OFFICE OF THE HEALTH INSURANCE COMMISSIONER
PROFESSIONAL PROVIDER_ HEALTH PLAN WORKGROUP
COST AND QUALITY INFORMATION REPORT
March 15, 2007

Statutory expectations §42-14.5-3

"To establish and provide guidance and assistance to a subcommittee ("The Professional Provider-Health Plan Work Group") of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed Health Plans. This subcommittee shall develop a plan to implement the following activities:

(i) By January 1, 2006, a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) By April 1, 2006, a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) By September 1, 2006, a uniform health plan claim form to be utilized by participating providers;

(iv) By March 15, 2007 a report to the legislature on proposed methods for health maintenance organizations, non-profit hospital or medical service corporations to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinician or physician practices in establishing the most appropriate cost comparisons.

(v) By December 1, 2006, contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(vi) By February 1, 2007, a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.

Overview

The Professional Provider Health Plan Workgroup composition for this task included: Jean Amaral- Care New England, David Balcolm- Kent PHO, Chris Dooley- W&I PHO, Joel Kaufman M.D- Lifespan/Physicians PSO, Shirley Carter-RIPCPC, Paul Carey- RI Urological, Lorraine Roberts- Lighthouse Medical Billing, Craig Syata- HARI, Pat Moran-HARI, Steve DeToy-RIMS, Sue Oberbech-DOH, Jay Buechner –DOH, Steve Lonardo-BCBSRI, Stephan Katinas-BCBSRI, Jason Martiesian-UHC, BJ Perry- UHC

The Workgroup began meeting in October 2006 to discuss the intent of the statute language that was added to the workgroup responsibility in the 2006 legislative session. In addition to the added transparency language, the same legislation expanded the responsibility of the Department of Health to add "licensed health care providers" to the list of health care entities for whom it is currently required to report quality performance measures. The group discussed both of these statutory revisions and how they interrelate. *The overriding policy objective is to have health plans make provider cost and quality information available and accessible to consumers via their web sites.*

Discussion

Increasing transparency of quality and cost information for medical services is a frequent focus of health policy reform nationally. Regarding Rhode Island effort, Steve DeToy from the Medical Society stated that he believed that the legislation intended that cost and quality information be reported together. The group generally agreed that cost information alone does not provide complete information regarding a provider. In order to make the most informed choice, cost information is best provided side by side with quality information.

At the first meeting the group agreed to the following principles:

- "Cost" for purposes of this project is defined as what the insurance company pays the provider, not the providers' billed charges
- Cost information and quality information should be reported together to be most useful to the consumer
- The group should not attempt to define/re-define quality as many national entities have established guidelines and standards
- Quality data is most valid if it is aggregated across all payers, as payers individual experiences may vary

Jay Buechner from the Department of Health (DOH) explained the current process for evaluating hospital quality and how the DOH plans to begin the process for professional providers as required by statute. They will begin by focusing on chronic diseases and surgical procedures. It was also discussed that although aggregated claims information can be a useful tool in quality reporting, there is an expense to creating and maintaining such a database.

With these principles in place and an understanding of DOH's quality reporting plans, the group turned to how to meet the statutory requirements. Although the group agreed that provider cost and quality information were best reported together, it did not want to delay requiring the disclosure of cost information until the DOH had published ambulatory quality information. Therefore the group determined that cost information could, in the short term, be reported in ranges of cost or averages by service, not by specific provider. Cost information displayed in this way may be posted in advance of public quality information being available. Once DOH quality information is available, the plans would be required to report cost and quality information at the provider level.

The group agreed to break into cost and quality subcommittees for more focused discussion. The Cost Subcommittee was charged with reviewing the health plans' utilization reports to define the specific services for which cost information will be reported. The Quality Subcommittee was tasked with formalizing a recommendation to DOH regarding what national standards and/or established indices should be used in its reporting of ambulatory provider quality.

Recommendations for Cost Reporting

- The group was sensitive to the fact that UnitedHealthcare already provides some detail on cost on its web site to its members and that BCBSRI does not provide cost information currently. The group wanted to be able incorporate best practices while establishing reasonable expectations for both plans.

- The subcommittee recommends that the health plans' post the allowable (contracted) cost information for a definitive list of high volume "discretionary" or "elective" high dollar services (e.g. MRIs, colonoscopies etc). This detail would include both the provider and any applicable facility or technical costs. The list of services for which cost information will be available is appended to this report. Services will be listed in common layperson terminology.

- Those services identified above will be limited to those that have an allowable amount between $100 and $2500. Services that are below $100 may be too inexpensive to be significant to a consumer's decision making and services over $2500 will most likely exceed the deductible.

- For a given service, a member could look up the allowable average or cost range for that service within their service area. Then the providers performing that service could be listed with an indicator as to that providers' cost relative to the posted range.

  <u>For Example:</u>

  Colonoscopy

Cost range $600- $1200

Providers performing this service in this service area:

ABC Medical Group $
111 Main Street
Providence

Roger Williams Hospital $$
Smith Street
Providence

Westminster Scope Center $$$
222 Westminster Street
Providence

- Providers represented expressed concern that all the cost information be qualified, especially information that the costs are averages and may vary based on particular patients' medical needs and that the place of services are not all the same in terms of the scope of care readily available at each location. The group agreed that the following language would be posted along with cost data on the plans' web sites:

  "Deciding where to seek treatment is complicated and requires discussion with your physician. Information on cost is provided to help you better understand how much you may be expected to pay if you have a high deductible. Many factors contribute to price variance among providers, including; what kind of care they provide, if they are a teaching facility, what patients they see, how much free care they provide to the uninsured, how many hours they are open and what kind of equipment they have.

  Many providers have websites that can provide you with additional detail about their services. "

Recommendations for Quality Reporting

The workgroup believes that best information for reporting professional provider quality is aggregated information across all payers in the state and is supportive of the establishment of a statewide database and reporting mechanism that incorporates all paid claim and other collected practice information. The group envisions that this responsibility will fall to the Department of Health under its new responsibility to report on professional provider quality.

Since there are a number of organizations that require or will require providers to report information, it was agreed that anything that DOH does should "piggy-back" on those requirements rather than requiring any additional provider reporting. The quality

subcommittee discussed the merits of existing standards for measuring professional provider quality, specifically the AMA and NCQA programs.

The group also expressed support for incorporating data from Electronic Medical Records (EHR) into any future quality reporting, as it may present a more specific description of the services rendered then health plan claims information. In addition it is more comprehensive since it would include data for all members of the community, not just those with insurance.

The workgroups' recommendation to the Department of Health is appended to this report.

Expectations and Timeframes

Locally, Blue Cross and Blue Shield of Rhode Island and UnitedHealthcare of New England are marketing plans with high deductibles.

United currently has available a "cost estimator" that provides the estimated cost information for a number of services, both in- network and out of network benefit levels. It is also in the process of rolling out its premium designation program which will provide quality and efficiency information for providers in certain key medical specialties. Providers that meet United's quality and/or efficiency criteria will be so noted on the online directory.

BCBSRI currently does not have any cost information available on its web site for consumers. BCBSRI will provide cost range information for the identified procedures by October 1, 2007.

Both Blue Cross and United will provide at a minimum for the list of services identified, a symbolic representation (e.g. $, $$, $$$) of provider cost relative to the posted cost ranges by July 2008.

Blue Cross and United are encouraged to evaluate their provider networks and make available to consumers provider specific quality information that meets NCQA and other nationally recognized standards.

Blue Cross and United will incorporate the RI Department of Health provider -specific quality data along with their reported cost data within 6 months of such data becoming available.

This is a first step toward reaching the goal of total transparency of provider cost and quality information. This office will reconvene the workgroup in early 2008 to assess health plans progress, review the adequacy of the list of codes reported and define next steps.

The Professional Provider-Health Plan Work Group
Subcommittee to the Health Insurance Advisory Council
Quality Transparency Recommendation
March 15, 2007

The Healthcare Reform Act of 2004 § 42-14.5-3 (d) required the creation of a subcommittee to the Health Care Advisory Council known as the Professional Provider-Health Plan Workgroup ("Workgroup") to address specifically identified areas for administrative improvement. [1]

In June 2006, the Rhode Island Health Care Affordability Act of 2006 – Part II – Transparency of Information on Health Care Quality and Cost was passed. This statute a) expanded the authority of the Director of Health to add "licensed health care providers" to the list of health care entities for which the Department of Health is currently authorized to report quality performance measures and b) added the following task for the Professional Provider Health Plan workgroup:

(iv) By March 15, 2007 a report to the legislature on proposed methods for health maintenance organizations, non-profit hospital or medical service corporations to make facility specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinician or physician practices in establishing the most appropriate cost comparisons.

Workgroup Discussion on quality reporting

The Workgroup began its review of the transparency language in October 2006. At the first meeting the group agreed to the following:

- Cost information and quality information should be reported together to be most useful to the consumer
- The group should not attempt to define/re-define quality
- Quality data is most valid if it is aggregated across all patients, regardless of pay source
- Aggregated quality information for physicians may be several years away

[1] The Workgroup is comprised of professional provider and hospital representatives, billing agents, physician group leaders and the major Rhode Island Health Plans. The members of the transparency workgroup are: Jean Amaral- Care New England, David Balcolm- Kent PHO, Chris Dooley- W&I PHO, Joel Kaufman M.D- Lifespan/Physicians PSO, Shirley Carter-RIPCPC, Paul Carey- RI Urological Associates, Lorraine Roberts- Lighthouse Medical Billing, Craig Syata- HARI, Pat Moran-HARI, Steve DeToy-RIMS, Sue Oberbeck-Department of Health, Jay Buechner –Department of Health, Steve Lonardo-BCBSRI, Stephan Katinas-BCBSRI, Jason Martiesian-UnitedHealthcare, Beverly Jane Perry-UnitedHealthcare.

The group is a proponent of aggregated information across all patients in the state and is supportive of the establishment of a statewide database and reporting mechanism that incorporates all health care encounters, utilizing data sources such as paid claims and/or other collected practice information, including data that may be extracted using electronic medical records as these data become more widely available. The group envisions that this responsibility will fall to the Department of Health under its new authority to report on professional provider quality. In order to exercise this authority in support of the purposes of the Act, the Department of Health should be provided with an appropriation for the collection and analysis of data that is of sufficient quality to allow the public reporting of accurate and timely information on the performance of health care providers. Since there are a number of organizations that now require or will require providers to report information, it was agreed that DOH should "piggy-back" on those requirements rather than requiring any additional provider reporting, to the extent possible. The quality subcommittee discussed the merits of existing standards for measuring professional provider quality, specifically the AMA and NCQA programs.

Recommendation to the Department of Health

Recently the American Medical Association (AMA) has established a Physician Consortium for Quality Improvement that is leading the charge to establish and test evidence-based clinical performance measures. This consortium has broad representation across all medical specialties and has the support and endorsement of the Centers for Medicare & Medicaid Services (CMS). Specifications for the measures are endorsed by the National Quality Foundation (NQF), an independent not for profit organization that is developing a strategy for nationwide quality measurement and reporting. The Consortium currently provides the performance specifications for obtaining the required data elements for 151 measures for 21 disease categories. The purpose of these measurements is to encourage physicians to improve patient care by comparing their practice with established clinical standards. CMS has indicated that these measurements when reported may be used for financial incentives for providers in the future. It is projected that these measures will be reported using CPT coding for simplified tracking. The subcommittee recommends that the Department of Health evaluate these clinical performance measures for their possible applicability to the public reporting of the quality of care of individual health care providers.

The National Committee on Quality Assurance (NCQA) is a non-profit organization that accredits a wide range of health care organizations. They recently began a voluntary program that evaluates how health plans measure the quality of their hospital and physician networks. This program is designed to evaluate that the plans' incorporate standardization, transparency and provider collaboration in their provider quality programs. The subcommittee recommends that DOH evaluate the NCQA requirements to determine if they may be incorporated into the state's quality reporting for providers and health plans.

Due to the lack of publicly available quality information on ambulatory providers, the sooner this information is made available the better for consumers of health care in Rhode Island.

		CPT CODE LISTING
CODE	**SHORT NAME**	**DESCRIPTION**
11401	removal small skin lesion	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM
11402	removal large skin lesion	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 1.1 TO 2.0 CM
29881	Knee Arthroscopy	ARTHROSCOPY, KNEE, SURGICAL WITH MENISCECTOMY (MEDIAL OR LATERAL INCLUDING ANY MENISCAL SHAVING) (ASA=01382)
31575	Laryngoscopy	LARYNGOSCOPY, FLEXIBLE FIBERSCOPIC DIAGNOSTIC (ASA=00320)
43235	Upper GI endoscopy- diagnostic	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE) (ASA=00740)
43239	Upper GI endoscopy with Biospy	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH BIOPSY, SINGLE OR MULTIPLE (ASA=00740)
45378	Colonoscopy- diagnostic	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WITH OR WITHOUT (ASA=00902)
45380	Colonoscopy- with Biopsy	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH BIOPSY, SINGLE OR MULTIPLE (ASA=00902)
45384	colonoscopy with tumor removal	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY (ASA=00902)
45385	Colonoscopy- tumor removal	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE (ASA=00902)
47562	gall Bladder removal	LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY
57454	cervical biospsy	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX AND ENDOCERVICAL CURETTAGE
58100	cervical biospsy	ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT ENDOCERVICAL SAMPLING (BIOPSY), WITHOUT CERVICAL DILATION, ANY METHOD (SEPARATE PROCEDURE) (ASA=00940)
64721	Carpal tunnel	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL TUNNEL (ASA=01810)
66984	Cataract removal	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG. IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION) (ASA=00142)
69436	Tympanostomy	TYMPANOSTOMY (REQUIRING INSERTIN OF VENTILATING TUBE), GENERAL ANESTHESIA UNILATERAL. (ASA=00126)
70486	CT jaw without contrast	COMPUTED TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL
70544	Head Angiography without contrast	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S)
70551	MRI brain	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM)
70553	MRI brain without contrast	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES
71250	CT thorax without contrast	COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL
71260	CT thorax with contrast	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX WITH CONTRAST MATERIAL(S)
72148	MRI spine without contrast	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL

72192	CT pelvis without contrast	COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL
72193	CT pelvis with contrast	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS WITH CONTRAST MATERIAL(S)
73221	MRI joint upper extremity without contrast	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL(S)
73721	MRI joint lower extremity without contrast	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWEREXTREMITY, WITHOUT CONTRAST MATERIAL.
74150	CT abdomen without contrast	COMPUTED TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL
74160	CT abdomen with contrast	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN WITH CONTRAST MATERIAL(S)
74170	CT abdomen w/wo contrast	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS
76075	Bone density study	DUAL ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, ONE OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
76700	Echography abdomen	ECHOGRAPHY, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION COMPLETE
76801	Ultrasound first trimester	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (<14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION
76805	Ultrasound after first trimester	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (> OR = 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION
76811	Ultrsound w/fetal exam	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION PLUS DETAILED FETAL ANATOMIC EXAMINATION, TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION
92004	Comprehensive Eye exam- Established Patient	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION WITH INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM COMPREHENSIVE, NEW PATIENT, ONE OR MORE VISITS
92014	Comprehensive Eye exam- New Patient	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION OR CONTINUATION OF DIAGNOSTIC AND TREATMENT PROGRAM COMPREHENSIVE, ESTABLISHED PATIENT, ONE OR MORE VISITS
93015	Cardiovascular Stress test	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINOUS ELECTROCARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; WITH PHYSICIAN SUPERVISION, WITH INTERPRETATION AND REPORT
93307	Echocardiography	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; COMPLETE
99202		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS; AN EXPANDED PROBLEM FOCUSED HISTORY, AN EXPANDED PROBLEM FOCUSED EXAM, AND STRAIGHTFORWARD MEDICAL DECISION MAKING
99203		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS; A DETAILED HISTORY;A DETAILED EXAM, AND MEDICAL DECISION MAKING OF LOW COMPLEXITY
99204		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENTOF A NEW PATIENT, WHICH REQUIRES THESE 3 COMPONENTS: A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAM, AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY
99205		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY
99211		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENTOF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY THE PRESENTING PROBLEM(S) ARE MINIMAL. APX 5 MINUTES ARE SPENT PREFORMING/SUPERVISING DUTIES
99212		OFFICE OR O/P VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 COMPONENTS: A PROBLEM FOCUSED HISTORY, PROBLEM FOCUSED EXAM, OR STRAIGHTFORWARD MEDICAL

		DECISION MAKING
99213		OFFICE OR OTHER O/P VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 FACTORS: AN EXPANDED PROBLEM FOCUSED HISTORY, EXPANDED PROBLEM FOCUSED EXAM, OR DECISIONS OF LOW COMPLEXITY
99243		OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS; A DETAILED HISTORY, A DETAILED EXAM, AND MEDICAL DECISION MAKING OF LOW COMPLEXITY
99244		OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAM, AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY
99245		OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3 FACTORS; A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAM, AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY
99385		INITIAL EVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAM, THE IDENTIFICATION OF RISK FACTORS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 18-39 YRS
99386		INITIAL EVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM, THE IDENTIFICATION OF RISK FACTORS, THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 40-64 YRS
99391		PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF SN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS AND THE ORDERING OF
99392		PERIODIC REEVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM,THE IDENTIFICATION OF RISK FACTORS AND THE ORDERING OF APPROPRIATE LAB/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT: 1-4 YRS
99393		PERIODIC REEVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM, THE IDENTIFICATION OF RISK FACTORS AND THE ORDERING OF APPROPRIATE LAB/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT: 5-11 YRS
99394		PERIODIC REEVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM, THE IDENTIFICATION OF RISK FACTORS AND THE ORDERING OF APPROPRIATE LAB/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT: 12-17 YRS
99395		PERIODIC REEVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM, IDENTIFICATION OF RISK FACTORS AND THE ORDERING OF APPROPRIATE LAB/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; 18-39 YRS
99396		PERIODIC REEVALUATION AND MANAGEMENT OF A HEALTHY INDIVIDUAL REQUIRING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAM, THE IDENTIFICATION OF RISK FACTORS AND THE ORDERING OF APPROPRIATE LAB/DIAG PROCEDURES ESTABLISHED PATIENT; 40 - 64