Maryland
DEPARTMENT OF HEALTH

*Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary*

May 6, 2026

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

The Honorable Heather Bagnall
Chair
House Health Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

**Re: HB 70 (Ch. 656 of the Acts of 2009); Health – General § 15-103.5; and Insurance Article § 19-807(d)(2) — Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates Annual Report (MSAR #7893)**

Dear Chair Beidle and Chair Bagnall:

Pursuant to Maryland Health-General §15-103.5 and Insurance Article §19-807(d)(2), 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 Meghan Lynch, Director, Office of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary

cc: Perrie Briskin, Deputy Secretary, Office of Health Care Financing and Medicaid
Liz Schulke, Deputy Director, Office of Health Care Financing
Meghan Lynch, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Maryland

DEPARTMENT OF HEALTH

# Maryland Medical Assistance Program and the Maryland Children's Health Program – Provider Reimbursement Rates

**Health – General § 15-103.5 and Chapter 656 of the Acts of 2009**

**Maryland Department of Health**

**February 2026**

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## I. Introduction

In 2002, Maryland enacted Senate Bill (SB) 481, which required the Maryland Department of Health (the Department) to establish 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.[1] 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.[2]

SB 481 followed House Bill (HB) 1071,[3] passed in 2001, which required the Department to release its first report analyzing the physician fees paid by Maryland Medicaid and CHIP in September 2001. SB 481 required this report to continue to be submitted on an annual basis 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, HB 70, passed in 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).[4] 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.[5] This report satisfies these requirements for the state fiscal year (FY) 2025 Maryland Medicaid physician fees based on the calendar year (CY) 2025 Medicare rates. This report also satisfies the physician fee reporting requirement of SB 481.

## II. Background

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

[1] 2002 MD Laws Ch. 464.
[2] 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. Medicare rates continue to inform the rate adjustment process.
[3] 2001 MD Laws Ch. 702.
[4] 2009 MD Laws Ch. 656, Sec. 15.
[5] Md. Code Ann., Health-Gen § 15-103.5.

2024, Maryland Medicaid's overall reimbursement rates were approximately 91.5% of the CY 2024 Medicare rates. In FY 2025, the overall percentage increased to 93.3% due to another decrease in CY 2025 Medicare rates from CY 2024.

SB 836, which was passed in 2005, created the Maryland Health Care Provider Rate Stabilization Fund (the Fund), which was administered by the Maryland Insurance Administration.[6] 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 and distributed a total of $226.5 million to the Maryland Medicaid program in FY 2021. However, it was repealed effective July 1, 2021.[7] Starting in FY 2022, the premium tax payments that previously made up the Fund are now deposited directly into the state's general fund.

## III. Physician Fee Changes in 2013 to 2025

### *Physician Fees Changes Due to the Affordable Care Act for 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 reimbursement 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 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 2014 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 2015 to 2023*

Following the expiration of 100% FMAP for E&M procedures provided by PCPs on January 1, 2015, Medicaid fees for these procedures were reduced to 87% of Medicare rates 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 CY 2015 rates.[8,9]

The Governor allocated approximately $13.2 million in state general funds in FY 2017 for increasing Medicaid fees for E&M procedures to 96% of Medicare CY 2016 rates, effective July 1, 2016.[10] Moreover, updates in relative value units (RVUs) led to decreases in Medicare rates

[6] 2005 MD Laws Ch. 1.
[7] 2020 MD Laws Ch. 538.
[8] 2015 MD Laws Ch 310.
[9] The Medicaid reimbursement rates for E&M procedures from FY 2015 to FY 2025 are listed in Appendix A.
[10] 2016 MD Laws Ch. 143.

for some procedures, resulting in Maryland Medicaid fees exceeding their corresponding Medicare rates. Therefore, effective January 1, 2017, the Department reduced any Medicaid fees that exceeded their corresponding Medicare rates and increased the lowest Medicaid fees for non-E&M procedures to approximately 72% of Medicare CY 2017 rates.

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 2021 American Rescue Plan Act (ARPA)[11] 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 the minimum of 93% of Medicare rates 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.

Federal legislation that increased the FMAP for various services passed during the COVID-19 global pandemic; the Families First Coronavirus Response Act (FFCRA) provided an increased FMAP for non-ACA expansion participants when Medicaid programs met their maintenance of effort (MOE) requirements, ensuring that enrollees had continuous Medicaid coverage.[12] This increased FMAP continued through FY 2022. However, the Consolidated Appropriations Act passed in 2023 ended the increased FMAP. The enhanced FMAP began phasing down in March 2023 and ended in December 2023.[13]

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 increased from 93% to 100% of Medicare's rates (a total of $60 million).

ARPA provided qualifying states with a temporary 10% increase to the FMAP for certain Medicaid expenditures for home and community-based services (HCBS).[14] 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. Maryland's FY 2022 budget bill directed Medicaid to spend at least 75% of ARPA 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

[11] H.R. 117th Congress (2021) (enacted).
[12] H.R. 6201, 116th Cong. (2020) (enacted).
[13] H.R. 2617, 117th Cong. (2022) (enacted).
[14] H.R. 117th Congress (2021) (enacted).

Administration (DDA). The DDA's rate changes included a retroactive payment as well. This retroactive payment was aligned with the ARPA start date of April 1, 2021.

This increased ARPA provider reimbursement primarily affected physicians in the psychiatry and rehabilitation specialties. In addition, the Department implemented one-time rate increases of 4% for all providers who render services to participants of the Waiver for Children with Autism Spectrum Disorder, the Home and Community-Based Options Waiver, the Medical Day Care Services Waiver, and the Home Care for Disabled Children under a Model Waiver, effective for all of state fiscal year (SFY) 2023, and 4% for providers who render services to participants of the Waiver for Adults with Brain Injury for the first quarter of SFY 2023. DDA also implemented a one-time emergency 10% provider rate increase for the third quarter of SFY 2022.

Rate increases for HCBS programs continued in FY 2023 with a temporary, one-time emergency 4% rate increase for FY 2023 only (from ARPA) effective on July 1, 2022,[15] and an additional 4% rate increase allocated in the Governor's Supplemental Budget no. 4 in amendment to the FY 2023 budget.[16] In FY 2024, there was a 4% rate increase effective July 1, 2023, while the temporary 4% rate increase authorized by ARPA terminated, and the 4% increase scheduled for FYs 2025 and 2026 were accelerated to provide an additional 8% rate increase effective January 1, 2024.[17, 18]

Medicare reimbursement rates continued to decrease in CY 2023, with a cut of around 2% in the conversion factor. Despite this reduction, the Maryland Medicaid reimbursement rates for E&M procedures were kept at the current level through FY 2023.
The Consolidated Appropriations Act passed in 2023 ended the increased FMAP from the FFCRA; the enhanced FMAP began phasing down in March 2023 and ended in December 2023.[19]

SB 150, passed in 2022, required the Maryland Medicaid program to provide adult dental services to all Medicaid participants over the age of 21 who receive full Medicaid benefits.[20] The implementation of the adult dental benefit went into effect on January 1, 2023. Rates for dental services increased 9.4% in CY 2022 for all participants. The Department increased rates again for some codes (effective August 1, 2023) and continued 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.

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[15] 2019 MD Laws Ch. 10.
[16] See https://dbm.maryland.gov/budget/Documents/operbudget/2023/proposed/FY2023-Supplemental-Budget-No4.pdf
[17] 2019 MD Laws Ch. 10.
[18] 2023 MD Laws Ch. 101.
[19] H.R. 2617, 117th Cong. (2022) (enacted).
[20] 2022 MD Laws Ch. 303.

## *Physician Fees for 2024 to 2025*

Medicare reimbursement rates decreased again in CY 2024. In late 2023, Medicare released a fee schedule with an average decrease to rates of 3.4% effective January 1, 2024. Subsequent federal legislation reduced the cut to 1.25%, and a new Medicare fee schedule was released in March 2024.

The Medicare fee schedule released in January 2025 contained a decrease of 2.83% to the conversion factor. This was due to the expiration of a temporary increase for CY 2024. No changes were made after the initial fee schedule was released.

As mentioned above, while the state has historically allocated funds to maintain E&M rates at a minimum of 93% of Medicare reimbursement rates, the state allocated funds for FY 2022 E&M services to be reimbursed at 100% of Medicare rates and maintained these rates in FY 2023 despite reductions in Medicare reimbursement rates. Maryland Medicaid's E&M reimbursement rates again did not change in FY 2024, while Medicare rates were cut, resulting in Maryland Medicaid's E&M rates equating to 102.8% of the CY 2023 Medicare rates, on average. On September 1, 2024 (in FY 2025), Maryland Medicaid's E&M reimbursement rates decreased slightly for many codes but remained steady for codes whose Medicaid rates were previously below those of Medicare, with rates for all codes averaging 97.6% of CY 2024 Medicare rates. Finally, a decrease in Medicare rates that occurred in January 2025 placed Maryland Medicaid's E&M rates at 99.2% of Medicare.

The Inflation Reduction Act included a provision that state Medicaid programs must cover adult vaccinations without cost sharing.[21] This required Maryland Medicaid to eliminate cost sharing for adult vaccinations billed by pharmacies. In addition, Maryland Medicaid needed to cover certain required vaccinations not previously covered. Maryland implemented these changes on October 1, 2023, receiving an additional 1% FMAP for adult vaccinations and their administration.[22] 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 continued through September 30, 2024.

The overall weighted average FMAP for FY 2024 was approximately 61.5%, resulting in an overall state share of 38.5%.[23] In FY 2025, the weighted FMAP was 60.15% and the overall state share was 39.85%.[24] This decrease to the FMAP was due to the expiration of the enhanced FMAP after the first quarter of FY 2024.

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[21] H.R. 5376, 117th Cong. (2022) (enacted). Please see: https://www.medicaid.gov/sites/default/files/2023-06/sho23003.pdf

[22] These changes were communicated in Provider Transmittal 67-24, sent on 3/28/2024.

[23] Due to the PHE unwinding, the FMAPs for FY 2024 were as follows: July 1, 2023, through September 30, 2023: ACA participants at 90.0%, MCHP participants at 69.34%, other participants at 52.5%; October 1, 2023, through July 31, 2024: ACA participants at 90%, MCHP participants at 65%, other participants at 50%.

[24] For FY 2025, the FMAP for ACA participants at 90%, MCHP participants at 65%, other participants at 50% for the entire period.

## IV. Maryland Medicaid Fees Compared with Medicare and Other States

The Hilltop Institute at University of Maryland, Baltimore County (UMBC) compiled data on the FY 2025 Medicaid physician fees from neighboring states—including Delaware, Pennsylvania, Virginia, West Virginia, and Washington, D.C.—by using the current physician fee schedules posted on the states' websites.

Physician fees include three components: the physician's services, practice expenses (e.g., costs of maintaining an office), and malpractice insurance expenses. The practice expenses compose, on average, approximately 40% of the total physician fee but only apply to non-facility fees (i.e., fees for services performed in the doctor's office rather than in an external facility). When physicians render services in facilities outside of their office, 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 non-facility and facility fees for all procedures. Virginia and Washington, D.C. have separate non-facility and 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 rates for the Baltimore region. Because Pennsylvania does not separate these fees, its fees are compared with Medicare non-facility fees. Hence, for Pennsylvania, Virginia, and Washington, D.C., the percentages of Medicare rates reported underestimate the percentages of Medicare rates for procedures performed in facilities.

Hilltop compared Maryland's and other states' Medicaid reimbursement rates with the Medicare fee schedule for Baltimore City and surrounding counties. The average CY 2025 Medicare rates in Maryland were approximately 7.2% higher than Delaware's corresponding Medicare rates, 2.0% higher than Pennsylvania's (Philadelphia locality) Medicare rates, 9.5% higher than Virginia's Medicare rates, and 9.8% higher than West Virginia's corresponding Medicare rates. Conversely, the average Medicare rates in Maryland were approximately 5.2% lower than the average Medicare rates 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 are included in Appendix B.

Table 1 compares the states' Medicaid reimbursement rates as percentages of Medicare rates by physician specialty in FY 2025. The states' average reimbursement rates as percentages of Medicare rates have remained relatively stable over the past five years. For reimbursement rates for E&M procedures, Maryland ranked highest of all states reviewed. For many of the other specialties, Maryland's rates ranked toward the middle of its neighboring states, although Maryland's facility reimbursement rates for neurosurgery procedures, musculoskeletal system procedures, and gynecology-obstetric procedures were highest among all the states, along with

its non-facility and facility reimbursement rates for chemotherapy administration and cardiovascular procedures. Delaware's reimbursement rates ranked the highest for most specialties, while Washington, D.C.'s reimbursement rates often ranked just below Delaware's. The individual state and Medicare rates for each code included in the analysis are listed in Appendix C.

**Table 1. Comparison of States' FY 2025 Medicaid Reimbursement Rates as Percentages of CY 2025 Medicare Rates, by Specialty**

| Specialty | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|
| 1-Evaluation & Management | 100% | 100% | 93% | 93% | 70% | 74% | 75% | 50% | 85% |
| 2-Integumentary System | 81% | 95% | 91% | 95% | 82% | 65% | 69% | 31% | 86% |
| 3-Musculoskeletal System | 91% | 93% | 91% | 92% | 82% | 66% | 69% | 39% | 84% |
| 4-Respiratory System | 81% | 80% | 91% | 92% | 82% | 66% | 70% | 45% | 86% |
| 5-Cardiovascular System – Surgical | 91% | 85% | 91% | 92% | 82% | 64% | 70% | 40% | 87% |
| 6-Hemic, Lymphatic System, and Mediastinum | 74% | 78% | 91% | 91% | 82% | 68% | 70% | 48% | 84% |
| 7-Digestive System | 79% | 83% | 91% | 92% | 82% | 66% | 70% | 53% | 86% |
| 8-Urinary System and Male Genital | 81% | 83% | 92% | 92% | 82% | 67% | 70% | 50% | 84% |
| 9-Gynecology and Obstetrics | 97% | 98% | 88% | 88% | 92% | 84% | 87% | 98% | 83% |
| 10-Endocrine System | 77% | 77% | 91% | 91% | 82% | 70% | 70% | 67% | 83% |
| 11-Nervous System | 92% | 96% | 91% | 93% | 82% | 65% | 70% | 37% | 86% |
| 12-Eye Surgery | 89% | 91% | 92% | 92% | 83% | 67% | 67% | 89% | 86% |
| 13-Ear Surgery | 89% | 88% | 91% | 92% | 82% | 67% | 68% | 50% | 85% |
| 14-Radiology | 86% | 86% | 91% | 91% | 86% | 64% | 64% | 79% | 87% |
| 15-Laboratory | 92% | 92% | 98% | 98% | 99% | 90% | 90% | 95% | 80% |
| 16-Psychiatry | 84% | 90% | 95% | 96% | 106% | 71% | 73% | 33% | 84% |
| 17-Dialysis | 65% | 65% | 93% | 93% | 109% | 70% | 70% | 46% | 84% |
| 18-Gastroenterology | 82% | 82% | 91% | 91% | 82% | 63% | 63% | 63% | 88% |
| 19-Ophthalmology and Vision Care | 80% | 84% | 93% | 94% | 83% | 66% | 69% | 67% | 86% |
| 20-ENT (Otorhinolaryngology) | 85% | 82% | 93% | 93% | 102% | 67% | 67% | 32% | 85% |
| 21-Cardiovascular System – Medical | 96% | 96% | 92% | 92% | 82% | 65% | 65% | 83% | 87% |
| 22-Noninvasive Vascular Diagnostic Studies | 83% | 83% | 87% | 87% | 82% | 60% | 60% | 76% | 87% |
| 23-Pulmonary | 82% | 82% | 91% | 91% | 82% | 64% | 66% | 68% | 87% |
| 24-Allergy and Immunology | 84% | 85% | 92% | 92% | 83% | 65% | 65% | 54% | 85% |
| 25-Neurology and Neuromuscular | 88% | 89% | 93% | 93% | 83% | 69% | 70% | 56% | 90% |
| 26- Central Nervous System Assessment Tests | 70% | 72% | 93% | 93% | 85% | 67% | 67% | 66% | 85% |
| 27-Chemotherapy Administration | 97% | 97% | 91% | 91% | 82% | 63% | 63% | 85% | 87% |
| 28-Special Dermatological | 54% | 51% | 90% | 90% | 82% | 61% | 61% | 20% | 88% |
| 29-Physical Medicine and Rehabilitation | 85% | 85% | 92% | 92% | 97% | 67% | 67% | 46% | 86% |
| 30-Osteopathy, Chiropractic, and Other Medicine | 81% | 79% | 91% | 92% | 79% | 66% | 67% | 120% | 78% |

## V. Reimbursement for Oral Health Services

The Maryland Medicaid program historically included dental (oral health) 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 did not reimburse for adult dental services; however, some of the MCOs provided this benefit from their own funds.[25] Starting June 1, 2019, the Department began an Adult Dental Pilot program to provide limited dental benefits to adults between the ages of 21 and 64 who receive full Medicaid and Medicare benefits. This Pilot program had an annual maximum benefit allowance of $800 per member, which reset at the beginning of each calendar year.

Legislation passed in 2022 required the Department to expand its adult dental benefit to all adults aged 21 and older beginning January 1, 2023.[26] Coverage for comprehensive dental services is provided through the Maryland Healthy Smiles Dental Program. The adult dental benefit provides diagnostic, preventive, and restorative services. There is no maximum dollar amount placed on services received, unlike with the Adult Dental Pilot program. Participants who were enrolled in the Pilot program transitioned into this new benefit, and the Pilot program concluded on December 31, 2022. More than 780,000 additional adults were enrolled in the new benefit in CY 2023.

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.

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 FY 2015 rate increase were included in the FY 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 Hilltop assessed a targeted list of Maryland CDT code rates identified in the stakeholder meetings for utilization among adults,

[25] 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.
[26] 2022 MD Laws Ch. 302; 2022 MD Laws Ch. 303.

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.

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 20.0% and all remaining preventative and restorative codes were raised by 5.5%. The codes eligible for the 20.0% increase included ten codes selected by stakeholders as most in need of increased reimbursement. 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.

Two states had significant rate changes to their dental fee schedules in CY 2025; Washington, D.C. and Delaware both raised rates. Table 2 compares Maryland Medicaid dental fees for selected high-volume procedures with the corresponding fees in Delaware, Virginia, West Virginia, Pennsylvania, and Washington, D.C., as well as fees from a 2022 ADA survey of dental fees. The number of claims in Maryland were used to calculate the weighted average rank of Maryland and its neighboring states' fees. Fee amounts for children's dental procedures were used for all inter-state dental comparisons because not all of the state Medicaid programs that were analyzed cover dental procedures for adults. Mean fees from the ADA report correspond to CY 2022, and the states' fees correspond to CY 2025. Due to legislative changes, the ADA will no longer be releasing new reports of commercial dental fees.

The ranking of states' weighted average dental fees are Delaware (first), Washington, D.C. (second), Virginia (third), Maryland (fourth), West Virginia (fifth), and Pennsylvania (sixth). Maryland ranked fifth in 2023 and rose to fourth in 2024, maintaining that place in 2025.

**Table 2. Comparison of States' FY 2025 Medicaid Oral Health Reimbursement Rates**

| Procedure Code | Procedure Description | ADA | MD | DC | VA | WV | PA | DE |
|---|---|---|---|---|---|---|---|---|
| D0120 | Periodic oral evaluation | $60 | $32 | $38 | $27 | $28 | $20 | $51 |
| D0150 | Comprehensive oral evaluation | $100 | $56 | $82 | $42 | $39 | $20 | $88 |
| D0220 | Intraoral periapical first | $33 | $12 | $21 | $15 | $17 | $8 | $29 |
| D0272 | Dental bitewings two images | $52 | $16 | $42 | $27 | $28 | $16 | $43 |
| D0274 | Bitewings four images | $74 | $24 | $51 | $37 | $41 | $28 | $61 |
| D1110 | Dental prophylaxis adult | $107 | $67 | $78 | $63 | $61 | $36 | $88 |
| D1120 | Dental prophylaxis child | $78 | $49 | $52 | $45 | $44 | $30 | $65 |
| D1206 | Topical fluoride varnish | $41 | $26 | $31 | $28 | $22 | $18 | $38 |
| D1208 | Topical app fluorid ex vrnsh | $42 | $24 | $29 | $28 | $22 | $19 | $37 |
| D1330 | Oral hygiene instructions | $57 | $7 | $0 | $0 | $0 | $11 | $0 |
| D1351 | Dental sealant per tooth | $59 | $40 | $45 | $43 | $33 | $25 | $52 |
| D2392 | Post 2 srfc resinbased cmpst | $267 | $138 | $184 | $119 | $125 | $60 | $308 |
| **Ranking** | | | **4** | **2** | **3** | **5** | **6** | **1** |

## VII. Access to Care

The Maryland Medicaid program includes many provisions to ensure that the network can provide access to care for all participants. For example, Maryland Medicaid has several network adequacy requirements for its MCOs.[27] 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.[28] These requirements exist for each of the state's 40 local access areas (LAAs). The Department also requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed

[27] COMAR 10.67.05.05-.08.
[28] COMAR 10.67.05.05B(8).

to meet an enrollee's medical needs, then it must arrange for care with an out-of-network specialist and compensate the provider. In addition, each MCO must meet the specified time and distance standards set out in regulations for 14 major medical specialties.[29] These medical specialties include eight core specialties—cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology—and six major specialties—allergy and immunology, dermatology, endocrinology, infectious disease, nephrology, and pulmonology.

The Department conducts a broad range of assessments to monitor the adequacy of FFS and MCO networks. This includes an Access Monitoring Review Plan, published in 2016 for the FFS population, and a 2019 assessment of the accuracy of provider directories published by MCOs.[30,31] On November 1, 2024, Maryland signed an agreement with CMS to participate in the federal program to incentivize primary care practices to focus on health-related social needs, care coordination, and behavioral health integration, which has been implemented as an enhanced payment to primary care providers as of September 1, 2025 (see more in the Plan for the Future section below).[32]

## VIII. Plan for the Future

The Department remains dedicated to ensuring that physicians are reimbursed equitably for their services and has continued to monitor provider network adequacy to ensure that patients' access to care is not compromised.

The Department implemented the Medicaid Advanced Primary Care Program on September 1, 2025. Under this program, providers who qualify as primary care providers receive an increased reimbursement rate for E&M services of 103% of the CY 2025 Medicare rate.[33] These rate increases were approved by CMS through December 31, 2026.[34] The AHEAD model will begin implementation in January 2026.[35]

Under Maryland regulations, providers are able to seek reimbursement for medical care provided at a telehealth appointment at the same rate as an in-person appointment.[36]

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[29] COMAR 10.67.05.05-1; COMAR 10.67.05.06.
[30] 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
[31]The Maryland Department of Health. (2019*). CY 2019 network adequacy validation report assessing accuracy of provider directories*. https://health.maryland.gov/mmcp/healthchoice/Documents/NAV%20Report_REPRINT.pdf
[32] The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) *Model State Agreement. Signed November 1, 2024*.
https://hscrc.maryland.gov/Documents/AHEAD/Final%20MD%20AHEAD%20State%20Agreement_102824.pdf
[33] CMS Letter of Approval to Ryan Moran, Medicaid Director, dated 6/23/2025
[34] CMS Letter of Approval to Perrie Briskin, Medicaid Director, dated 11/14/2025
[35] For more information please see:
https://health.maryland.gov/mdpcp/Documents/AHEAD_Primary_Care_Council_7.16.25.pdf
[36] COMAR 10.09.49.08

On July 4, 2025, the budget reconciliation bill, known as the "One Big Beautiful Bill Act" or H.R. 1, was signed into law. This bill included several provisions over the coming years that will affect funding states receive for Medicaid services as well as the total that Medicaid services will cost to states.[37] These provisions include a work requirement, cost sharing requirements for certain Medicaid participants, reduction in provider taxes used to fund state share of Medicaid services, and a reduction in the upper limit of state directed Medicaid payments in relation to the Medicare fee schedule.

States will decide how to react to these changes, but many other states in the region are already finding ways to control Medicaid costs. West Virginia, Pennsylvania, and the District of Columbia were identified by Kaiser Family Foundation as ranking in the top five states for at least one of the four risk factors to responding to Medicaid cuts.[38] Pennsylvania has seen several hospitals close in 2025 partly due to already low Medicaid reimbursement.[39] The 2025-2026 Pennsylvania state budget included limiting medically necessary services (such as GLP1 medications) and chose to not include a previously agreed-to $21 million rate increase for home health care workers.[40] In Virginia, payments to providers are expected to decrease significantly as a result of the new federal requirements as most Virginia managed care organizations pay significantly more than Medicare, and these rates will need to be reduced by 10% per year until they are no more than 100% of Medicare.[41]

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

[37] https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/
[38] https://www.kff.org/medicaid/responding-to-federal-medicaid-reductions-which-states-are-most-at-risk/
[39] https://nurse.org/news/pennsylvania-hospital-closures-impact-nurses/
[40] https://commonwealthfoundation.org/research/2025-2026-pennsylvania-state-budget-analysis/
[41] https://www.vpm.org/news/2025-07-22/va-medicaid-cuts-trump-dmas-gordon-youngkin-ebbin-vhha-walker-wittman

## Appendix A. Maryland Medicaid Reimbursement Rates for E&M Procedures

**Table A. Maryland Medicaid Reimbursement Rates as a Percentage of Medicare Rates for E&M Procedures, FY 2015–FY 2024**

| Fiscal Year | Percentage of Medicare |
|---|---|
| **2025** | 97.6% |
| **2024** | 103% |
| **2023** | 100% |
| **2022** | 93% |
| **2021** | 93% |
| **2020** | 93% |
| **2019** | 93% |
| **2018** | No change |
| **2017** | 96% |
| **2016** | 92% |
| **2015** | 87% |

## Appendix B. Maryland Medicaid Codes Excluded from Analysis

**Table B. Codes Excluded from Analysis Due to Medicare Non-Coverage**

| Specialty | Codes |
|---|---|
| Cardiovascular Surgery | 36415, 36416 |
| Digestive System Surgery | 41899 |
| Dialysis | 90999 |
| Non-Invasive Vascular Tests | 93998 |
| Pulmonary | 94774, 94777, 94799 |
| Special Dermatological | 96999 |
| Physical Medicine | 97153, 97155 |
| Osteopathy, Chiropractic, and Other Medicine | 99000, 99001, 99024, 99050, 99051, 99053, 99058, 99070, 99072, 99080, 99140, 99199 |

## Appendix C. Ranking of State Reimbursement Rates by Procedure Code

Table C compares Maryland's Medicaid fees as of July 1, 2025, with the corresponding Medicare CY 2025 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. Procedure fees are rounded to the nearest dollar amount, and the last row of each specialty provides each state's weighted average Medicaid fees for the surveyed procedures as a percentage of Medicare rates in the Baltimore region. Maryland Medicaid's numbers of claims and encounters were used as the weights for fees. The average percentages of Medicare rates 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, Delaware, and West Virginia, are compared with Medicare facility fees.

**Table C. Comparison of Maryland and Neighboring States' Medicaid Fees with Medicare Rates, as of July 1, 2025**

| 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** | | | | | | | | | | | |
| 99212 | Office o/p est sf 10-19 min | $58 | $36 | $59 | $36 | $54 | $33 | $41 | $39 | $25 | $26 | $50 |
| 99203 | Office o/p new low 30-44 min | $116 | $84 | $116 | $84 | $107 | $78 | $82 | $78 | $59 | $54 | $98 |
| 99285 | Emergency dept visit hi mdm | $178 | $178 | $179 | $179 | $166 | $166 | $120 | $129 | $129 | $139 | $147 |
| 99233 | Sbsq hosp ip/obs high 50 | $120 | $120 | $109 | $109 | $112 | $112 | $85 | $85 | $85 | $93 | $100 |
| 99204 | Office o/p new mod 45-59 min | $173 | $136 | $174 | $137 | $160 | $127 | $122 | $118 | $96 | $90 | $147 |
| 99215 | Office o/p est hi 40-54 min | $186 | $146 | $188 | $148 | $172 | $136 | $132 | $127 | $102 | $78 | $158 |
| 99283 | Emergency dept visit low mdm | $72 | $72 | $73 | $73 | $67 | $67 | $48 | $52 | $52 | $57 | $59 |
| 99232 | Sbsq hosp ip/obs moderate 35 | $80 | $80 | $76 | $76 | $75 | $75 | $57 | $57 | $57 | $62 | $67 |
| 99284 | Emergency dept visit mod mdm | $123 | $123 | $124 | $124 | $114 | $114 | $83 | $89 | $89 | $95 | $101 |
| 99281 | Emr dpt vst mayx req phy/qhp | $12 | $12 | $12 | $12 | $11 | $11 | $8 | $8 | $8 | $0 | $10 |
| 99213 | Office o/p est low 20-29 min | $94 | $67 | $95 | $67 | $87 | $63 | $67 | $84 | $62 | $35 | $80 |
| 99214 | Office o/p est mod 30-39 min | $132 | $99 | $133 | $99 | $123 | $92 | $94 | $90 | $70 | $54 | $113 |
| | **Weighted Average % of Medicare Fees** | | | **100%** | **100%** | **93%** | **93%** | **70%** | **74%** | **75%** | **50%** | **85%** |
| | **Ranking** | | | **1** | **2** | **4** | **2** | **8** | **7** | **6** | **9** | **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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Integumentary/General Surgery** | | | | | | | | | | | |
| 11720 | Debride nail 1-5 | $34 | $15 | $25 | $13 | $31 | $14 | $28 | $22 | $11 | $16 | $29 |
| 11981 | Insertion drug dlvr implant | $105 | $65 | $208 | $208 | $96 | $96 | $86 | $70 | $46 | $76 | $89 |
| 12011 | Rpr f/e/e/n/l/m 2.5 cm/< | $117 | $58 | $113 | $58 | $106 | $53 | $96 | $77 | $41 | $32 | $100 |
| 11043 | Dbrdmt musc&/fsca 1st 20/< | $241 | $159 | $187 | $129 | $220 | $146 | $198 | $161 | $112 | $33 | $205 |
| 11102 | Tangntl bx skin single les | $102 | $38 | $87 | $35 | $93 | $36 | $84 | $65 | $26 | $32 | $89 |
| 10060 | I&d abscess simple/single | $133 | $112 | $93 | $77 | $121 | $102 | $109 | $87 | $74 | $24 | $114 |
| 11056 | Parng/cutg b9 hyprkr les 2-4 | $84 | $22 | $46 | $22 | $77 | $21 | $69 | $54 | $16 | $30 | $73 |
| 12001 | Rpr s/n/ax/gen/trnk 2.5cm/< | $98 | $46 | $88 | $44 | $89 | $42 | $80 | $64 | $33 | $25 | $84 |
| 11900 | Inject skin lesions </w 7 | $59 | $30 | $44 | $25 | $54 | $28 | $49 | $39 | $21 | $0 | $51 |
| 11721 | Debride nail 6 or more | $46 | $24 | $35 | $21 | $43 | $23 | $38 | $31 | $17 | $20 | $40 |
| 11042 | Dbrdmt subq tis 1st 20sqcm/< | $134 | $63 | $93 | $49 | $122 | $58 | $110 | $87 | $43 | $33 | $116 |
| 17110 | Destruct b9 lesion 1-14 | $118 | $72 | $89 | $56 | $107 | $66 | $97 | $75 | $47 | $49 | $102 |
| | **Weighted Average % of Medicare Fees** | | | **81%** | **95%** | **91%** | **95%** | **82%** | **65%** | **69%** | **31%** | **86%** |
| | **Ranking** | | | **6** | **2** | **3** | **1** | **5** | **8** | **7** | **9** | **4** |
| | **Musculoskeletal System** | | | | | | | | | | | |
| 20680 | Removal of support implant | $625 | $443 | $553 | $380 | $568 | $404 | $512 | $413 | $302 | $172 | $534 |
| 20552 | Inj trigger point 1/2 muscl | $54 | $37 | $50 | $33 | $50 | $35 | $45 | $36 | $26 | $31 | $0 |
| 20605 | Drain/inj joint/bursa w/o us | $57 | $38 | $55 | $38 | $52 | $35 | $47 | $38 | $26 | $22 | $48 |
| 29075 | Application of forearm cast | $96 | $67 | $80 | $59 | $87 | $61 | $78 | $63 | $45 | $46 | $82 |
| 29540 | Strapping of ankle and/or ft | $29 | $18 | $28 | $18 | $27 | $17 | $24 | $20 | $13 | $20 | $25 |
| 29515 | Application lower leg splint | $78 | $53 | $65 | $47 | $71 | $48 | $64 | $52 | $36 | $35 | $67 |
| 29581 | Apply multlay comprs lwr leg | $90 | $26 | $69 | $14 | $82 | $25 | $74 | $57 | $19 | $25 | $78 |
| 20553 | Inject trigger points 3/> | $62 | $42 | $55 | $37 | $57 | $39 | $51 | $42 | $30 | $34 | $53 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 29125 | Apply forearm splint | $72 | $43 | $61 | $39 | $66 | $39 | $59 | $47 | $29 | $26 | $62 |
| 20611 | Drain/inj joint/bursa w/us | $103 | $61 | $98 | $61 | $94 | $56 | $85 | $68 | $43 | $50 | $88 |
| 20550 | Inj tendon sheath/ligament | $60 | $40 | $56 | $39 | $55 | $37 | $50 | $41 | $28 | $32 | $51 |
| 20610 | Drain/inj joint/bursa w/o us | $68 | $47 | $66 | $47 | $62 | $43 | $56 | $46 | $33 | $24 | $58 |
| | **Weighted Average % of Medicare Fees** | | | **91%** | **93%** | **91%** | **92%** | **82%** | **66%** | **69%** | **39%** | **84%** |
| | **Ranking** | | | **3** | **1** | **4** | **2** | **6** | **8** | **7** | **9** | **5** |
| | **Respiratory** | | | | | | | | | | | |
| 30901 | Control of nosebleed | $162 | $58 | $75 | $45 | $147 | $53 | $133 | $104 | $41 | $27 | $140 |
| 32551 | Insertion of chest tube | $159 | $159 | $128 | $128 | $146 | $146 | $131 | $114 | $114 | $133 | $131 |
| 31622 | Dx bronchoscope/wash | $260 | $133 | $236 | $108 | $237 | $124 | $214 | $171 | $94 | $134 | $223 |
| 30520 | Repair of nasal septum | $699 | $699 | $493 | $493 | $638 | $638 | $575 | $463 | $463 | $416 | $598 |
| 31237 | Nasal/sinus endoscopy surg | $276 | $166 | $232 | $136 | $251 | $153 | $226 | $181 | $115 | $160 | $236 |
| 30140 | Resect inferior turbinate | $308 | $185 | $308 | $185 | $281 | $170 | $253 | $203 | $129 | $259 | $263 |
| 31579 | Laryngoscopy telescopic | $204 | $124 | $167 | $104 | $186 | $114 | $167 | $134 | $86 | $75 | $175 |
| 31624 | Dx bronchoscope/lavage | $264 | $134 | $241 | $108 | $242 | $125 | $218 | $173 | $95 | $135 | $227 |
| 32555 | Aspirate pleura w/ imaging | $318 | $109 | $287 | $94 | $290 | $102 | $261 | $204 | $78 | $89 | $275 |
| 31500 | Insert emergency airway | $145 | $145 | $112 | $112 | $134 | $134 | $120 | $105 | $105 | $72 | $120 |
| 31575 | Diagnostic laryngoscopy | $133 | $72 | $91 | $57 | $121 | $66 | $109 | $86 | $49 | $69 | $115 |
| 31231 | Nasal endoscopy dx | $198 | $66 | $167 | $57 | $179 | $61 | $162 | $126 | $46 | $59 | $172 |
| | **Weighted Average % of Medicare Fees** | | | **81%** | **80%** | **91%** | **92%** | **82%** | **66%** | **70%** | **45%** | **86%** |
| | **Ranking** | | | **5** | **6** | **2** | **1** | **4** | **8** | **7** | **9** | **3** |
| | **Cardiovascular System Surgery** | | | | | | | | | | | |
| 36471 | Njx sclrsnt mlt incmptnt vn | $206 | $77 | $140 | $77 | $187 | $71 | $169 | $134 | $56 | $91 | $178 |
| 36512 | Apheresis rbc | $107 | $107 | $75 | $75 | $100 | $100 | $89 | $75 | $75 | $50 | $90 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 37252 | Intrvasc us noncoronary 1st | $927 | $90 | $927 | $82 | $837 | $83 | $756 | $572 | $65 | $0 | $814 |
| 36589 | Removal tunneled cv cath | $169 | $140 | $131 | $110 | $155 | $128 | $140 | $115 | $97 | $130 | $143 |
| 36475 | Endovenous rf 1st vein | $1,066 | $283 | $1,066 | $254 | $964 | $258 | $870 | $678 | $203 | $290 | $925 |
| 36558 | Insert tunneled cv cath | $818 | $264 | $670 | $218 | $743 | $243 | $671 | $521 | $185 | $266 | $711 |
| 36561 | Insert tunneled cv cath | $966 | $339 | $938 | $274 | $877 | $311 | $791 | $618 | $238 | $319 | $837 |
| 36430 | Blood transfusion service | $45 | $45 | $31 | $31 | $41 | $41 | $37 | $28 | $28 | $28 | $40 |
| 36591 | Draw blood off venous device | $29 | $29 | $19 | $19 | $26 | $26 | $0 | $18 | $18 | $0 | $26 |
| 36410 | Non-routine bl draw 3/> yrs | $19 | $9 | $14 | $7 | $17 | $9 | $15 | $12 | $7 | $0 | $16 |
| 36556 | Insert non-tunnel cv cath | $215 | $85 | $194 | $85 | $196 | $79 | $177 | $140 | $61 | $113 | $186 |
| 36620 | Insertion catheter artery | $44 | $44 | $40 | $40 | $41 | $41 | $37 | $32 | $32 | $48 | $36 |
| | **Weighted Average % of Medicare Fees** | | | **91%** | **85%** | **91%** | **92%** | **82%** | **64%** | **70%** | **40%** | **87%** |
| | **Ranking** | | | **2** | **5** | **3** | **1** | **6** | **8** | **7** | **9** | **4** |
| | **Hemic, Lymphatic and Mediastinum** | | | | | | | | | | | |
| 38724 | Removal of lymph nodes neck | $1,508 | $1,508 | $1,160 | $1,160 | $1,384 | $1,384 | $1,244 | $1,048 | $1,048 | $844 | $1,264 |
| 38570 | Laparoscopy lymph node biop | $539 | $539 | $405 | $405 | $493 | $493 | $443 | $375 | $375 | $487 | $450 |
| 38221 | Dx bone marrow biopsies | $166 | $71 | $136 | $59 | $152 | $66 | $137 | $107 | $49 | $70 | $144 |
| 38220 | Dx bone marrow aspirations | $163 | $69 | $134 | $49 | $149 | $64 | $134 | $105 | $48 | $55 | $141 |
| 38500 | Biopsy/removal lymph nodes | $352 | $269 | $266 | $205 | $319 | $244 | $288 | $237 | $186 | $279 | $298 |
| 38571 | Laparoscopy lymphadenectomy | $683 | $683 | $582 | $582 | $630 | $630 | $566 | $479 | $479 | $633 | $571 |
| 38510 | Biopsy/removal lymph nodes | $550 | $438 | $338 | $338 | $501 | $400 | $451 | $373 | $305 | $136 | $465 |
| 38792 | Ra tracer id of sentinl node | $85 | $32 | $32 | $32 | $78 | $30 | $70 | $55 | $23 | $0 | $74 |
| 38900 | Io map of sent lymph node | $143 | $143 | $113 | $113 | $130 | $130 | $117 | $102 | $102 | $110 | $118 |
| 38505 | Needle biopsy lymph nodes | $178 | $87 | $101 | $57 | $163 | $81 | $146 | $116 | $61 | $67 | $153 |
| 38525 | Biopsy/removal lymph nodes | $468 | $468 | $353 | $353 | $424 | $424 | $382 | $324 | $324 | $156 | $391 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 38222 | Dx bone marrow bx & aspir | $181 | $76 | $149 | $67 | $165 | $70 | $149 | $117 | $53 | $63 | $156 |
| | **Weighted Average % of Medicare Fees** | | | **74%** | **78%** | **91%** | **91%** | **82%** | **68%** | **70%** | **48%** | **84%** |
| | **Ranking** | | | **6** | **5** | **2** | **1** | **4** | **8** | **7** | **9** | **3** |
| | **Digestive System** | | | | | | | | | | | |
| 46600 | Diagnostic anoscopy spx | $119 | $43 | $71 | $33 | $108 | $39 | $98 | $75 | $29 | $20 | $104 |
| 43775 | Lap sleeve gastrectomy | $1,157 | $1,157 | $969 | $969 | $1,047 | $1,047 | $943 | $829 | $829 | $1,034 | $949 |
| 42830 | Removal of adenoids | $226 | $226 | $167 | $167 | $206 | $206 | $186 | $151 | $151 | $134 | $192 |
| 44970 | Laparoscopy appendectomy | $637 | $637 | $486 | $486 | $577 | $577 | $520 | $445 | $445 | $444 | $530 |
| 43235 | Egd diagnostic brush wash | $296 | $125 | $229 | $104 | $269 | $116 | $243 | $191 | $87 | $125 | $256 |
| 47562 | Laparoscopic cholecystectomy | $699 | $699 | $532 | $532 | $633 | $633 | $570 | $489 | $489 | $589 | $581 |
| 42820 | Remove tonsils and adenoids | $307 | $307 | $231 | $231 | $281 | $281 | $253 | $209 | $209 | $184 | $259 |
| 49083 | Abd paracentesis w/imaging | $297 | $108 | $267 | $91 | $270 | $100 | $244 | $190 | $76 | $84 | $257 |
| 45385 | Colonoscopy w/lesion removal | $465 | $257 | $400 | $221 | $425 | $238 | $383 | $306 | $181 | $268 | $399 |
| 45378 | Diagnostic colonoscopy | $350 | $188 | $299 | $155 | $320 | $174 | $288 | $230 | $132 | $181 | $301 |
| 45380 | Colonoscopy and biopsy | $444 | $205 | $357 | $187 | $404 | $189 | $365 | $288 | $143 | $225 | $383 |
| 43239 | Egd biopsy single/multiple | $383 | $141 | $274 | $123 | $348 | $130 | $314 | $245 | $98 | $149 | $332 |
| | **Weighted Average % of Medicare Fees** | | | **79%** | **83%** | **91%** | **92%** | **82%** | **66%** | **70%** | **53%** | **86%** |
| | **Ranking** | | | **6** | **4** | **2** | **1** | **5** | **8** | **7** | **9** | **3** |
| | **Urinary & Male Genital** | | | | | | | | | | | |
| 51784 | Anal/urinary muscle study | $66 | $66 | $66 | $66 | $61 | $61 | $55 | $44 | $44 | $96 | $57 |
| 55700 | Biopsy of prostate | $249 | $132 | $198 | $104 | $228 | $122 | $205 | $164 | $93 | $90 | $213 |
| 51701 | Insert bladder catheter | $46 | $26 | $46 | $26 | $42 | $24 | $38 | $30 | $18 | $25 | $39 |
| 51705 | Change of bladder tube | $101 | $54 | $92 | $51 | $92 | $50 | $83 | $66 | $38 | $28 | $87 |
| 52332 | Cystoscopy and treatment | $388 | $159 | $388 | $124 | $354 | $147 | $319 | $250 | $112 | $144 | $336 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 52310 | Cystoscopy and treatment | $313 | $155 | $205 | $121 | $285 | $143 | $257 | $205 | $109 | $129 | $269 |
| 51741 | Electro-uroflowmetry first | $15 | $15 | $15 | $15 | $14 | $14 | $12 | $10 | $10 | $24 | $13 |
| 52356 | Cysto/uretero w/lithotripsy | $422 | $422 | $337 | $337 | $390 | $390 | $350 | $299 | $299 | $333 | $351 |
| 54161 | Circum 28 days or older | $205 | $205 | $157 | $157 | $189 | $189 | $170 | $142 | $142 | $128 | $172 |
| 52000 | Cystoscopy | $228 | $82 | $144 | $82 | $208 | $76 | $187 | $147 | $58 | $75 | $198 |
| 51798 | Us urine capacity measure | $12 | $12 | $12 | $12 | $11 | $11 | $10 | $8 | $8 | $14 | $0 |
| 54150 | Circumcision w/regionl block | $153 | $98 | $145 | $78 | $141 | $91 | $127 | $103 | $70 | $79 | $130 |
| | **Weighted Average % of Medicare Fees** | | | **81%** | **83%** | **92%** | **92%** | **82%** | **67%** | **70%** | **50%** | **84%** |
| | **Ranking** | | | **6** | **4** | **2** | **1** | **5** | **8** | **7** | **9** | **3** |
| | **Gynecology-Obstetric** | | | | | | | | | | | |
| 58100 | Biopsy of uterus lining | $104 | $65 | $104 | $65 | $95 | $60 | $97 | $70 | $46 | $51 | $89 |
| 58661 | Laparoscopy remove adnexa | $678 | $678 | $620 | $620 | $621 | $621 | $631 | $269 | $269 | $565 | $565 |
| 57454 | Bx/curett of cervix w/scope | $175 | $139 | $152 | $133 | $160 | $127 | $163 | $120 | $97 | $106 | $148 |
| 58558 | Hysteroscopy biopsy | $1,299 | $239 | $1,183 | $239 | $1,175 | $220 | $1,199 | $811 | $169 | $239 | $1,136 |
| 58301 | Remove intrauterine device | $114 | $68 | $111 | $104 | $104 | $63 | $105 | $76 | $49 | $17 | $97 |
| 59410 | Obstetrical care | $1,136 | $1,136 | $942 | $942 | $1,025 | $1,025 | $1,044 | $1,066 | $1,066 | $1,200 | $933 |
| 59840 | Abortion | $263 | $235 | $541 | $300 | $237 | $211 | $241 | $236 | $214 | $82 | $0 |
| 58300 | Insert intrauterine device | $112 | $52 | $168 | $168 | $103 | $103 | $104 | $73 | $36 | $17 | $97 |
| 59430 | Care after delivery | $276 | $187 | $149 | $125 | $249 | $169 | $254 | $247 | $177 | $0 | $232 |
| 59514 | Cesarean delivery only | $954 | $954 | $954 | $954 | $757 | $757 | $874 | $902 | $902 | $1,200 | $780 |
| 59409 | Obstetrical care | $838 | $838 | $838 | $838 | $757 | $757 | $771 | $791 | $791 | $1,200 | $687 |
| 59025 | Fetal non-stress test | $52 | $52 | $46 | $46 | $47 | $47 | $48 | $35 | $35 | $18 | $44 |
| | **Weighted Average % of Medicare Fees** | | | **97%** | **98%** | **88%** | **88%** | **92%** | **84%** | **87%** | **98%** | **83%** |
| | **Ranking** | | | **3** | **1** | **6** | **4** | **4** | **8** | **7** | **2** | **9** |

| 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 | $1,135 | $1,135 | $875 | $875 | $1,037 | $1,037 | $933 | $795 | $795 | $375 | $946 |
| 60650 | Laparoscopy adrenalectomy | $1,248 | $1,248 | $960 | $960 | $1,136 | $1,136 | $1,023 | $882 | $882 | $977 | $1,034 |
| 60210 | Partial thyroid excision | $745 | $745 | $567 | $567 | $678 | $678 | $611 | $518 | $518 | $605 | $622 |
| 60512 | Autotransplant parathyroid | $249 | $249 | $195 | $195 | $227 | $227 | $204 | $177 | $177 | $217 | $206 |
| 60252 | Removal of thyroid | $1,376 | $1,376 | $1,059 | $1,059 | $1,255 | $1,255 | $1,130 | $963 | $963 | $826 | $1,146 |
| 60271 | Removal of thyroid | $1,103 | $1,103 | $847 | $847 | $1,006 | $1,006 | $905 | $772 | $772 | $925 | $918 |
| 60280 | Remove thyroid duct lesion | $477 | $477 | $354 | $354 | $437 | $437 | $393 | $324 | $324 | $304 | $404 |
| 60100 | Biopsy of thyroid | $113 | $77 | $89 | $63 | $104 | $72 | $94 | $76 | $55 | $66 | $96 |
| 60500 | Explore parathyroid glands | $1,019 | $1,019 | $775 | $775 | $926 | $926 | $834 | $712 | $712 | $705 | $848 |
| 60220 | Partial removal of thyroid | $741 | $741 | $565 | $565 | $676 | $676 | $609 | $514 | $514 | $521 | $620 |
| 60240 | Removal of thyroid | $960 | $960 | $737 | $737 | $875 | $875 | $788 | $671 | $671 | $591 | $800 |
| | **Weighted Average % of Medicare Fees** | | | **77%** | **77%** | **91%** | **91%** | **82%** | **70%** | **70%** | **67%** | **83%** |
| | **Ranking** | | | **6** | **5** | **2** | **1** | **4** | **8** | **7** | **9** | **3** |
| | **Neurosurgery** | | | | | | | | | | | |
| 64415 | Njx aa&/strd brch plxs img | $137 | $71 | $124 | $67 | $126 | $66 | $113 | $91 | $50 | $35 | $118 |
| 64450 | Njx aa&/strd other pn/branch | $77 | $42 | $77 | $42 | $70 | $39 | $63 | $50 | $29 | $21 | $66 |
| 64615 | Chemodenerv musc migraine | $162 | $131 | $128 | $115 | $145 | $117 | $131 | $111 | $92 | $102 | $135 |
| 64636 | Destroy l/s facet jnt addl | $243 | $60 | $188 | $60 | $221 | $56 | $199 | $153 | $42 | $48 | $0 |
| 64447 | Njx aa&/strd femoral nrv img | $120 | $65 | $94 | $57 | $110 | $60 | $99 | $79 | $46 | $61 | $103 |
| 64484 | Njx aa&/strd tfrm epi l/s ea | $113 | $51 | $95 | $51 | $104 | $48 | $93 | $74 | $36 | $60 | $98 |
| 62321 | Njx interlaminar crv/thrc | $268 | $110 | $246 | $109 | $245 | $102 | $221 | $173 | $76 | $89 | $232 |
| 64635 | Destroy lumb/sac facet jnt | $449 | $197 | $449 | $197 | $410 | $183 | $370 | $289 | $137 | $179 | $0 |
| 64494 | Inj paravert f jnt l/s 2 lev | $94 | $52 | $87 | $52 | $86 | $48 | $77 | $62 | $37 | $42 | $80 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 62323 | Njx interlaminar lmbr/sac | $264 | $101 | $242 | $99 | $241 | $94 | $217 | $169 | $71 | $81 | $229 |
| 64493 | Inj paravert f jnt l/s 1 lev | $184 | $94 | $170 | $94 | $168 | $86 | $151 | $119 | $65 | $72 | $159 |
| 64483 | Njx aa&/strd tfrm epi l/s 1 | $252 | $114 | $238 | $101 | $230 | $106 | $208 | $163 | $78 | $95 | $218 |
| | **Weighted Average % of Medicare Fees** | | | **92%** | **96%** | **91%** | **93%** | **82%** | **65%** | **70%** | **37%** | **86%** |
| | **Ranking** | | | **3** | **1** | **4** | **2** | **6** | **8** | **7** | **9** | **5** |
| | **Eye Surgery** | | | | | | | | | | | |
| 67113 | Repair retinal detach cplx | $1,345 | $1,345 | $1,062 | $1,062 | $1,243 | $1,243 | $1,117 | $911 | $911 | $1,086 | $1,144 |
| 66761 | Revision of iris | $303 | $240 | $285 | $240 | $278 | $221 | $251 | $199 | $161 | $181 | $261 |
| 67820 | Revise eyelashes | $19 | $23 | $19 | $23 | $18 | $21 | $16 | $13 | $15 | $35 | $16 |
| 65778 | Cover eye w/membrane | $1,311 | $44 | $1,142 | $44 | $1,184 | $41 | $1,070 | $799 | $31 | $60 | $1,158 |
| 66821 | After cataract laser surgery | $340 | $318 | $260 | $246 | $313 | $292 | $281 | $223 | $210 | $217 | $293 |
| 65855 | Trabeculoplasty laser surg | $250 | $208 | $227 | $195 | $230 | $193 | $207 | $166 | $142 | $237 | $214 |
| 67311 | Revise eye muscle | $466 | $466 | $466 | $466 | $430 | $430 | $386 | $313 | $313 | $468 | $398 |
| 67228 | Treatment x10sv retinopathy | $346 | $308 | $333 | $300 | $319 | $285 | $286 | $232 | $209 | $491 | $295 |
| 66982 | Xcapsl ctrc rmvl cplx wo ecp | $757 | $757 | $678 | $678 | $699 | $699 | $628 | $511 | $511 | $697 | $645 |
| 68761 | Close tear duct opening | $147 | $120 | $117 | $94 | $136 | $110 | $122 | $96 | $79 | $63 | $127 |
| 66984 | Xcapsl ctrc rmvl w/o ecp | $553 | $553 | $503 | $503 | $510 | $510 | $459 | $372 | $372 | $603 | $472 |
| 67028 | Injection eye drug | $116 | $94 | $99 | $94 | $107 | $87 | $96 | $77 | $64 | $106 | $99 |
| | **Weighted Average % of Medicare Fees** | | | **89%** | **91%** | **92%** | **92%** | **83%** | **67%** | **67%** | **89%** | **86%** |
| | **Ranking** | | | **5** | **3** | **2** | **1** | **7** | **9** | **8** | **4** | **6** |
| | **Ear Surgery** | | | | | | | | | | | |
| 69205 | Clear outer ear canal | $99 | $99 | $91 | $91 | $91 | $91 | $82 | $66 | $66 | $89 | $84 |
| 69200 | Clear outer ear canal | $84 | $50 | $82 | $49 | $76 | $46 | $69 | $55 | $34 | $30 | $72 |
| 69436 | Create eardrum opening | $168 | $168 | $149 | $149 | $153 | $153 | $138 | $113 | $113 | $99 | $142 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 69209 | Remove impacted ear wax uni | $16 | $16 | $11 | $11 | $15 | $15 | $13 | $10 | $10 | $10 | $14 |
| 69210 | Remove impacted ear wax uni | $50 | $33 | $44 | $29 | $46 | $30 | $41 | $33 | $23 | $20 | $42 |
| | **Weighted Average % of Medicare Fees** | | | **89%** | **88%** | **91%** | **92%** | **82%** | **67%** | **68%** | **50%** | **85%** |
| | **Ranking** | | | **3** | **4** | **2** | **1** | **6** | **8** | **7** | **9** | **5** |
| | **Radiology** | | | | | | | | | | | |
| 76819 | Fetal biophys profil w/o nst | $88 | $88 | $78 | $78 | $81 | $81 | $83 | $57 | $57 | $86 | $77 |
| 76856 | Us exam pelvic complete | $109 | $109 | $88 | $88 | $99 | $99 | $101 | $69 | $69 | $77 | $94 |
| 76830 | Transvaginal us non-ob | $122 | $122 | $98 | $98 | $111 | $111 | $113 | $77 | $77 | $77 | $106 |
| 73610 | X-ray exam of ankle | $38 | $38 | $25 | $25 | $34 | $34 | $31 | $24 | $24 | $27 | $33 |
| 77067 | Scr mammo bi incl cad | $133 | $133 | $108 | $108 | $121 | $121 | $124 | $85 | $85 | $105 | $116 |
| 73630 | X-ray exam of foot | $35 | $35 | $24 | $24 | $32 | $32 | $29 | $23 | $23 | $19 | $31 |
| 76820 | Umbilical artery echo | $45 | $45 | $45 | $45 | $42 | $42 | $42 | $30 | $30 | $46 | $39 |
| 76816 | Ob us follow-up per fetus | $112 | $112 | $93 | $93 | $103 | $103 | $104 | $72 | $72 | $72 | $97 |
| 74177 | Ct abd & pelv w/contrast | $318 | $318 | $287 | $287 | $290 | $290 | $261 | $202 | $202 | $263 | $277 |
| 70450 | Ct head/brain w/o dye | $112 | $112 | $112 | $112 | $103 | $103 | $92 | $72 | $72 | $117 | $97 |
| 71045 | X-ray exam chest 1 view | $27 | $27 | $17 | $17 | $25 | $25 | $22 | $17 | $17 | $15 | $23 |
| 71046 | X-ray exam chest 2 views | $35 | $35 | $27 | $27 | $32 | $32 | $29 | $22 | $22 | $24 | $30 |
| | **Weighted Average % of Medicare Fees** | | | **86%** | **86%** | **91%** | **91%** | **86%** | **64%** | **64%** | **79%** | **87%** |
| | **Ranking** | | | **5** | **5** | **1** | **1** | **4** | **8** | **8** | **7** | **3** |
| | **Laboratory** | | | | | | | | | | | |
| 87661 | Trichomonas vaginalis amplif | $35 | $35 | $34 | $34 | $34 | $34 | $35 | $32 | $32 | $38 | $28 |
| 82306 | Vitamin d 25 hydroxy | $30 | $30 | $29 | $29 | $29 | $29 | $30 | $27 | $27 | $41 | $24 |
| 87880 | Strep a assay w/optic | $17 | $17 | $13 | $13 | $16 | $16 | $14 | $15 | $15 | $6 | $13 |
| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 87591 | N.gonorrhoeae dna amp prob | $35 | $35 | $34 | $34 | $34 | $34 | $35 | $32 | $32 | $23 | $28 |
| 87491 | Chlmyd trach dna amp probe | $35 | $35 | $34 | $34 | $34 | $34 | $35 | $32 | $32 | $23 | $28 |
| 84443 | Assay thyroid stim hormone | $17 | $17 | $17 | $17 | $16 | $16 | $17 | $15 | $15 | $23 | $13 |
| 83036 | Hemoglobin glycosylated a1c | $10 | $10 | $10 | $10 | $10 | $10 | $10 | $9 | $9 | $7 | $8 |
| 80061 | Lipid panel | $13 | $13 | $13 | $13 | $13 | $13 | $13 | $12 | $12 | $14 | $11 |
| 80307 | Drug test prsmv chem anlyzr | $62 | $62 | $49 | $49 | $61 | $61 | $62 | $56 | $56 | $64 | $50 |
| 80053 | Comprehen metabolic panel | $11 | $11 | $10 | $10 | $10 | $10 | $11 | $10 | $10 | $12 | $8 |
| 85025 | Complete cbc w/auto diff wbc | $8 | $8 | $8 | $8 | $8 | $8 | $8 | $7 | $7 | $6 | $6 |
| | **Weighted Average % of Medicare Fees** | | | **92%** | **92%** | **98%** | **98%** | **99%** | **90%** | **90%** | **95%** | **80%** |
| | **Ranking** | | | **5** | **5** | **2** | **2** | **1** | **7** | **7** | **4** | **9** |
| | **Psychiatry** | | | | | | | | | | | |
| 90833 | Psytx w pt w e/m 30 min | $76 | $67 | $69 | $66 | $72 | $63 | $80 | $54 | $48 | $0 | $64 |
| 90832 | Psytx w pt 30 minutes | $82 | $71 | $67 | $67 | $78 | $68 | $86 | $58 | $52 | $26 | $69 |
| 90847 | Family psytx w/pt 50 min | $106 | $106 | $106 | $58 | $101 | $101 | $113 | $77 | $77 | $13 | $88 |
| 90853 | Group psychotherapy | $29 | $25 | $24 | $24 | $28 | $24 | $31 | $21 | $18 | $4 | $25 |
| 90834 | Psytx w pt 45 minutes | $108 | $94 | $88 | $88 | $103 | $90 | $114 | $77 | $68 | $39 | $91 |
| | **Weighted Average % of Medicare Fees** | | | **84%** | **90%** | **95%** | **96%** | **106%** | **71%** | **73%** | **33%** | **84%** |
| | **Ranking** | | | **6** | **4** | **3** | **2** | **1** | **8** | **7** | **9** | **5** |
| | **Dialysis** | | | | | | | | | | | |
| 90961 | Esrd srv 2-3 vsts p mo 20+ | $299 | $299 | $184 | $184 | $279 | $279 | $250 | $208 | $208 | $0 | $252 |
| 90945 | Dialysis one evaluation | $87 | $87 | $66 | $66 | $82 | $82 | $138 | $61 | $61 | $35 | $74 |
| 90960 | Esrd srv 4 visits p mo 20+ | $360 | $360 | $219 | $219 | $336 | $336 | $301 | $252 | $252 | $0 | $303 |
| 90935 | Hemodialysis one evaluation | $71 | $71 | $56 | $56 | $67 | $67 | $138 | $50 | $50 | $35 | $60 |
| 90966 | Esrd home pt serv p mo 20+ | $299 | $299 | $184 | $184 | $279 | $279 | $250 | $208 | $208 | $0 | $0 |

| 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** | | | **65%** | **65%** | **93%** | **93%** | **109%** | **70%** | **70%** | **46%** | **84%** |
| | **Ranking** | | | **7** | **7** | **2** | **2** | **1** | **5** | **5** | **9** | **4** |
| | **Gastroenterology** | | | | | | | | | | | |
| 91035 | G-esoph reflx tst w/electrod | $455 | $455 | $384 | $384 | $413 | $413 | $373 | $284 | $284 | $351 | $399 |
| 91037 | Esoph imped function test | $171 | $171 | $127 | $127 | $156 | $156 | $141 | $109 | $109 | $114 | $149 |
| 91120 | Rectal sensation test | $498 | $498 | $341 | $341 | $451 | $451 | $407 | $306 | $306 | $337 | $0 |
| 91110 | Gi trc img intral esoph-ile | $725 | $725 | $725 | $725 | $658 | $658 | $594 | $450 | $450 | $680 | $637 |
| 91122 | Anal pressure record | $282 | $282 | $190 | $190 | $258 | $258 | $232 | $180 | $180 | $69 | $246 |
| 91010 | Esophagus motility study | $224 | $224 | $155 | $155 | $204 | $204 | $184 | $142 | $142 | $28 | $195 |
| 91065 | Breath hydrogen/methane test | $68 | $68 | $60 | $60 | $62 | $62 | $56 | $42 | $42 | $17 | $60 |
| 91200 | Liver elastography | $31 | $31 | $31 | $31 | $29 | $29 | $26 | $20 | $20 | $30 | $0 |
| | **Weighted Average % of Medicare Fees** | | | **82%** | **82%** | **91%** | **91%** | **82%** | **63%** | **63%** | **63%** | **88%** |
| | **Ranking** | | | **4** | **4** | **1** | **1** | **6** | **8** | **8** | **7** | **3** |
| | **Ophthalmology/Vision Care** | | | | | | | | | | | |
| 92340 | Fit spectacles monofocal | $36 | $18 | $0 | $0 | $0 | $0 | $0 | $24 | $13 | $0 | $31 |
| 92083 | Visual field examination(s) | $65 | $65 | $57 | $57 | $60 | $60 | $54 | $42 | $42 | $63 | $57 |
| 92133 | Cmptr ophth img optic nerve | $32 | $32 | $32 | $32 | $29 | $29 | $26 | $21 | $21 | $35 | $27 |
| 92012 | Eye exam establish patient | $91 | $50 | $67 | $41 | $83 | $47 | $75 | $59 | $35 | $48 | $78 |
| 92060 | Special eye evaluation | $65 | $65 | $51 | $51 | $60 | $60 | $54 | $43 | $43 | $61 | $57 |
| 92134 | Cptr ophth dx img post segmt | $33 | $33 | $33 | $33 | $31 | $31 | $28 | $22 | $22 | $38 | $29 |
| 92250 | Eye exam with photos | $38 | $38 | $38 | $38 | $35 | $35 | $31 | $25 | $25 | $53 | $33 |
| 92004 | Eye exam new patient | $151 | $93 | $117 | $77 | $140 | $88 | $126 | $100 | $65 | $90 | $130 |
| 92014 | Eye exam&tx estab pt 1/>vst | $128 | $75 | $97 | $62 | $118 | $71 | $106 | $84 | $52 | $73 | $110 |
| 92015 | Determine refractive state | $19 | $19 | $19 | $15 | $18 | $17 | $16 | $14 | $13 | $18 | $16 |

| 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** | | | **80%** | **84%** | **93%** | **94%** | **83%** | **66%** | **69%** | **67%** | **86%** |
| | **Ranking** | | | **6** | **4** | **2** | **1** | **5** | **9** | **7** | **8** | **3** |
| | **ENT (Otorhinolaryngology)** | | | | | | | | | | | |
| 92526 | Oral function therapy | $87 | $87 | $81 | $67 | $81 | $81 | $73 | $59 | $59 | $48 | $74 |
| 92552 | Pure tone audiometry air | $42 | $42 | $25 | $25 | $38 | $38 | $34 | $25 | $25 | $8 | $37 |
| 92551 | Pure tone hearing test air | $13 | $13 | $10 | $10 | $12 | $12 | $11 | $8 | $8 | $8 | $12 |
| 92507 | Speech/hearing therapy | $79 | $79 | $64 | $61 | $74 | $74 | $82 | $54 | $54 | $22 | $67 |
| 92508 | Speech/hearing therapy | $25 | $25 | $25 | $25 | $23 | $23 | $26 | $17 | $17 | $10 | $21 |
| | **Weighted Average % of Medicare Fees** | | | **85%** | **82%** | **93%** | **93%** | **102%** | **67%** | **67%** | **32%** | **85%** |
| | **Ranking** | | | **5** | **6** | **2** | **2** | **1** | **7** | **7** | **9** | **4** |
| | **Cardiovascular** | | | | | | | | | | | |
| 93308 | Tte f-up or lmtd | $101 | $101 | $100 | $100 | $92 | $92 | $83 | $64 | $64 | $37 | $88 |
| 93042 | Rhythm ecg report | $7 | $7 | $6 | $6 | $6 | $6 | $6 | $5 | $5 | $7 | $6 |
| 93015 | Cardiovascular stress test | $75 | $75 | $75 | $75 | $69 | $69 | $62 | $49 | $49 | $90 | $65 |
| 93303 | Echo transthoracic | $223 | $223 | $188 | $188 | $203 | $203 | $183 | $141 | $141 | $157 | $194 |
| 93320 | Doppler echo exam heart | $52 | $52 | $52 | $52 | $47 | $47 | $43 | $33 | $33 | $61 | $45 |
| 93325 | Doppler color flow add-on | $24 | $24 | $24 | $24 | $21 | $21 | $19 | $15 | $15 | $19 | $21 |
| 93306 | Tte w/doppler complete | $200 | $200 | $200 | $200 | $183 | $183 | $165 | $128 | $128 | $141 | $174 |
| 93005 | Electrocardiogram tracing | $7 | $7 | $7 | $7 | $6 | $6 | $5 | $4 | $4 | $10 | $6 |
| 93000 | Electrocardiogram complete | $15 | $15 | $15 | $15 | $14 | $14 | $12 | $10 | $10 | $19 | $13 |
| 93010 | Electrocardiogram report | $8 | $8 | $7 | $7 | $8 | $8 | $7 | $6 | $6 | $8 | $7 |
| | **Weighted Average % of Medicare Fees** | | | **96%** | **96%** | **92%** | **92%** | **82%** | **65%** | **65%** | **83%** | **87%** |
| | **Ranking** | | | **1** | **1** | **3** | **2** | **7** | **8** | **8** | **6** | **5** |
| | **Non-Invasive Vascular Tests** | | | | | | | | | | | |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 93976 | Vascular study | $164 | $164 | $153 | $153 | $139 | $139 | $135 | $96 | $96 | $131 | $143 |
| 93978 | Vascular study | $187 | $187 | $153 | $153 | $169 | $169 | $153 | $118 | $118 | $122 | $163 |
| 93979 | Vascular study | $121 | $121 | $96 | $96 | $110 | $110 | $99 | $76 | $76 | $100 | $106 |
| 93980 | Penile vascular study | $120 | $120 | $119 | $119 | $111 | $111 | $100 | $79 | $79 | $154 | $104 |
| 93985 | Dup-scan hemo compl bi std | $257 | $257 | $236 | $236 | $232 | $232 | $210 | $161 | $161 | $205 | $225 |
| 93986 | Dup-scan hemo compl uni std | $151 | $151 | $120 | $120 | $125 | $125 | $123 | $86 | $86 | $119 | $132 |
| 93990 | Doppler flow testing | $151 | $151 | $109 | $109 | $125 | $125 | $123 | $86 | $86 | $92 | $132 |
| 93975 | Vascular study | $271 | $271 | $225 | $225 | $246 | $246 | $222 | $170 | $170 | $182 | $237 |
| | **Weighted Average % of Medicare Fees** | | | **83%** | **83%** | **87%** | **87%** | **82%** | **60%** | **60%** | **76%** | **87%** |
| | **Ranking** | | | **4** | **4** | **2** | **2** | **6** | **8** | **8** | **7** | **1** |
| | **Pulmonary** | | | | | | | | | | | |
| 94729 | Co/membane diffuse capacity | $58 | $58 | $46 | $46 | $53 | $53 | $48 | $37 | $37 | $40 | $51 |
| 94760 | Measure blood oxygen level | $4 | $4 | $3 | $3 | $3 | $3 | $3 | $2 | $2 | $2 | $3 |
| 94761 | Measure blood oxygen level | $4 | $4 | $4 | $4 | $4 | $4 | $3 | $2 | $2 | $4 | $4 |
| 94762 | Measure blood oxygen level | $26 | $26 | $22 | $22 | $23 | $23 | $21 | $16 | $16 | $0 | $23 |
| 94727 | Pulm function test by gas | $47 | $47 | $36 | $36 | $43 | $43 | $38 | $30 | $30 | $32 | $41 |
| 94728 | Airwy resist by oscillometry | $46 | $46 | $36 | $36 | $42 | $42 | $38 | $29 | $29 | $32 | $40 |
| 94780 | Cars/bd tst inft-12mo 60 min | $55 | $23 | $47 | $20 | $0 | $0 | $46 | $36 | $16 | $0 | $48 |
| 94781 | Cars/bd tst inft-12mo +30min | $22 | $8 | $18 | $7 | $0 | $0 | $18 | $14 | $6 | $0 | $19 |
| 94726 | Pulm funct tst plethysmograp | $59 | $59 | $47 | $47 | $54 | $54 | $48 | $37 | $37 | $40 | $52 |
| | **Weighted Average % of Medicare Fees** | | | **82%** | **82%** | **91%** | **91%** | **82%** | **64%** | **66%** | **68%** | **87%** |
| | **Ranking** | | | **4** | **6** | **1** | **1** | **5** | **9** | **8** | **7** | **3** |
| | **Allergy/Immunology** | | | | | | | | | | | |
| 95170 | Antigen therapy services | $11 | $3 | $8 | $2 | $10 | $3 | $9 | $7 | $2 | $0 | $10 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 95180 | Rapid desensitization | $143 | $103 | $111 | $79 | $133 | $97 | $119 | $96 | $72 | $9 | $122 |
| 95249 | Cont gluc mntr pt prov eqp | $69 | $69 | $49 | $49 | $62 | $62 | $0 | $42 | $42 | $42 | $61 |
| 95250 | Cont gluc mntr phys/qhp eqp | $151 | $151 | $127 | $127 | $135 | $135 | $123 | $91 | $91 | $88 | $0 |
| 95251 | Cont gluc mntr analysis i&r | $35 | $35 | $34 | $34 | $33 | $33 | $29 | $25 | $25 | $29 | $29 |
| | **Weighted Average % of Medicare Fees** | | | **84%** | **85%** | **92%** | **92%** | **83%** | **65%** | **65%** | **54%** | **85%** |
| | **Ranking** | | | **5** | **4** | **2** | **1** | **6** | **8** | **7** | **9** | **3** |
| | **Neurology/Neuromuscular** | | | | | | | | | | | |
| 95977 | Alys cplx cn npgt prgrmg | $51 | $51 | $47 | $46 | $48 | $47 | $43 | $36 | $36 | $43 | $43 |
| 95981 | Io anal gast n-stim subsq | $41 | $18 | $26 | $14 | $38 | $17 | $0 | $27 | $13 | $0 | $36 |
| 95983 | Alys brn npgt prgrmg 15 min | $50 | $49 | $45 | $44 | $47 | $46 | $42 | $35 | $35 | $41 | $42 |
| 95984 | Alys brn npgt prgrmg addl 15 | $44 | $44 | $39 | $38 | $41 | $41 | $37 | $31 | $30 | $36 | $37 |
| 95990 | Spin/brain pump refil & main | $91 | $91 | $73 | $73 | $82 | $82 | $74 | $56 | $56 | $47 | $0 |
| 95991 | Spin/brain pump refil & main | $113 | $40 | $95 | $31 | $103 | $37 | $93 | $73 | $28 | $34 | $98 |
| 95992 | Canalith repositioning proc | $43 | $36 | $34 | $29 | $40 | $34 | $36 | $30 | $25 | $0 | $37 |
| 96000 | Motion analysis video/3d | $84 | $84 | $74 | $74 | $0 | $0 | $71 | $59 | $59 | $0 | $0 |
| 96001 | Motion test w/ft press meas | $108 | $108 | $96 | $96 | $0 | $0 | $90 | $76 | $76 | $0 | $90 |
| 96002 | Dynamic surface emg | $22 | $22 | $17 | $17 | $0 | $0 | $18 | $15 | $15 | $0 | $18 |
| 96004 | Phys review of motion tests | $108 | $108 | $91 | $91 | $0 | $0 | $90 | $76 | $76 | $0 | $90 |
| 96020 | Functional brain mapping | $156 | $156 | $151 | $151 | $148 | $148 | $0 | $0 | $0 | $0 | $0 |
| | **Weighted Average % of Medicare Fees** | | | **88%** | **89%** | **93%** | **93%** | **83%** | **69%** | **70%** | **56%** | **90%** |
| | **Ranking** | | | **5** | **4** | **2** | **1** | **6** | **8** | **7** | **9** | **3** |
| | **CNS Assessment Tests** | | | | | | | | | | | |
| 96159 | Hlth bhv ivntj indiv ea addl | $24 | $21 | $18 | $16 | $23 | $20 | $20 | $17 | $15 | $20 | $20 |
| 96158 | Hlth bhv ivntj indiv 1st 30 | $71 | $61 | $36 | $33 | $67 | $59 | $60 | $50 | $45 | $39 | $59 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 96161 | Caregiver health risk assmt | $3 | $3 | $3 | $3 | $3 | $3 | $3 | $2 | $2 | $3 | $3 |
| 96160 | Pt-focused hlth risk assmt | $3 | $3 | $3 | $3 | $3 | $3 | $3 | $2 | $2 | $3 | $0 |
| 96110 | Developmental screen w/score | $12 | $12 | $10 | $10 | $11 | $11 | $10 | $7 | $7 | $7 | $11 |
| 96127 | Brief emotional/behav assmt | $5 | $5 | $5 | $5 | $4 | $4 | $5 | $3 | $3 | $4 | $4 |
| | **Weighted Average % of Medicare Fees** | | | **70%** | **72%** | **93%** | **93%** | **85%** | **67%** | **67%** | **66%** | **85%** |
| | **Ranking** | | | **6** | **5** | **2** | **1** | **3** | **8** | **7** | **9** | **4** |
| | **Chemotherapy Administration** | | | | | | | | | | | |
| 96360 | Hydration iv infusion init | $32 | $32 | $32 | $32 | $29 | $29 | $26 | $20 | $20 | $32 | $28 |
| 96401 | Chemo anti-neopl sq/im | $71 | $71 | $60 | $60 | $65 | $65 | $58 | $44 | $44 | $50 | $62 |
| 96417 | Chemo iv infus each addl seq | $63 | $63 | $62 | $62 | $57 | $57 | $52 | $39 | $39 | $62 | $55 |
| 96366 | Ther/proph/diag iv inf addon | $21 | $21 | $18 | $18 | $19 | $19 | $17 | $13 | $13 | $12 | $18 |
| 96415 | Chemo iv infusion addl hr | $27 | $27 | $27 | $27 | $25 | $25 | $22 | $17 | $17 | $28 | $24 |
| 96361 | Hydrate iv infusion add-on | $12 | $12 | $12 | $12 | $11 | $11 | $10 | $8 | $8 | $9 | $11 |
| 96367 | Tx/proph/dg addl seq iv inf | $28 | $28 | $28 | $28 | $26 | $26 | $23 | $18 | $18 | $19 | $25 |
| 96374 | Ther/proph/diag inj iv push | $36 | $36 | $36 | $36 | $33 | $33 | $30 | $23 | $23 | $31 | $32 |
| 96375 | Tx/pro/dx inj new drug addon | $15 | $15 | $15 | $15 | $14 | $14 | $13 | $10 | $10 | $13 | $13 |
| 96413 | Chemo iv infusion 1 hr | $129 | $129 | $126 | $126 | $116 | $116 | $105 | $80 | $80 | $125 | $113 |
| 96365 | Ther/proph/diag iv inf init | $62 | $62 | $57 | $57 | $56 | $56 | $51 | $39 | $39 | $39 | $54 |
| 96372 | Ther/proph/diag inj sc/im | $15 | $15 | $15 | $15 | $14 | $14 | $12 | $10 | $10 | $13 | $13 |
| | **Weighted Average % of Medicare Fees** | | | **97%** | **97%** | **91%** | **91%** | **82%** | **63%** | **63%** | **85%** | **87%** |
| | **Ranking** | | | **1** | **1** | **3** | **2** | **7** | **8** | **8** | **6** | **5** |
| | **Special Dermatological Procedures** | | | | | | | | | | | |
| 96913 | Photochemotherapy uv-a or b | $158 | $158 | $104 | $104 | $142 | $142 | $129 | $96 | $96 | $0 | $139 |
| 96921 | Laser tx skin 250-500 sq cm | $156 | $59 | $136 | $59 | $143 | $55 | $129 | $99 | $40 | $59 | $136 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 96920 | Laser tx skin < 250 sq cm | $146 | $52 | $124 | $52 | $133 | $48 | $120 | $93 | $35 | $59 | $128 |
| 96900 | Ultraviolet light therapy | $26 | $26 | $17 | $17 | $24 | $24 | $21 | $16 | $16 | $0 | $23 |
| 96910 | Photochemotherapy with uv-b | $123 | $123 | $57 | $57 | $110 | $110 | $100 | $75 | $75 | $20 | $108 |
| | **Weighted Average % of Medicare Fees** | | | **54%** | **51%** | **90%** | **90%** | **82%** | **61%** | **61%** | **20%** | **88%** |
| | **Ranking** | | | **7** | **8** | **2** | **1** | **4** | **6** | **5** | **9** | **3** |
| | **Phys Medicine/Rehab/Therapy** | | | | | | | | | | | |
| 97161 | Pt eval low complex 20 min | $103 | $103 | $69 | $69 | $96 | $96 | $108 | $70 | $70 | $64 | $88 |
| 97150 | Group therapeutic procedures | $18 | $18 | $18 | $18 | $17 | $17 | $16 | $13 | $13 | $7 | $16 |
| 97014 | Electric stimulation therapy | $13 | $13 | $13 | $13 | $12 | $12 | $11 | $9 | $9 | $17 | $11 |
| 97010 | Hot or cold packs therapy | $7 | $7 | $5 | $5 | $6 | $6 | $6 | $4 | $4 | $17 | $6 |
| 97162 | Pt eval mod complex 30 min | $103 | $103 | $69 | $69 | $96 | $96 | $108 | $70 | $70 | $25 | $88 |
| 97140 | Manual therapy 1/> regions | $29 | $29 | $23 | $23 | $27 | $27 | $30 | $19 | $19 | $21 | $24 |
| 97112 | Neuromuscular reeducation | $34 | $34 | $27 | $27 | $29 | $29 | $35 | $23 | $23 | $17 | $29 |
| 97016 | Vasopneumatic device therapy | $12 | $12 | $12 | $12 | $11 | $11 | $10 | $8 | $8 | $13 | $10 |
| 97530 | Therapeutic activities | $37 | $37 | $31 | $31 | $34 | $34 | $30 | $24 | $24 | $13 | $31 |
| 97110 | Therapeutic exercises | $30 | $30 | $29 | $29 | $28 | $28 | $32 | $20 | $20 | $8 | $26 |
| | **Weighted Average % of Medicare Fees** | | | **85%** | **85%** | **92%** | **92%** | **97%** | **67%** | **67%** | **46%** | **86%** |
| | **Ranking** | | | **5** | **5** | **2** | **2** | **1** | **7** | **7** | **9** | **4** |
| | **Osteo/Chiropractic & Other Medicine** | | | | | | | | | | | |
| 98943 | Chiropract manj xtrspinl 1/> | $26 | $23 | $21 | $18 | $24 | $21 | $22 | $18 | $16 | $0 | $0 |
| 98960 | Self-mgmt educ & train 1 pt | $33 | $33 | $0 | $0 | $30 | $30 | $0 | $20 | $20 | $0 | $0 |
| 99188 | App topical fluoride varnish | $12 | $10 | $0 | $0 | $20 | $20 | $21 | $20 | $20 | $18 | $10 |
| 99153 | Mod sed same phys/qhp ea | $13 | $13 | $10 | $10 | $11 | $11 | $10 | $8 | $8 | $8 | $11 |
| 98966 | Hc pro phone call 5-10 min | $14 | $12 | $0 | $0 | $13 | $11 | $11 | $9 | $8 | $0 | $11 |

| Procedure Code | Procedure Description | MC NF | MC FA | MD NF | MD FA | DE NF | DE FA | VA NF | WV NF | WV FA | PA | DC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 98941 | Chiropract manj 3-4 regions | $40 | $34 | $32 | $27 | $38 | $32 | $34 | $28 | $24 | $13 | $0 |
| 99173 | Visual acuity screen | $4 | $4 | $3 | $3 | $3 | $3 | $2 | $2 | $2 | $6 | $3 |
| 99177 | Ocular instrumnt screen bil | $5 | $5 | $5 | $5 | $5 | $5 | $4 | $3 | $3 | $15 | $5 |
| 99174 | Ocular instrumnt screen bil | $7 | $7 | $6 | $6 | $6 | $6 | $5 | $4 | $4 | $8 | $6 |
| 98967 | Hc pro phone call 11-20 min | $25 | $23 | $0 | $0 | $24 | $22 | $21 | $18 | $16 | $0 | $21 |
| 98968 | Hc pro phone call 21-30 min | $34 | $32 | $0 | $0 | $32 | $30 | $29 | $25 | $23 | $0 | $29 |
| 99152 | Mod sed same phys/qhp 5/>yrs | $52 | $12 | $45 | $11 | $47 | $11 | $43 | $33 | $9 | $10 | $45 |
| | **Weighted Average % of Medicare Fees** | | | **81%** | **79%** | **91%** | **92%** | **79%** | **66%** | **67%** | **120%** | **78%** |
| | **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.*