	$28	$20	$35
D0150	Comprehensive Oral Evaluation – New or Established Patient	$100	$56	$79	$41	$39	$20	$78
D0220	Intraoral – Periapical First Radiographic Image	$33	$10	$26	$15	$17	$8	$20
D0272	Bitewings – Two Radiographic Images	$52	$16	$38	$26	$28	$16	$40
D0274	Bitewings – Four Radiographic Images	$74	$24	$56	$36	$41	$28	$48
D1110	Prophylaxis – Adult	$107	$64	$79	$61	$61	$36	$78
D1120	Prophylaxis – Child	$78	$46	$58	$44	$44	$30	$47
D1206	Topical Application of Fluoride Varnish	$41	$25	$34	$27	$22	$18	$29
D1208	Topical Application of Fluoride – Excluding Varnish	$42	$23	$32	$27	$22	$19	$25
D1330	Oral Hygiene Instructions	$57	$6	$0	$0	$0	$11	$0
D1351	Sealant – Per Tooth	$59	$33	$48	$42	$33	$25	$38

D2392	Resin-Based Composite – Two Surfaces, Posterior	$267	$131	$276	$116	$125	$60	$160
Ranking			**5**	**1**	**3**	**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.[9] 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. The Department 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.

The Department 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[10] for the FFS population, and a 2019 assessment of the accuracy of provider directories published by MCOs.[11]

VIII. Plan for the Future

The Department 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 2022, funds were allocated for E&M services to be reimbursed at 100 percent of Medicare and these rates were maintained in FY 2023 despite reductions in Medicare reimbursement rates. Furthermore, the Department has continued to monitor provider network adequacy to ensure that patients' access to care is not compromised. In addition, the Department 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.

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[9] COMAR 10.67.05.05-.08.

[10] 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.

[11] 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

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.[12] 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 requirements, ensuring current enrollees have continuous Medicaid coverage. This increased FMAP continued through FY 2022. The Consolidated Appropriations Act passed in 2023 ended the increased FMAP and the enhanced FMAP began phasing down in March 2023 and is expected to end in December 2023.[13]

The Inflation Reduction Act included a provision that state Medicaid programs must cover adult vaccinations without cost sharing.[14] This would require Maryland Medicaid to eliminate cost sharing for adult vaccinations billed by pharmacies. In addition, certain required vaccinations were not covered. Maryland plans to cover these services and will receive an additional 1% FMAP for adult vaccinations and their administration. While the provision of COVID-19 vaccine product by the federal government ended on September 11, 2023, the 100% FMAP for COVID-19 vaccine product and administration will continue through September 30, 2023.

The Department will continue to monitor reimbursement rates and access to care for surgical, professional and dental services.

[12] See: https://health.maryland.gov/mmcp/provider/Documents/Telehealth/Maryland%20Medicaid%20Telehealth%20Program%20Policy%20Guide.pdf
[13] H.R.2617, 118th Cong. (2023) (enacted).
[14] Please see: https://www.medicaid.gov/sites/default/files/2023-06/sho23003.pdf

Appendix A. Ranking of State Reimbursement Rates by Procedure Code

Table A compares Maryland's FY 2023 Medicaid fees with the corresponding Medicare 2023 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 2023

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												
99203	Office o/p new low 30-44 min	$121	$88	$122	$90	$111	$82	$82	$79	$60	$54	$103
99204	Office o/p new mod 45-59 min	$178	$141	$182	$146	$165	$131	$122	$117	$96	$90	$152
99212	Office o/p est sf 10-19 min	$61	$38	$62	$39	$56	$35	$41	$39	$26	$26	$52
99213	Office o/p est low 20-29 min	$97	$70	$99	$72	$89	$65	$66	$63	$47	$35	$83
99214	Office o/p est mod 30-39 min	$137	$103	$139	$105	$126	$96	$94	$89	$70	$54	$117
99215	Office o/p est hi 40-54 min	$191	$151	$196	$156	$177	$141	$131	$126	$102	$78	$163
99232	Sbsq hosp ip/obs moderate 35	$84	$84	$76	$76	$78	$78	$58	$57	$57	$62	$70
99233	Sbsq hosp ip/obs high 50	$126	$126	$109	$109	$117	$117	$87	$86	$86	$93	$106
99281	Emr dpt vst mayx req phy/qhp	$13	$13	$24	$24	$12	$12	$8	$9	$9	$16	$10
99283	Emergency dept visit low mdm	$76	$76	$78	$78	$71	$71	$49	$53	$53	$57	$63
99284	Emergency dept visit mod mdm	$128	$128	$131	$131	$119	$119	$82	$89	$89	$95	$106
99285	Emergency dept visit hi mdm	$187	$187	$190	$190	$173	$173	$120	$130	$130	$139	$155
Weighted Average % of Medicare Fees					**102%**	**102%**	**93%**	**93%**	**68%**	**66%**	**68%**	49%
Ranking					**2**	**1**	**4**	**2**	**7**	**8**	**6**	9
Integumentary / General Surgery												
10060	Drainage of skin abscess	$137	$114	$93	$77	$125	$105	$107	$86	$73	$24	$119
11042	Deb subq tissue 20 sq cm/<	$141	$64	$93	$49	$129	$59	$110	$87	$43	$33	$123

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
11043	Deb musc/fascia 20 sq cm/<	$253	$165	$187	$129	$231	$151	$198	$162	$111	$33	$217
11056	Trim skin lesions 2 to 4	$90	$23	$46	$24	$83	$22	$71	$55	$16	$30	$79
11102	Tangntl bx skin single les	$111	$40	$87	$35	$102	$37	$87	$69	$27	$32	$98
11719	Trim nail(s) any number	$15	$8	$14	$7	$14	$7	$12	$10	$5	$0	$13
11720	Debride nail 1-5	$36	$15	$25	$12	$33	$14	$28	$22	$11	$16	$31
11721	Debride nail 6 or more	$48	$25	$35	$21	$44	$23	$38	$31	$17	$20	$41
11900	Inject skin lesions </w 7	$62	$32	$44	$25	$57	$30	$49	$39	$22	$0	$54
12001	Rpr s/n/ax/gen/trnk 2.5cm/<	$104	$49	$88	$43	$94	$44	$81	$66	$33	$25	$90
12011	Rpr f/e/e/n/l/m 2.5 cm/<	$124	$60	$113	$61	$113	$54	$97	$78	$41	$32	$107
17110	Destruct b9 lesion 1-14	$125	$73	$89	$56	$114	$67	$97	$76	$46	$49	$109
Weighted Average % of Medicare Fees				**72%**	**80%**	**91%**	**92%**	**78%**	**62%**	**66%**	**27%**	**87%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Musculoskeletal System												
20550	Inj tendon sheath/ligament	$63	$42	$56	$39	$58	$39	$49	$41	$29	$32	$54
20552	Inj trigger point 1/2 muscl	$57	$40	$50	$33	$53	$37	$45	$37	$27	$31	$0
20553	Inject trigger points 3/>	$67	$46	$55	$37	$61	$42	$52	$43	$31	$34	$57
20605	Drain/inj joint/bursa w/o us	$60	$40	$55	$40	$55	$37	$47	$39	$27	$22	$51
20610	Drain/inj joint/bursa w/o us	$70	$49	$66	$48	$64	$45	$55	$45	$33	$24	$60
20611	Drain/inj joint/bursa w/us	$109	$65	$98	$64	$100	$59	$85	$70	$44	$50	$94
29075	Application of forearm cast	$97	$69	$80	$58	$88	$62	$76	$61	$45	$46	$84
29125	Apply forearm splint	$73	$44	$61	$39	$67	$40	$57	$46	$29	$26	$64
29130	Application of finger splint	$46	$32	$37	$27	$42	$29	$36	$30	$22	$0	$39
29515	Application lower leg splint	$78	$53	$65	$47	$72	$49	$61	$50	$35	$35	$68
29540	Strapping of ankle and/or ft	$30	$19	$28	$19	$28	$17	$24	$20	$13	$20	$26
29581	Apply multlay comprs lwr leg	$97	$28	$69	$14	$89	$26	$76	$59	$19	$25	$85
Weighted Average % of Medicare Fees				**89%**	**94%**	**91%**	**92%**	**78%**	**64%**	**67%**	**39%**	**86%**
Ranking				**4**	**1**	**3**	**2**	**6**	**8**	**7**	**9**	**5**
Respiratory												
30140	Resect inferior turbinate	$327	$193	$315	$194	$298	$177	$256	$207	$129	$259	$282
30520	Repair of nasal septum	$746	$746	$493	$493	$682	$682	$585	$473	$473	$416	$644

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
31231	Nasal endoscopy dx	$209	$70	$167	$57	$190	$64	$163	$128	$47	$59	$183
31237	Nasal/sinus endoscopy surg	$282	$173	$232	$136	$257	$158	$221	$178	$115	$160	$243
31500	Insert emergency airway	$150	$150	$112	$112	$138	$138	$119	$104	$104	$72	$125
31575	Diagnostic laryngoscopy	$143	$74	$91	$57	$130	$68	$111	$88	$48	$69	$124
31579	Laryngoscopy telescopic	$218	$129	$167	$104	$199	$118	$171	$137	$85	$75	$189
31615	Visualization of windpipe	$189	$124	$134	$92	$173	$114	$148	$120	$82	$115	$163
31622	Dx bronchoscope/wash	$269	$139	$236	$108	$246	$128	$211	$170	$94	$134	$233
31624	Dx bronchoscope/lavage	$276	$140	$241	$108	$254	$130	$217	$175	$96	$135	$239
32551	Insertion of chest tube	$166	$166	$128	$128	$152	$152	$131	$114	$114	$133	$138
32555	Aspirate pleura w/ imaging	$346	$115	$287	$94	$317	$107	$271	$213	$79	$89	$303
Weighted Average % of Medicare Fees				**77%**	**76%**	**91%**	**92%**	**78%**	**63%**	**67%**	**45%**	**86%**
Ranking				**5**	**6**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Cardiovascular System Surgery												
36410	Non-routine bl draw 3/> yrs	$19	$10	$14	$7	$17	$9	$15	$12	$7	$0	$16
36430	Blood transfusion service	$43	$43	$31	$31	$39	$39	$33	$25	$25	$28	$39
36556	Insert non-tunnel cv cath	$234	$89	$194	$91	$214	$82	$183	$146	$62	$113	$204
36591	Draw blood off venous device	$30	$30	$19	$19	$27	$27	$0	$17	$17	$0	$26
36620	Insertion catheter artery	$47	$47	$40	$40	$44	$44	$37	$33	$33	$48	$39
Weighted Average % of Medicare Fees				**81%**	**89%**	**91%**	**92%**	**73%**	**63%**	**67%**	**58%**	**87%**
Ranking				**5**	**3**	**2**	**1**	**6**	**8**	**7**	**9**	**4**
Hemic, Lymphatic and Mediastinum												
38220	Dx bone marrow aspirations	$169	$72	$134	$49	$155	$67	$133	$105	$48	$55	$148
38221	Dx bone marrow biopsies	$176	$74	$136	$59	$161	$69	$138	$109	$50	$70	$153
38222	Dx bone marrow bx & aspir	$190	$80	$149	$67	$175	$74	$149	$118	$54	$63	$166
38500	Biopsy/removal lymph nodes	$372	$280	$266	$205	$337	$254	$290	$240	$186	$114	$318
38505	Needle biopsy lymph nodes	$193	$91	$101	$57	$177	$85	$151	$121	$62	$67	$168
38510	Biopsy/removal lymph nodes	$581	$457	$337	$337	$529	$416	$454	$377	$305	$136	$495
38525	Biopsy/removal lymph nodes	$485	$485	$353	$353	$439	$439	$378	$322	$322	$156	$408
38571	Laparoscopy lymphadenectomy	$707	$707	$582	$582	$651	$651	$559	$477	$477	$633	$594

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
38724	Removal of lymph nodes neck	$1,576	$1,576	$1,160	$1,160	$1,444	$1,444	$1,241	$1,051	$1,051	$844	$1,328
38792	Ra tracer id of sentinl node	$90	$35	$32	$32	$82	$32	$71	$56	$24	$0	$79
38900	Io map of sent lymph node	$149	$149	$113	$113	$134	$134	$116	$101	$101	$110	$123
39501	Repair diaphragm laceration	$926	$926	$685	$685	$838	$838	$722	$623	$623	$743	$773
Weighted Average % of Medicare Fees				**71%**	**75%**	**91%**	**91%**	**78%**	**65%**	**67%**	**45%**	**85%**
Ranking				**6**	**5**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Digestive System												
42820	Remove tonsils and adenoids	$318	$318	$231	$231	$292	$292	$250	$209	$209	$184	$271
43235	Egd diagnostic brush wash	$317	$130	$229	$104	$289	$120	$247	$196	$87	$125	$276
43239	Egd biopsy single/multiple	$415	$147	$274	$123	$379	$135	$324	$254	$98	$149	$363
43775	Lap sleeve gastrectomy	$1,210	$1,210	$969	$969	$1,091	$1,091	$942	$829	$829	$1,034	$1,000
44970	Laparoscopy appendectomy	$662	$662	$486	$486	$599	$599	$516	$443	$443	$444	$555
45378	Diagnostic colonoscopy	$372	$196	$299	$155	$340	$180	$291	$234	$132	$181	$322
45380	Colonoscopy and biopsy	$476	$213	$357	$186	$435	$196	$373	$296	$143	$255	$414
45385	Colonoscopy w/lesion removal	$496	$269	$400	$221	$454	$248	$389	$313	$181	$268	$429
46600	Diagnostic anoscopy spx	$132	$45	$71	$33	$120	$41	$103	$80	$29	$20	$116
47562	Laparoscopic cholecystectomy	$725	$725	$532	$532	$655	$655	$565	$486	$486	$589	$607
49083	Abd paracentesis w/imaging	$323	$112	$267	$91	$296	$104	$253	$198	$76	$84	$283
Weighted Average % of Medicare Fees				**74%**	**80%**	**91%**	**92%**	**78%**	**63%**	**67%**	**50%**	**86%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Urinary & Male Genital												
51700	Irrigation of bladder	$83	$32	$70	$33	$76	$30	$65	$52	$22	$29	$73
51701	Insert bladder catheter	$48	$27	$47	$28	$44	$25	$38	$31	$18	$25	$42
51705	Change of bladder tube	$106	$55	$92	$51	$97	$51	$83	$67	$37	$28	$92
51741	Electro-uroflowmetry first	$15	$15	$15	$15	$14	$14	$12	$10	$10	$24	$13
51798	Us urine capacity measure	$12	$12	$12	$12	$11	$11	$9	$7	$7	$14	$0
52000	Cystoscopy	$264	$85	$144	$87	$241	$78	$206	$162	$58	$75	$231
52310	Cystoscopy and treatment	$348	$160	$205	$121	$319	$147	$273	$218	$108	$129	$302
52332	Cystoscopy and treatment	$441	$164	$393	$124	$402	$151	$344	$272	$111	$144	$385
52356	Cysto/uretero w/lithotripsy	$436	$436	$337	$337	$403	$403	$346	$297	$297	$333	$365

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
54150	Circumcision w/regionl block	$161	$103	$145	$78	$148	$95	$127	$104	$70	$79	$138
54161	Circum 28 days or older	$211	$211	$157	$157	$194	$194	$167	$141	$141	$128	$178
55700	Biopsy of prostate	$263	$137	$198	$104	$240	$127	$206	$166	$93	$90	$227
Weighted Average % of Medicare Fees				**74%**	**81%**	**92%**	**92%**	**78%**	**64%**	**68%**	**45%**	**86%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
Gynecology-Obstetric												
57454	Bx/curett of cervix w/scope	$185	$144	$152	$133	$169	$132	$164	$121	$97	$106	$157
58100	Biopsy of uterus lining	$112	$68	$109	$70	$102	$62	$99	$72	$46	$51	$96
58300	Insert intrauterine device	$121	$54	$76	$51	$111	$111	$107	$76	$37	$17	$105
58301	Remove intrauterine device	$121	$71	$95	$66	$111	$65	$107	$77	$49	$17	$104
58558	Hysteroscopy biopsy	$1,488	$250	$1,092	$253	$1,353	$229	$1,307	$889	$169	$239	$1,315
58661	Laparoscopy remove adnexa	$711	$711	$620	$620	$650	$650	$631	$270	$270	$565	$596
59025	Fetal non-stress test	$54	$54	$46	$46	$49	$49	$47	$34	$34	$13	$46
59409	Obstetrical care	$881	$881	$860	$860	$793	$793	$773	$796	$796	$1,200	$729
59410	Obstetrical care	$1,168	$1,168	$942	$942	$1,050	$1,050	$1,025	$1,051	$1,051	$1,200	$968
59430	Care after delivery	$294	$198	$149	$125	$265	$178	$258	$253	$179	$0	$249
59514	Cesarean delivery only	$1,000	$1,000	$993	$993	$793	$793	$876	$905	$905	$1,200	$826
Weighted Average % of Medicare Fees				**88%**	**93%**	**87%**	**88%**	**88%**	**81%**	**84%**	**95%**	**84%**
Ranking				**3**	**2**	**6**	**3**	**5**	**9**	**7**	**1**	**8**
Endocrine System												
60100	Biopsy of thyroid	$120	$82	$89	$63	$110	$76	$94	$78	$56	$66	$102
60210	Partial thyroid excision	$774	$774	$567	$567	$704	$704	$606	$516	$516	$605	$651
60220	Partial removal of thyroid	$773	$773	$565	$565	$704	$704	$606	$514	$514	$521	$651
60240	Removal of thyroid	$1,002	$1,002	$737	$737	$911	$911	$785	$671	$671	$591	$841
60252	Removal of thyroid	$1,441	$1,441	$1,059	$1,059	$1,311	$1,311	$1,129	$967	$967	$826	$1,208
60271	Removal of thyroid	$1,150	$1,150	$847	$847	$1,048	$1,048	$902	$772	$772	$925	$965
60280	Remove thyroid duct lesion	$497	$497	$354	$354	$455	$455	$391	$324	$324	$304	$424
60500	Explore parathyroid glands	$1,062	$1,062	$775	$775	$964	$964	$830	$710	$710	$705	$890
60512	Autotransplant parathyroid	$262	$262	$195	$195	$238	$238	$205	$178	$178	$217	$218
60650	Laparoscopy adrenalectomy	$1,292	$1,292	$960	$960	$1,174	$1,174	$1,011	$874	$874	$977	$1,078

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Weighted Average % of Medicare Fees				**73%**	**73%**	**91%**	**91%**	**78%**	**67%**	**67%**	**65%**	**84%**
Ranking				**6**	**5**	**2**	**1**	**4**	**8**	**7**	**9**	**3**
Neurosurgery												
62321	Njx interlaminar crv/thrc	$286	$113	$246	$109	$262	$105	$224	$177	$76	$89	$250
62323	Njx interlaminar lmbr/sac	$283	$105	$242	$99	$258	$97	$221	$174	$71	$81	$247
64415	Njx aa&/strd brach plexus	$146	$73	$124	$67	$135	$68	$115	$93	$50	$35	$126
64447	Njx aa&/strd femoral nerve	$126	$66	$94	$57	$116	$62	$99	$80	$46	$61	$109
64450	Njx aa&/strd other pn/branch	$82	$45	$85	$46	$75	$41	$64	$51	$30	$21	$71
64483	Njx aa&/strd tfrm epi l/s 1	$268	$118	$238	$101	$246	$109	$210	$166	$78	$95	$234
64484	Njx aa&/strd tfrm epi l/s ea	$122	$55	$95	$55	$111	$51	$95	$76	$37	$60	$106
64493	Inj paravert f jnt l/s 1 lev	$192	$96	$170	$94	$176	$89	$151	$120	$64	$72	$167
64494	Inj paravert f jnt l/s 2 lev	$98	$54	$87	$54	$90	$50	$77	$63	$37	$42	$85
64495	Inj paravert f jnt l/s 3 lev	$98	$55	$88	$55	$90	$51	$77	$63	$37	$42	$85
64635	Destroy lumb/sac facet jnt	$482	$204	$453	$208	$441	$189	$378	$298	$136	$179	$0
64636	Destroy l/s facet jnt addl	$265	$62	$188	$64	$242	$58	$207	$160	$42	$48	$0
Weighted Average % of Medicare Fees				**87%**	**95%**	**92%**	**93%**	**78%**	**62%**	**67%**	**34%**	**87%**
Ranking				**5**	**1**	**3**	**2**	**6**	**8**	**7**	**9**	**4**
Eye Surgery												
65222	Remove foreign body from eye	$72	$53	$52	$41	$67	$49	$57	$46	$35	$26	$62
65855	Trabeculoplasty laser surg	$263	$218	$227	$195	$242	$201	$207	$168	$142	$237	$226
66761	Revision of iris	$322	$251	$285	$253	$296	$232	$253	$203	$162	$181	$279
66821	After cataract laser surgery	$359	$333	$260	$246	$330	$307	$283	$226	$211	$217	$311
66982	Xcapsl ctrc rmvl cplx wo ecp	$790	$790	$678	$678	$730	$730	$625	$512	$512	$697	$677
66984	Xcapsl ctrc rmvl w/o ecp	$577	$577	$503	$503	$533	$533	$457	$374	$374	$603	$495
67028	Injection eye drug	$121	$97	$99	$98	$112	$90	$96	$78	$64	$106	$104
67113	Repair retinal detach cplx	$1,407	$1,407	$1,062	$1,062	$1,301	$1,301	$1,114	$917	$917	$1,086	$1,203
67228	Treatment x10sv retinopathy	$362	$321	$333	$300	$334	$297	$286	$233	$210	$491	$311
67311	Revise eye muscle	$484	$484	$470	$470	$447	$447	$383	$312	$312	$468	$415
67800	Remove eyelid lesion	$139	$109	$100	$81	$128	$100	$109	$88	$71	$41	$120
68761	Close tear duct opening	$158	$125	$117	$94	$145	$116	$124	$99	$80	$63	$137

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
Weighted Average % of Medicare Fees				**85%**	**88%**	**92%**	**92%**	**79%**	**65%**	**65%**	**94%**	**86%**
Ranking				**6**	**4**	**3**	**2**	**7**	**9**	**8**	**1**	**5**
Ear Surgery												
69200	Clear outer ear canal	$88	$51	$82	$49	$80	$47	$69	$56	$34	$30	$76
69205	Clear outer ear canal	$105	$105	$91	$91	$96	$96	$82	$68	$68	$89	$90
69209	Remove impacted ear wax uni	$17	$17	$11	$11	$15	$15	$13	$10	$10	$10	$15
69210	Remove impacted ear wax uni	$52	$35	$44	$29	$47	$32	$41	$33	$24	$20	$44
69436	Create eardrum opening	$175	$175	$149	$149	$160	$160	$137	$113	$113	$99	$149
Weighted Average % of Medicare Fees				**85%**	**84%**	**92%**	**92%**	**78%**	**64%**	**66%**	**46%**	**86%**
Ranking				**4**	**5**	**2**	**1**	**6**	**8**	**7**	**9**	**3**
Radiology												
70450	Ct head/brain w/o dye	$120	$120	$114	$114	$110	$110	$94	$74	$74	$117	$105
71045	X-ray exam chest 1 view	$29	$29	$17	$17	$26	$26	$22	$18	$18	$15	$25
71046	X-ray exam chest 2 views	$37	$37	$27	$27	$34	$34	$29	$23	$23	$24	$32
73610	X-ray exam of ankle	$41	$41	$25	$25	$37	$37	$32	$25	$25	$27	$36
73630	X-ray exam of foot	$38	$38	$24	$24	$34	$34	$29	$23	$23	$19	$33
74177	Ct abd & pelv w/contrast	$348	$348	$287	$287	$318	$318	$272	$211	$211	$263	$306
76816	Ob us follow-up per fetus	$120	$120	$93	$93	$110	$110	$106	$74	$74	$72	$105
76820	Umbilical artery echo	$48	$48	$50	$50	$45	$45	$43	$31	$31	$46	$42
76830	Transvaginal us non-ob	$132	$132	$98	$98	$121	$121	$117	$80	$80	$77	$116
76856	Us exam pelvic complete	$116	$116	$88	$88	$106	$106	$103	$71	$71	$77	$102
77063	Breast tomosynthesis bi	$57	$57	$48	$48	$53	$53	$51	$36	$36	$44	$49
77067	Scr mammo bi incl cad	$141	$141	$108	$108	$129	$129	$124	$85	$85	$105	$123
Weighted Average % of Medicare Fees				**80%**	**80%**	**92%**	**92%**	**82%**	**61%**	**61%**	**73%**	**88%**
Ranking				**5**	**5**	**1**	**1**	**4**	**8**	**8**	**7**	**3**
Laboratory												
80053	Comprehen metabolic panel	$11	$11	$10	$10	$10	$10	$11	$11	$11	$12	$8
80061	Lipid panel	$13	$13	$13	$13	$13	$13	$13	$13	$13	$14	$11
80307	Drug test prsmv chem anlyzr	$62	$62	$49	$49	$61	$61	$62	$62	$62	$64	$50
81001	Urinalysis auto w/scope	$3	$3	$3	$3	$3	$3	$3	$3	$3	$3	$3

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
82306	Vitamin d 25 hydroxy	$30	$30	$29	$29	$29	$29	$30	$30	$30	$41	$24
83036	Hemoglobin glycosylated a1c	$10	$10	$10	$10	$10	$10	$10	$10	$10	$7	$8
84443	Assay thyroid stim hormone	$17	$17	$17	$17	$16	$16	$17	$17	$17	$23	$13
85025	Complete cbc w/auto diff wbc	$8	$8	$8	$8	$8	$8	$8	$8	$8	$6	$6
87086	Urine culture/colony count	$8	$8	$8	$8	$8	$8	$8	$8	$8	$8	$6
87426	Sarscov coronavirus ag ia	$35	$35	$45	$45	$0	$0	$31	$35	$35	$35	$45
87491	Chlmyd trach dna amp probe	$35	$35	$34	$34	$34	$34	$35	$35	$35	$23	$28
87591	N.gonorrhoeae dna amp prob	$35	$35	$34	$34	$34	$34	$35	$35	$35	$23	$28
Weighted Average % of Medicare Fees				**97%**	**97%**	**98%**	**98%**	**99%**	**100%**	**100%**	**96%**	**86%**
Ranking				**6**	**6**	**4**	**4**	**3**	**1**	**1**	**8**	**9**
Psychiatry												
90791	Psych diagnostic evaluation	$183	$156	$147	$147	$172	$149	$180	$125	$110	$26	$153
90832	Psytx w pt 30 minutes	$79	$69	$67	$67	$74	$65	$78	$54	$48	$26	$66
90834	Psytx w pt 45 minutes	$104	$91	$88	$88	$99	$87	$103	$72	$64	$39	$88
90837	Psytx w pt 60 minutes	$153	$134	$133	$133	$145	$128	$151	$105	$94	$52	$129
90847	Family psytx w/pt 50 min	$103	$103	$106	$58	$98	$98	$102	$72	$72	$13	$86
90853	Group psychotherapy	$28	$24	$24	$24	$26	$23	$28	$19	$17	$4	$23
Weighted Average % of Medicare Fees				**85%**	**94%**	**94%**	**95%**	**99%**	**69%**	**70%**	**33%**	**84%**
Ranking				**5**	**4**	**3**	**2**	**1**	**8**	**7**	**9**	**6**
Dialysis												
90935	Hemodialysis one evaluation	$75	$75	$56	$56	$70	$70	$60	$52	$52	$35	$63
90945	Dialysis one evaluation	$90	$90	$66	$66	$84	$84	$72	$61	$61	$35	$76
90960	Esrd srv 4 visits p mo 20+	$372	$372	$219	$219	$347	$347	$297	$251	$251	$0	$314
90961	Esrd srv 2-3 vsts p mo 20+	$310	$310	$184	$184	$289	$289	$247	$208	$208	$0	$262
90966	Esrd home pt serv p mo 20+	$309	$309	$184	$184	$288	$288	$247	$208	$208	$0	$0
Weighted Average % of Medicare Fees				**63%**	**63%**	**93%**	**93%**	**80%**	**68%**	**68%**	**44%**	**84%**
Ranking				**7**	**7**	**1**	**1**	**4**	**5**	**5**	**9**	**3**
Gastroenterology												
91010	Esophagus motility study	$242	$242	$155	$155	$222	$222	$189	$147	$147	$28	$213
91035	G-esoph reflx tst w/electrod	$508	$508	$384	$384	$463	$463	$396	$304	$304	$351	$449

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
91037	Esoph imped function test	$184	$184	$127	$127	$169	$169	$144	$112	$112	$114	$162
91065	Breath hydrogen/methane test	$93	$93	$60	$60	$84	$84	$72	$55	$55	$17	$82
91110	Gi trc img intral esoph-ile	$818	$818	$733	$733	$747	$747	$638	$487	$487	$680	$725
91120	Rectal sensation test	$563	$563	$341	$341	$512	$512	$438	$332	$332	$337	$0
91122	Anal pressure record	$300	$300	$190	$190	$275	$275	$235	$183	$183	$69	$263
91200	Liver elastography	$33	$33	$31	$31	$30	$30	$26	$20	$20	$30	$0
Weighted Average % of Medicare Fees				**75%**	**75%**	**91%**	**91%**	**78%**	**60%**	**60%**	**58%**	**88%**
Ranking				**5**	**5**	**1**	**1**	**4**	**7**	**7**	**9**	**3**
Ophthalmology/Vision Care												
92002	Eye exam new patient	$92	$48	$64	$37	$85	$45	$73	$58	$32	$28	$80
92004	Eye exam new patient	$160	$98	$117	$77	$148	$93	$127	$102	$66	$59	$138
92012	Eye exam establish patient	$97	$53	$67	$41	$89	$50	$76	$61	$36	$29	$84
92014	Eye exam&tx estab pt 1/>vst	$135	$80	$97	$62	$125	$75	$107	$86	$53	$45	$117
92015	Determine refractive state	$20	$20	$19	$15	$19	$18	$16	$14	$13	$5	$17
92060	Special eye evaluation	$68	$68	$51	$51	$63	$63	$54	$43	$43	$34	$59
92083	Visual field examination(s)	$68	$68	$57	$57	$62	$62	$53	$42	$42	$63	$59
92133	Cmptr ophth img optic nerve	$39	$39	$37	$37	$36	$36	$31	$25	$25	$35	$34
92134	Cptr ophth dx img post segmt	$43	$43	$37	$37	$40	$40	$34	$28	$28	$35	$38
92250	Eye exam with photos	$40	$40	$41	$41	$37	$37	$32	$25	$25	$53	$35
92340	Fit spectacles monofocal	$37	$19	$0	$0	$0	$0	$0	$23	$13	$0	$32
Weighted Average % of Medicare Fees				**75%**	**80%**	**93%**	**94%**	**79%**	**64%**	**66%**	**40%**	**87%**
Ranking				**6**	**4**	**2**	**1**	**5**	**8**	**7**	**9**	**3**
ENT (Otorhinolaryngology)												
92507	Speech/hearing therapy	$82	$82	$64	$61	$76	$76	$65	$54	$54	$22	$69
92508	Speech/hearing therapy	$26	$26	$26	$26	$24	$24	$20	$16	$16	$10	$22
92526	Oral function therapy	$91	$91	$81	$67	$85	$85	$72	$59	$59	$47	$78
92551	Pure tone hearing test air	$13	$13	$10	$10	$12	$12	$10	$8	$8	$8	$12
92552	Pure tone audiometry air	$39	$39	$25	$25	$35	$35	$30	$23	$23	$8	$35
Weighted Average % of Medicare Fees				**83%**	**80%**	**93%**	**93%**	**80%**	**65%**	**65%**	**31%**	**86%**
Ranking				**4**	**5**	**1**	**1**	**6**	**7**	**7**	**9**	**3**

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												
93000	Electrocardiogram complete	$16	$16	$16	$16	$14	$14	$12	$10	$10	$19	$13
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
93015	Cardiovascular stress test	$76	$76	$77	$77	$70	$70	$60	$48	$48	$90	$66
93042	Rhythm ecg report	$7	$7	$6	$6	$7	$7	$6	$5	$5	$7	$6
93303	Echo transthoracic	$241	$241	$188	$188	$220	$220	$188	$146	$146	$157	$211
93306	Tte w/doppler complete	$213	$213	$206	$206	$196	$196	$167	$132	$132	$141	$187
93320	Doppler echo exam heart	$55	$55	$53	$53	$50	$50	$43	$34	$34	$61	$48
93325	Doppler color flow add-on	$26	$26	$25	$25	$23	$23	$20	$15	$15	$19	$23
Weighted Average % of Medicare Fees				**93%**	**93%**	**92%**	**92%**	**79%**	**62%**	**62%**	**79%**	**87%**
Ranking				**1**	**1**	**3**	**2**	**7**	**8**	**8**	**6**	**5**
Non-Invasive Vascular Tests												
93880	Extracranial bilat study	$210	$210	$162	$162	$191	$191	$164	$127	$127	$148	$185
93922	Upr/l xtremity art 2 levels	$91	$91	$93	$93	$82	$82	$70	$54	$54	$49	$80
93923	Upr/lxtr art stdy 3+ lvls	$141	$141	$145	$145	$128	$128	$110	$85	$85	$92	$124
93925	Lower extremity study	$264	$264	$208	$208	$241	$241	$206	$158	$158	$147	$234
93970	Extremity study	$207	$207	$158	$158	$189	$189	$161	$125	$125	$147	$183
93971	Extremity study	$131	$131	$96	$96	$120	$120	$102	$79	$79	$100	$116
93975	Vascular study	$293	$293	$225	$225	$267	$267	$228	$176	$176	$182	$258
93976	Vascular study	$156	$156	$161	$161	$143	$143	$136	$97	$97	$131	$153
Weighted Average % of Medicare Fees				**83%**	**83%**	**91%**	**91%**	**80%**	**61%**	**61%**	**71%**	**90%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**
Pulmonary												
94010	Breathing capacity test	$29	$29	$29	$29	$27	$27	$23	$18	$18	$15	$26
94060	Evaluation of wheezing	$42	$42	$43	$43	$38	$38	$33	$26	$26	$19	$37
94640	Airway inhalation treatment	$10	$10	$13	$13	$9	$9	$8	$6	$6	$0	$9
94664	Evaluate pt use of inhaler	$19	$19	$14	$14	$17	$17	$15	$11	$11	$12	$17
94726	Pulm funct tst plethysmograph	$59	$59	$47	$47	$54	$54	$46	$36	$36	$40	$52
94727	Pulm function test by gas	$47	$47	$36	$36	$43	$43	$37	$29	$29	$32	$42

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
94729	Co/membane diffuse capacity	$62	$62	$46	$46	$56	$56	$48	$37	$37	$40	$55
94760	Measure blood oxygen level	$3	$3	$3	$3	$2	$2	$2	$1	$1	$2	$2
Weighted Average % of Medicare Fees				**87%**	**87%**	**91%**	**91%**	**78%**	**60%**	**60%**	**61%**	**88%**
Ranking				**4**	**4**	**1**	**1**	**6**	**8**	**8**	**7**	**3**
Allergy/Immunology												
95004	Percut allergy skin tests	$4	$4	$5	$5	$4	$4	$3	$3	$3	$2	$4
95115	Immunotherapy one injection	$11	$11	$9	$9	$10	$10	$9	$6	$6	$4	$10
95117	Immunotherapy injections	$13	$13	$10	$10	$12	$12	$10	$7	$7	$7	$12
95165	Antigen therapy services	$17	$4	$10	$2	$15	$3	$13	$10	$2	$8	$15
95251	Cont gluc mntr analysis i&r	$36	$36	$34	$34	$34	$34	$29	$25	$25	$29	$31
Weighted Average % of Medicare Fees				**80%**	**82%**	**91%**	**91%**	**78%**	**60%**	**60%**	**53%**	**88%**
Ranking				**5**	**4**	**1**	**2**	**6**	**8**	**7**	**9**	**3**
Neurology/Neuromuscular												
95806	Sleep study unatt&resp efft	$99	$99	$101	$101	$91	$91	$78	$63	$63	$0	$86
95810	Polysom 6/> yrs 4/> param	$665	$665	$628	$628	$606	$606	$519	$400	$400	$347	$587
95811	Polysom 6/>yrs cpap 4/> parm	$696	$696	$691	$691	$634	$634	$543	$418	$418	$648	$614
95816	Eeg awake and drowsy	$420	$420	$289	$289	$382	$382	$327	$250	$250	$23	$372
95819	Eeg awake and asleep	$487	$487	$333	$333	$444	$444	$379	$289	$289	$23	$432
95885	Musc tst done w/nerv tst lim	$67	$67	$48	$48	$62	$62	$53	$41	$41	$42	$59
95886	Musc test done w/n test comp	$106	$106	$72	$72	$97	$97	$83	$66	$66	$66	$92
95910	Nrv cndj test 7-8 studies	$189	$189	$157	$157	$174	$174	$149	$120	$120	$140	$163
95911	Nrv cndj test 9-10 studies	$228	$228	$186	$186	$210	$210	$180	$145	$145	$170	$197
95913	Nrv cndj test 13/> studies	$307	$307	$258	$258	$284	$284	$243	$196	$196	$231	$265
95921	Autonomic nrv parasym inervj	$95	$95	$67	$67	$87	$87	$75	$60	$60	$0	$82
95923	Autonomic nrv syst funj test	$134	$134	$112	$112	$123	$123	$105	$82	$82	$0	$117
Weighted Average % of Medicare Fees				**82%**	**82%**	**91%**	**91%**	**78%**	**61%**	**61%**	**42%**	**88%**
Ranking				**4**	**4**	**1**	**1**	**6**	**7**	**7**	**9**	**3**
CNS Assessment Tests												
96110	Developmental screen w/score	$12	$12	$9	$9	$11	$11	$9	$7	$7	$7	$11
96127	Brief emotional/behav assmt	$5	$5	$5	$5	$5	$5	$5	$3	$3	$4	$5

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
96159	Hlth bhv ivntj indiv ea addl	$23	$20	$15	$13	$22	$19	$19	$16	$14	$20	$20
96160	Pt-focused hlth risk assmt	$3	$3	$3	$3	$3	$3	$2	$2	$2	$3	$0
96161	Caregiver health risk assmt	$3	$3	$3	$3	$3	$3	$2	$2	$2	$3	$3
Weighted Average % of Medicare Fees				**77%**	**78%**	**91%**	**91%**	**81%**	**61%**	**61%**	**74%**	**88%**
Ranking				**6**	**5**	**2**	**1**	**4**	**9**	**8**	**7**	**3**
Chemotherapy Administration												
96360	Hydration iv infusion init	$35	$35	$38	$38	$32	$32	$28	$21	$21	$32	$31
96361	Hydrate iv infusion add-on	$14	$14	$14	$14	$13	$13	$11	$8	$8	$9	$12
96365	Ther/proph/diag iv inf init	$70	$70	$57	$57	$64	$64	$55	$42	$42	$39	$62
96366	Ther/proph/diag iv inf addon	$22	$22	$18	$18	$20	$20	$17	$14	$14	$12	$19
96367	Tx/proph/dg addl seq iv inf	$31	$31	$29	$29	$29	$29	$25	$19	$19	$19	$28
96372	Ther/proph/diag inj sc/im	$15	$15	$15	$15	$14	$14	$12	$10	$10	$13	$13
96374	Ther/proph/diag inj iv push	$41	$41	$44	$44	$37	$37	$32	$25	$25	$31	$36
96375	Tx/pro/dx inj new drug addon	$17	$17	$18	$18	$15	$15	$13	$10	$10	$13	$15
96413	Chemo iv infusion 1 hr	$144	$144	$126	$126	$130	$130	$111	$85	$85	$125	$127
96415	Chemo iv infusion addl hr	$31	$31	$28	$28	$28	$28	$24	$19	$19	$28	$27
96417	Chemo iv infus each addl seq	$71	$71	$62	$62	$64	$64	$55	$42	$42	$62	$62
Weighted Average % of Medicare Fees				**91%**	**91%**	**91%**	**91%**	**78%**	**61%**	**61%**	**78%**	**88%**
Ranking				**1**	**1**	**3**	**2**	**7**	**8**	**8**	**6**	**5**
Special Dermatological Procedures												
96900	Ultraviolet light therapy	$27	$27	$17	$17	$24	$24	$21	$16	$16	$0	$24
96910	Photochemotherapy with uv-b	$130	$130	$57	$57	$118	$118	$101	$76	$76	$20	$116
96920	Laser tx skin < 250 sq cm	$170	$67	$124	$53	$156	$62	$133	$104	$44	$59	$0
96921	Laser tx skin 250-500 sq cm	$187	$76	$136	$60	$171	$71	$147	$115	$51	$59	$0
96922	Laser tx skin >500 sq cm	$254	$123	$124	$53	$156	$62	$200	$104	$44	$98	$0
Weighted Average % of Medicare Fees				**50%**	**47%**	**90%**	**91%**	**78%**	**59%**	**59%**	**19%**	**89%**
Ranking				**7**	**8**	**2**	**1**	**4**	**6**	**5**	**9**	**3**
Phys Medicine/Rehab/Therapy												
97010	Hot or cold packs therapy	$7	$7	$5	$5	$6	$6	$5	$4	$4	$17	$6
97012	Mechanical traction therapy	$15	$15	$13	$13	$14	$14	$12	$10	$10	$13	$13

Procedure Code	Procedure Description	MC NF	MC FA	MD NF	MD FA	DE NF	DE FA	VA NF	WV NF	WV FA	PA	DC
97014	Electric stimulation therapy	$13	$13	$13	$13	$12	$12	$11	$8	$8	$17	$11
97110	Therapeutic exercises	$32	$32	$29	$29	$29	$29	$25	$20	$20	$8	$27
97112	Neuromuscular reeducation	$36	$36	$27	$27	$34	$34	$33	$23	$23	$17	$31
97140	Manual therapy 1/> regions	$29	$29	$23	$23	$27	$27	$33	$19	$19	$21	$25
97150	Group therapeutic procedures	$19	$19	$18	$18	$18	$18	$15	$12	$12	$7	$16
97161	Pt eval low complex 20 min	$108	$108	$69	$69	$100	$100	$85	$70	$70	$64	$92
97162	Pt eval mod complex 30 min	$108	$108	$69	$69	$100	$100	$85	$70	$70	$64	$92
97530	Therapeutic activities	$40	$40	$31	$31	$37	$37	$30	$25	$25	$13	$35
Weighted Average % of Medicare Fees				**80%**	**80%**	**93%**	**93%**	**86%**	**64%**	**64%**	**48%**	**86%**
Ranking				**5**	**5**	**1**	**1**	**4**	**7**	**7**	**9**	**3**
Osteo/Chiropractic & Other Medicine												
98941	Chiropract manj 3-4 regions	$42	$35	$32	$27	$39	$33	$34	$28	$24	$13	$0
98943	Chiropract manj xtrspinl 1/>	$28	$24	$21	$18	$26	$23	$22	$19	$16	$0	$0
98966	Hc pro phone call 5-10 min	$14	$12	$0	$0	$13	$11	$11	$9	$8	$0	$12
98967	Hc pro phone call 11-20 min	$25	$23	$0	$0	$24	$22	$20	$17	$16	$0	$21
98968	Hc pro phone call 21-30 min	$35	$32	$0	$0	$33	$31	$28	$24	$23	$0	$29
99152	Mod sed same phys/qhp 5/>yrs	$55	$13	$45	$11	$50	$12	$43	$33	$9	$10	$0
99153	Mod sed same phys/qhp ea	$12	$12	$10	$10	$11	$11	$9	$7	$7	$8	$0
99173	Visual acuity screen	$3	$3	$3	$3	$3	$3	$2	$2	$2	$6	$3
99174	Ocular instrumnt screen bil	$7	$7	$6	$6	$6	$6	$5	$4	$4	$8	$6
99177	Ocular instrumnt screen bil	$5	$5	$5	$5	$0	$0	$4	$3	$3	$15	$5
Weighted Average % of Medicare Fees				**81%**	**81%**	**91%**	**91%**	**77%**	**62%**	**63%**	**118%**	**73%**
Ranking				**4**	**5**	**3**	**2**	**6**	**9**	**8**	**1**	**7**

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