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TO: Representative Mark Larson, Chair of House Health Care
Senator Douglas A. Racine, Chair of Senate Health & Welfare

FROM: Michael S. Bertrand, Commissioner 
Department of Banking, Insurance, Securities and
Health Care Administration

DATE: December 17, 2010

SUBJECT: Act 42 Section 31 of 2009: Health care insurance reimbursement survey of
reimbursement for primary care services

Act 71 of the 2007 legislative session, "Ensuring Success in Health Care Reform", included a requirement that the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct an annual survey of health insurers doing business in Vermont to provide information comparing average reimbursement rates paid by insurers to primary care providers for the most common services. Act 42 included an amendment requiring that primary care services be subdivided into two categories for the purpose of ranking that include evaluation and management services and all other services with the exception of routine venipuncture.

The "2010 Provider Reimbursement Report: Primary Care Services" presents comparative information on the average reimbursement paid by major insurers to primary care providers for the ten the most common billing codes for services within the current procedure terminology category of Evaluation and Management services and the ten most common billing codes outside the category of Evaluation and Management, excluding routine venipuncture. As in prior reports dating back to 2007, there was minimal variation in average reimbursement for primary care services among the major insurers.

The major health insurers including Blue Cross Blue Shield of Vermont, The Vermont Health Plan, CIGNA, and MVP Health Plan provided the information included in this report. These insurers account for over 95 percent of the market in comprehensive major medical insurance as measured by their share of the total earned premium dollars.

If you have any questions about this report, please contact Dian Kahn at 828-2906 or Dian.Kahn@state.vt.us.

cc: Legislative Council
Office of Joint Fiscal



BISHCA



LEGISLATIVE REPORT

DIVISION OF HEALTH CARE ADMINISTRATION

2010 Provider Reimbursement Report: Primary Care Services

Submitted to the
Vermont General Assembly

December 31, 2010

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Acknowledgements

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect, prepare and submit the data required for this report.

Executive Summary

Act 71 of the Vermont Legislature's 2007 Session, "Ensuring Success in Health Care Reform,"¹ included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct an annual survey of private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont".

During the 2009 Legislative Session, Sec. 31. 18 V.S.A. § 9409a was amended so that the survey would include, "the ten most common billing codes for primary care health services within the current procedural terminology category of Evaluation and Management Services and the ten most common billing codes outside the category of Evaluation and Management, excluding routine venipuncture." This survey of 2010 reimbursement rates for the highest volume primary care services is the fourth annual report.

Vermont has a concentrated health insurance market. Three insurers – Vermont Blue Cross Blue Shield (BCBS) (including its wholly owned subsidiary, The Vermont Health Plan (TVHP)), CIGNA, and MVP – account for over 95 percent of the market as measured by earned premium.

There was little variation in average reimbursement among the major insurers for primary care services for the ten most common procedure codes within the category of Evaluation and Management and the ten most common procedure codes outside the category of Evaluation and Management.

¹ See Appendix 1 for statutory language

Summary Table 1 below shows the average reimbursement across insurers, the ratio of highest to lowest reimbursement, and the rank of each insurer on average reimbursement for each of the top ten procedure codes within the category of Evaluation and Management for 2010.

**Summary Table 1 – Average Reimbursement
Evaluation and Management**

Procedure Code Ranked by Service Count Volume	Average	Hi / Low Ratio	Rank in Reimbursement		
			BCBS	CIGNA	MVP
99213 Office visit, established patient, 15 minutes	\$75.01	1.160	3	2	1
99214 Office visit, established patient, 25 minutes	\$114.19	1.163	2	3	1
99396 Preventive care, 40-64 years of age	\$146.83	1.098	1	2	3
99212 Office visit, established patient, 10 minutes	\$50.93	1.020	2	1	3
99203 Office visit, new patient, 30 minutes	\$131.73	1.039	1	3	2
99395 Preventive care, 18-39 years of age	\$132.89	1.087	1	2	3
99211 Office visit, established patient, 5 minutes	\$27.69	1.086	1	2	3
99215 Office visit, established patient, 40 minutes	\$160.81	1.113	2	3	1
99391 Well child care under 1 year of age	\$106.19	1.075	1	3	2
99392 Well child care between 1 and 4 years of age	\$118.89	1.071	1	3	2

Summary Table 2 below shows the average reimbursement across insurers, the ratio of highest to lowest reimbursement, and the rank of each insurer on average reimbursement for each of the top ten procedure codes outside the category of Evaluation and Management for 2010.

**Summary Table 2 – Average Reimbursement
Non-Evaluation and Management**

Procedure Code Ranked by Service Count Volume	Average	Hi / Low Ratio ²	Rank in Reimbursement		
			BCBS	CIGNA	MVP
90471 Immunization administration	\$24.17	1.281	1	3	2
87880 Strep test, group A	\$25.19	1.550	1	2	3
95165 Supervision of allergen preparation	\$11.05	-	1	2	3
90472 Administration of multiple immunizations	\$14.16	1.748	2	3	1
81002 Chemical urine testing only	\$4.39	1.764	1	2	3
93000 Electrocardiogram (EKG)	\$42.87	1.247	1	2	3
88305 Level IV surgical pathology examination	\$120.74	-	2	1	2
80061 Cholesterol and lipid testing	\$26.92	1.345	1	2	3
90470 Hepatitis B Vaccine	\$25.53	-	1	3	2
96372 Therapeutic, prophylactic, or diagnostic injection	\$25.95	1.172	1	2	3

² Hi/Low Ratios are shown as missing for procedure codes within the aggregate top ten for the category of Non-Evaluation and Management services that are not present across all three insurers.

Introduction

Act 71 of the Vermont Legislature's 2007 Session, "Ensuring Success in Health Care Reform,"³ included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct an annual survey of private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont".

During the 2009 Legislative Session, Sec. 31. 18 V.S.A. § 9409a was amended under Act 42 so that the survey would include, "the ten most common billing codes for primary care health services within the current procedural terminology category of Evaluation and Management Services and the ten most common billing codes outside the category of Evaluation and Management, excluding routine venipuncture." This survey of 2010 reimbursement rates for the highest volume primary care services is the fourth annual report

In preparing for the 2010 reporting year, BISHCA and representatives from the major insurance companies agreed to carry over the approach and methods from the prior three reimbursement reports. The prior report was published in December 2009 using 2009 data. Parties followed reporting specifications in the statute mandating the report including:

- A requirement that information be sufficiently aggregated so that the amount paid to a specific provider or facility could not be determined
- An exemption of any provider or facility-specific information from disclosure under a public records request
- A requirement that data be at least 90 days old at time of release of the report

Methodology

In implementing the requirements of the relevant sections of Act 42, several principles were carried forward from prior surveys and are listed below.

Which insurers to include in the survey? - The Vermont commercial health insurance market is concentrated. Measured in terms of earned premiums in 2009 for comprehensive major medical products, the top three companies represent over 95% of the market⁴. Because of this concentration, the survey focused on Vermont Blue Cross Blue Shield (55.4%)/ TVHP (14.0), CIGNA (12.1%), and MVP (17.3%). Note that these market share figures do not include any third-party administrator (TPA) business. However, as will be explained later in this report, BCBSVT, CIGNA and MVP included TPA business in the reporting of average reimbursement rates.

Define primary care - The following physician specialties were used to define primary care for the purpose of this report addressing reimbursement for primary care services: Family Practice, General Practice, Internal Medicine, Obstetrics & Gynecology (OBGYN), Pediatrics, and Naturopathic Physicians. For the purpose of this survey, OBGYN providers were included only if they had been identified as a primary care provider by a beneficiary (extremely rare).

³ See Appendix 1 for statutory language

⁴ <http://www.bishca.state.vt.us/health-care/health-insurers/market-share-reports-earned-premiums-year>

Identify the top 10 procedure codes - Claims submitted by health care professionals most frequently identify the services provided using a coding system called Current Procedural Terminology (CPT)⁵. A description of CPT codes used in this report can be found in Table 1 and Table 3. To identify the top 10 codes, BISHCA conducted a preliminary survey to identify the top 20 procedure codes within the category of Evaluation and Management Services and the top 30 procedure codes outside of the category of Evaluation and Management, excluding routine venipuncture, by each insurer based on claims volume. Data submitted included the total allowed charges and average reimbursement (payment) for each code. Determination of the top 10 codes for each of the two categories was based on combining this information across the three insurers.

Scope of the data collected - The information provided by the insurers was based on the claims incurred by Vermont residents. Although the vast majority of these claims were paid to Vermont providers, claims paid to Non-Vermont providers were also included in counts and averages.

Self-insured / Administrative Services Only business - One concern in developing this survey was that in some cases, insurers may provide administrative services between insurers and providers (pay claims), but not have a contractual relationship with providers. Information included in this survey is limited to transactions based on a contract between the insurer and the provider. BCBS, CIGNA and MVP included self-insured business when reimbursement was based on the same contracts as insured business.

Data Collection Process

To ensure comparability among insurers and to comply with the requirement that data be at least 90 days old at time of publication, averages were to be based on claims incurred (date of service) between January 1, 2010 and June 30, 2010 and paid through September 30, 2010.

The figure used in calculation of reimbursement was “allowed charges.” This is the amount set in a provider contract, prior to any reductions for cost sharing (deductibles, coinsurance, or copayments). Any pay-for-performance or other quality-based reimbursement arrangements were excluded. This was done to ensure comparability, because some carriers include this type of payment reimbursement for individual services, while others make a periodic aggregate payment.

Services that were covered under a direct capitation agreement were excluded, but services that were reimbursed under any form of aggregate agreement such as a per-member-per-month target and settlement contract were included.

BISHCA relied on the accuracy of the information provided by the insurers. No external validation of the data was attempted.

This report makes use of weighted averages in both the data collection process and analyses. Weighted average is a way of computing averages that recognizes the different counts of services at different reimbursement levels. For example, if an insurer paid 10 claims at \$20 and 5 claims at \$30, the weighted average would recognize that twice as many claims were paid at

⁵ CPT codes, descriptions, and other data are copyright 1966, 1970, 1973, 1977, 1981, 1983-2010 by the American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

\$20 than at \$30. The calculation is $((10 \times \$20) + (5 \times \$30)) / (10 + 5)$, or \$23.33, rather than $(\$20 + \$30) / 2$.

Findings – Evaluation and Management Services/ Primary Care

Using the service count information provided by the insurers, the aggregate top 10 primary care codes within the category of Evaluation and Management Services were identified. Table 1 shows the Evaluation and Management codes and their descriptions. Figure 1 shows the proportion of the top 10 that each code represents.

Table 1 - Evaluation and Management Services

Code	Description
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history, A detailed examination; Medical decision making of low complexity. Counseling and /or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires two of these three components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and or family's needs. Usually the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face to face with the patient and/or family.
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, established patient; early childhood (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, established patient; early childhood (age 1 through 4)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, established patient; 18-39 years old.
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, established patient; 40-64 years old.

Figure 1 shows the distribution of specific codes among the top 10. The most common code, 99213, accounts for nearly 46 percent of services among the top 10 E&M codes across the major insurers.

Figure 1

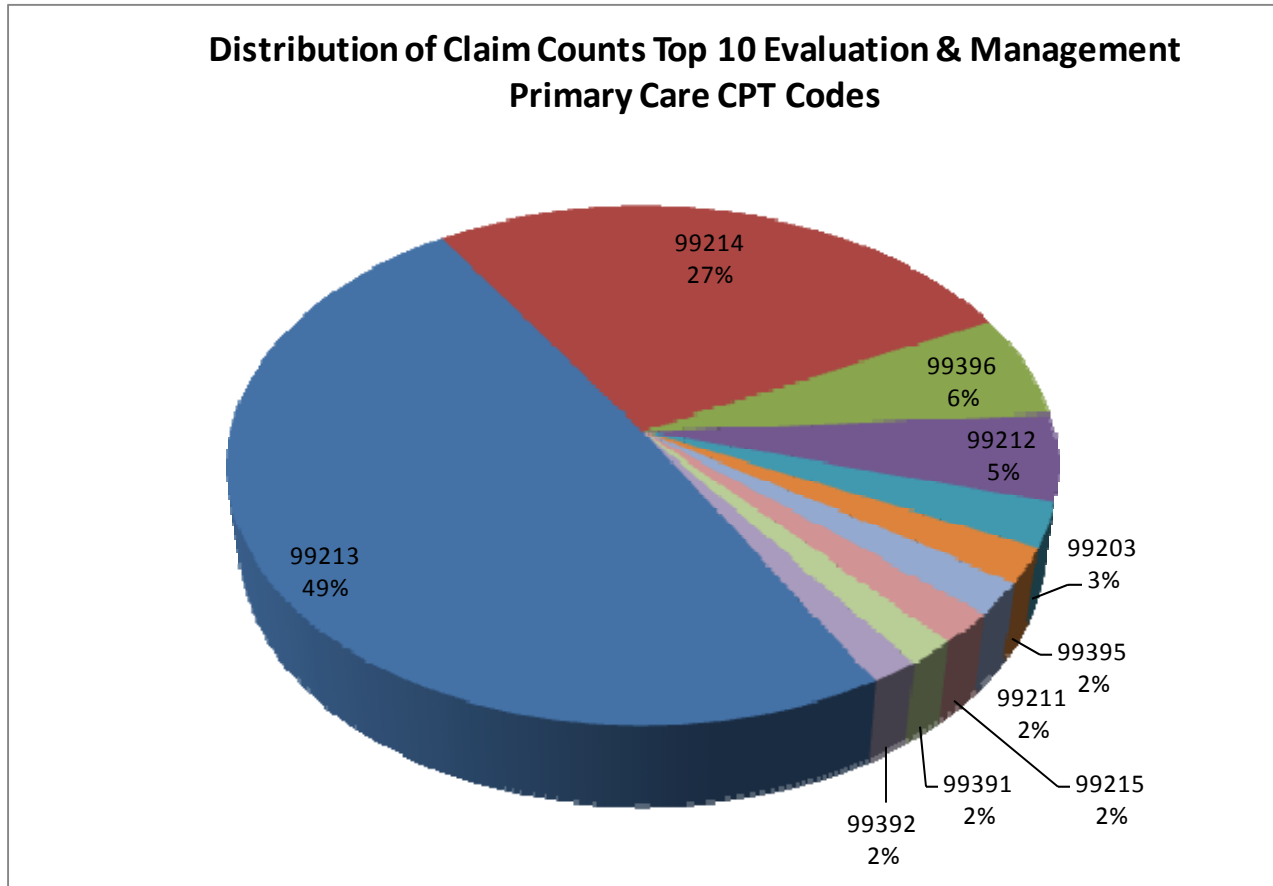


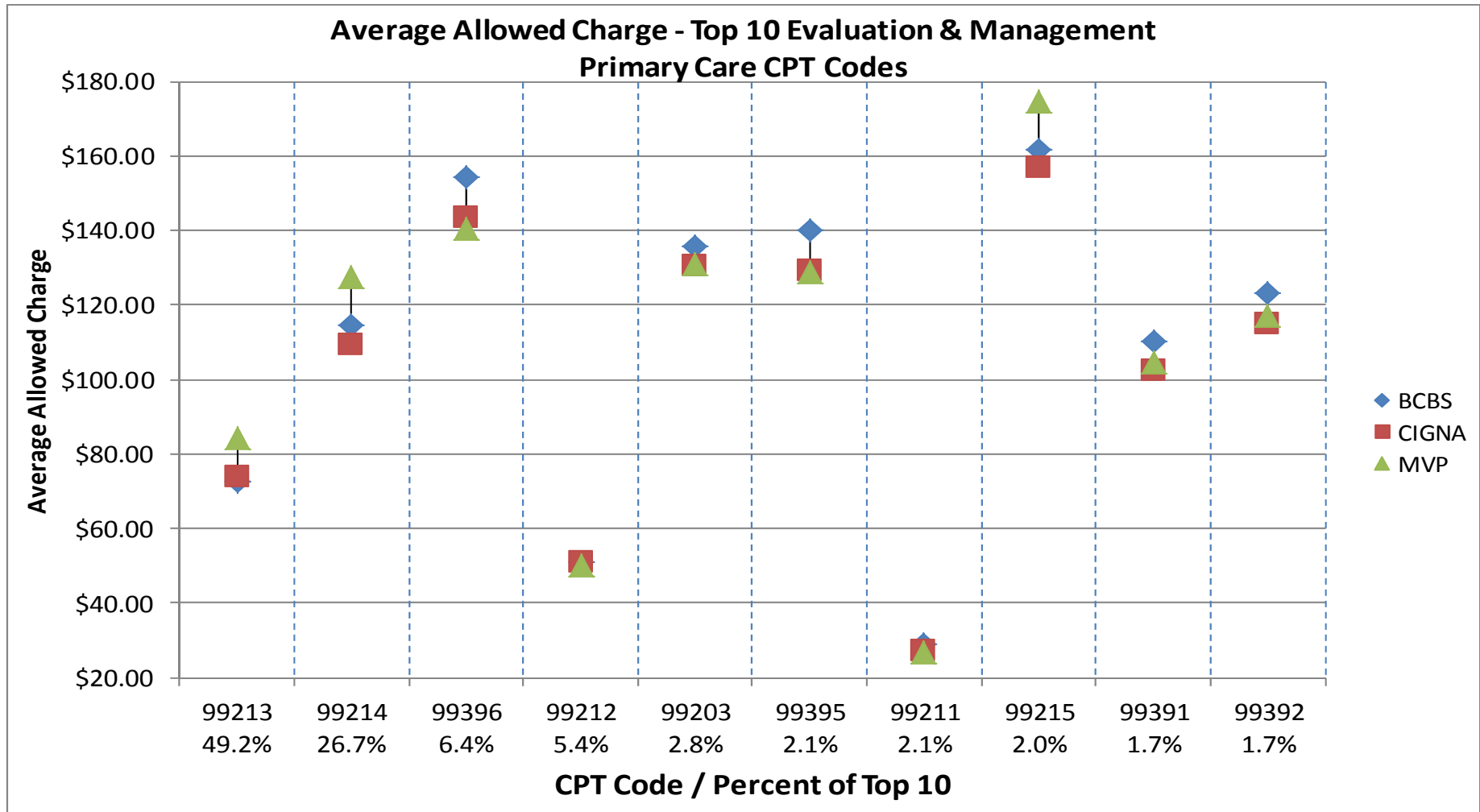
Table 2 shows the reported average allowed charge for each insurer for each of the top 10 primary care E&M CPT codes, the percent that each code represents of the top 10 codes, and the weighted average allowed charge across insurers.

Table 2 – Allowed Charges for Top 10 Evaluation and Management Primary Care Procedure Codes

CPT Code	BCBS/TVHP	CIGNA	MVP	Percent of top 10 claims	Weighted average
99213	\$72.55	\$73.96	\$84.18	49.2%	\$ 75.01
99214	\$114.74	\$109.55	\$127.41	26.7%	\$ 114.19
99396	\$154.36	\$143.32	\$140.54	6.4%	\$ 146.83
99212	\$50.90	\$51.08	\$50.08	5.4%	\$ 50.93
99203	\$135.56	\$130.48	\$131.06	2.8%	\$ 131.73
99395	\$140.08	\$129.39	\$128.87	2.1%	\$ 132.89
99211	\$28.84	\$27.06	\$26.56	2.1%	\$ 27.69
99215	\$161.82	\$156.85	\$174.55	2.0%	\$ 160.81
99391	\$110.15	\$102.51	\$104.48	1.7%	\$ 106.19
99392	\$123.22	\$115.03	\$117.07	1.7%	\$ 118.89

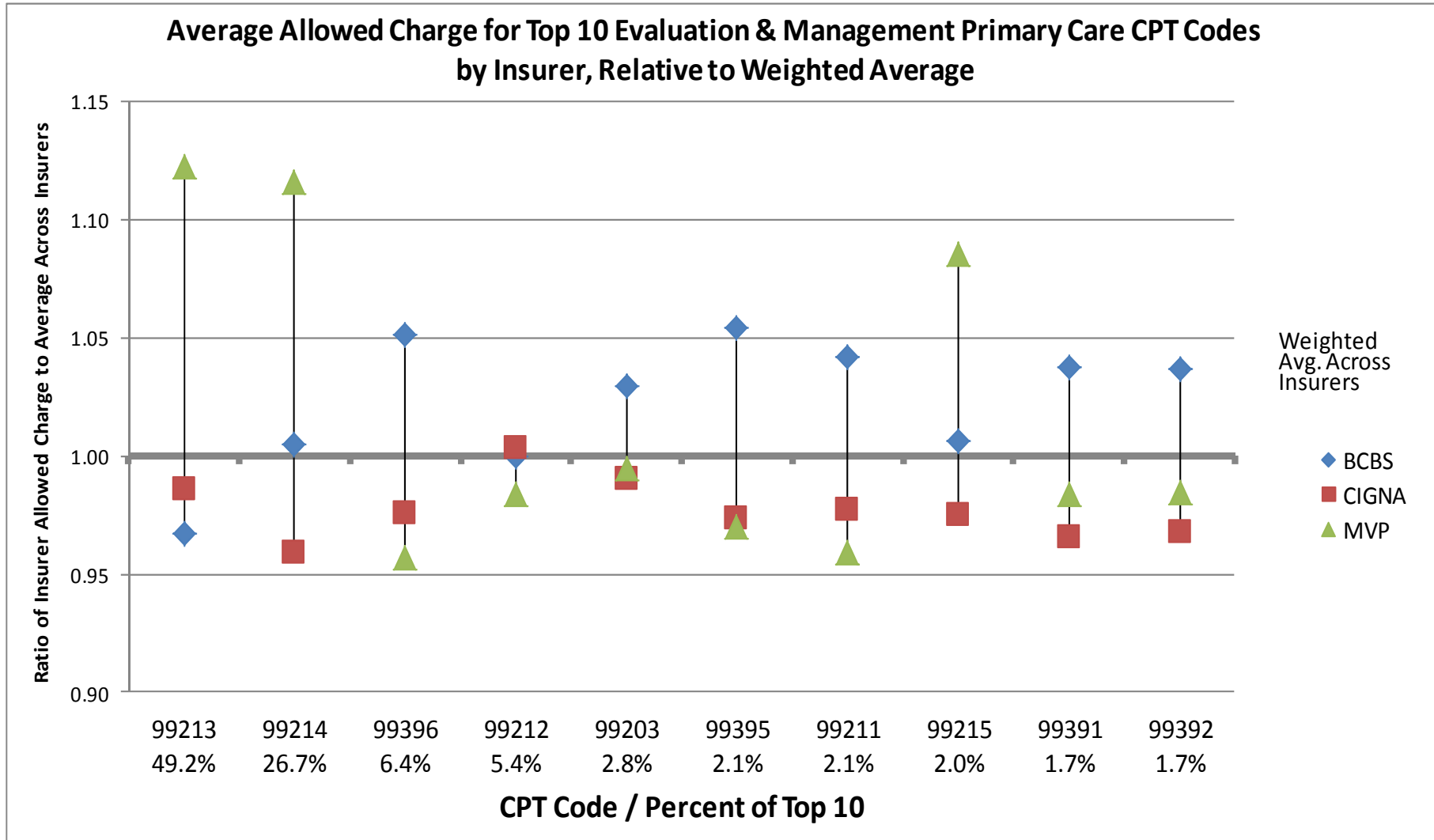
Figures 2 and 3 show the distribution and variation of average reimbursement rates among the insurers for each of the top 10 codes. Figure 2 shows the actual average for each insurer for each procedure code. In Figure 2, a 10 percent variation in a procedure code with higher reimbursement will look larger than the same percentage variation in a procedure code with lower reimbursement. As reported in previous years, the most frequent code, 99213, is among the least variable on a dollar basis. Variation within this category of services was relatively low with the highest variation within 99214 and the lowest for 99212 (see Summary Table 1 for more details).

Figure 2



Another approach is taken to show variation. Figure 3 shows variation in allowed charges among insurers relative to the aggregate weighted average allowed charge for each service. In Figure 3, the same percentage variation will look the same regardless of the underlying dollars.

Figure 3



Findings – Non-Evaluation and Management Services/ Primary Care

Using the service count information provided by the insurers, the aggregate top 10 primary care codes outside of the category of Evaluation and Management, excluding routine venipuncture, were identified. Table 3 shows the Non-Evaluation and Management codes and their descriptions. Figure 3 shows the proportion of the top 10 that each code represents.

Table 3 – Non-Evaluation and Management Services

Code	Description
80061	Laboratory - Lipid panel
81002	Urinalysis - non-automated, without microscopy
85018	Hematology and Coagulation - hemoglobin (Hgb)
87880	Microbiology - Streptococcus, group A
90470	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90471	Immunization administration (including percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Each additional vaccine (single or combination vaccine/toxoid) In conjunction with 90471
93000	Electrocardiogram, routine EEG with at least 12 leads, with interpretation and report
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single and multiple antigens
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular

Figure 3 shows the distribution of specific codes among the top 10. The most common code, 90471, accounts for 25 percent of services among the top 10 Non-Evaluation and Management codes.

Figure 3

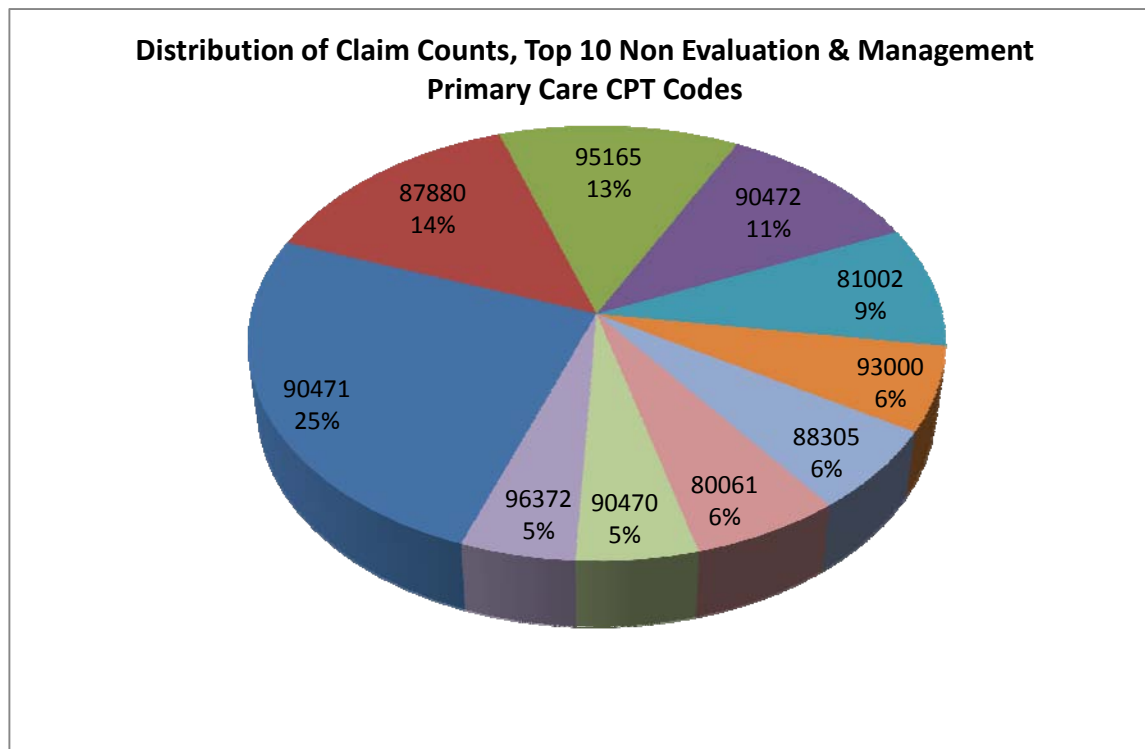


Table 4 shows the reported average allowed charge for each insurer for each of the top 10 primary care Non-Evaluation and Management CPT codes, the percent that each code represents of the top 10 codes, and the weighted average allowed charge across insurers.

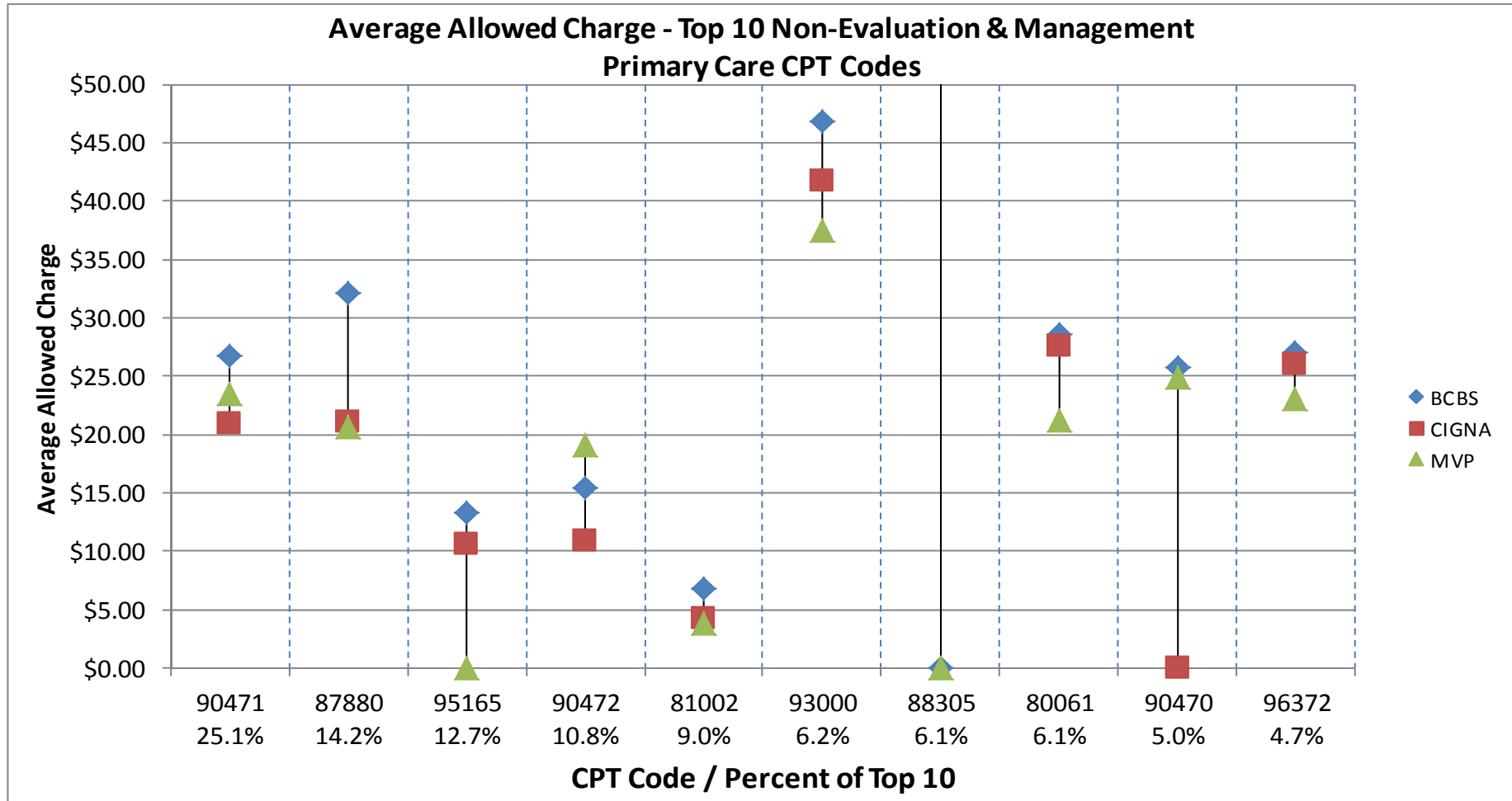
Table 4 – Allowed Charges for Top 10 Non-Evaluation and Management Primary Care Procedure Codes

CPT Code	BCBS/TVHP	CIGNA	MVP	Percent of top 10 claims	Weighted average
90471	\$26.81	\$20.93	\$23.46	25.1%	\$24.17
87880	\$32.09	\$21.06	\$20.70	14.2%	\$25.19
95165	\$13.26	\$10.67	-	12.7%	\$11.05
90472	\$15.43	\$10.92	\$19.09	10.8%	\$14.16
81002	\$6.81	\$4.24	\$3.86	9.0%	\$4.39
93000	\$46.79	\$41.73	\$37.53	6.2%	\$42.87
88305	-	\$120.74	-	6.1%	\$120.74
80061	\$28.62	\$27.56	\$21.28	6.1%	\$26.92
90470	\$25.77	-	\$24.86	5.0%	\$25.53
96372	\$27.01	\$26.01	\$23.04	4.7%	\$25.95

Missing values for BCBS for 88305, CIGNA for 90470 and MVP for 95165 and 88305 occurred because these codes are not in their top 30 lists that were used to determine the aggregate top 10 codes across all three insurers.

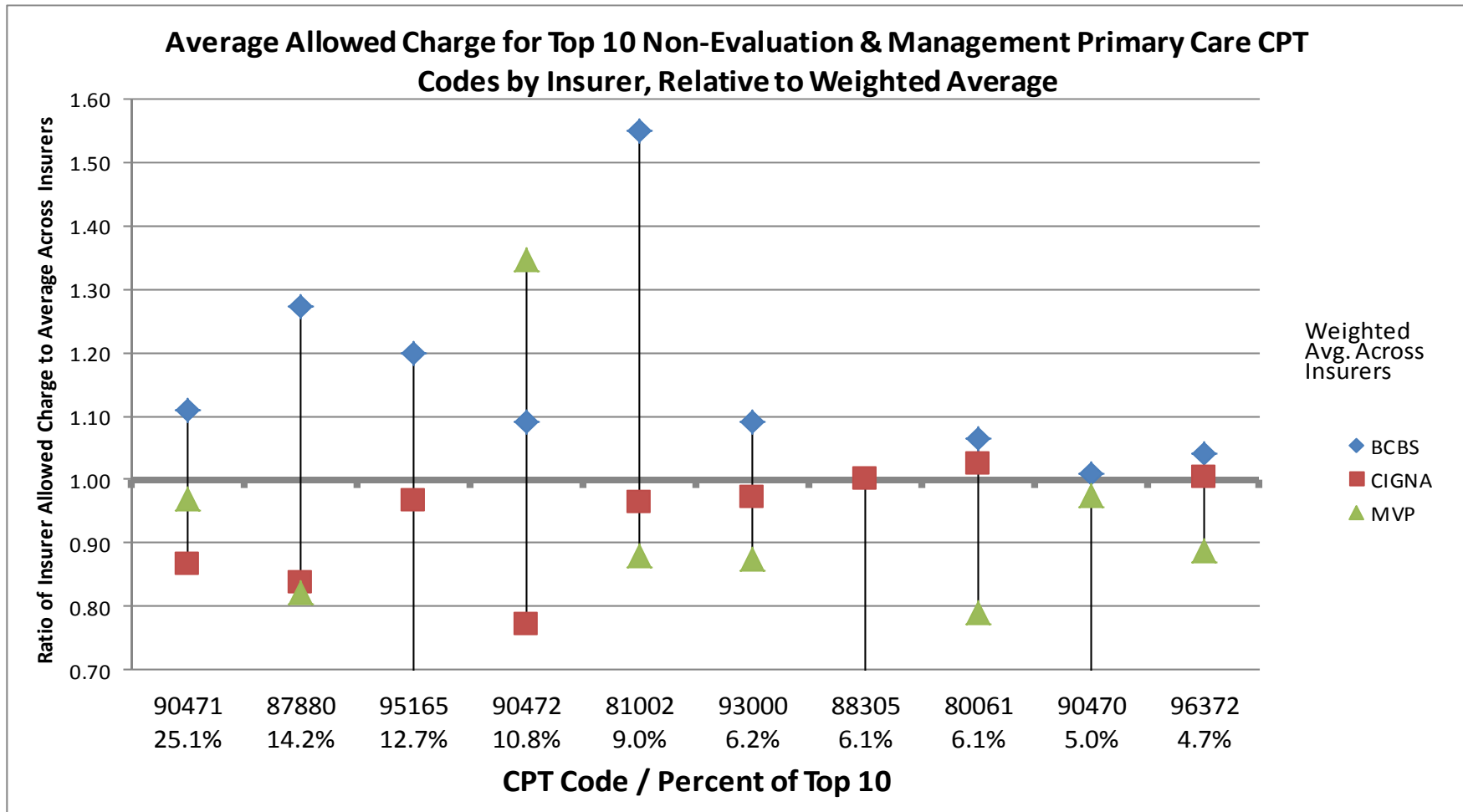
Figures 4 and 5 show the distribution and variation of average allowed charges among the insurers for each of the top 10 codes. As stated earlier, these two different approaches are taken to show variation. Figure 4 shows the actual average allowed charge for each insurer for each procedure code.

Figure 4



The dollar value of \$120 for code 88305 is not shown in this figure so the variation in average reimbursement for most procedure codes within the category is more accurately represented.

Figure 5 shows variation in allowed charges among insurers relative to the aggregate weighted average allowed charge for each service. Figure 5



Not shown in this figure are the procedure codes missing ratios for values that were not present for all providers' top ten Non-Evaluation and Management.

Conclusion

This report compares reimbursement for the highest volume primary care services within the current procedural terminology category of Evaluation and Management Services and the ten most common billing codes outside the category of Evaluation and Management among Vermont's major health insurers. There is minimal variation in average reimbursement for procedure codes within the category of Evaluation and Management and more variation in procedure codes outside the category of Evaluation and Management for services with generally lower reimbursement.

Office visits with an established patient for either 15 minutes or 25 minutes accounted for 75% of the top 10 Evaluation and Management claim counts. Blue Cross Blue Shield VT /TVHP had the highest reimbursement for six out of the top ten Evaluation and Management procedure codes. MVP, while having the highest reimbursement for three of the top ten Evaluation and Management procedure codes also had the three highest rates when compared to the aggregate weighted average. All but one of the top ten Evaluation and Management rates for CIGNA were below the weighted average.

Immunization administration and vaccines accounted for 42% of the top ten Non-Evaluation and Management claims. Blue Cross Blue Shield VT/TVHP had the highest reimbursement for eight of the top ten Non-Evaluation and Management procedure codes. MVP had the lowest reimbursement for six of the top ten Non-Evaluation and Management procedure codes.

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect prepare and submit the data required for this report.

Appendices

Appendix 1 – Excerpt from Act 42 (2009)

Sec. 31. 18 V.S.A. § 9409a is amended to read:

§ 9409a. HEALTH CARE INSURANCE REIMBURSEMENT SURVEY

In order to understand the impact of reimbursement on access to health care, the cost shift, the workforce shortages and recruitment and retention of health care professionals, the commissioner shall annually survey health insurers to determine the reimbursement paid for the ten most common billing codes for primary care health services within the current procedural terminology category of Evaluation and Management Services and the ten most common billing codes outside the category of Evaluation and Management, excluding routine venipuncture. Each insurer shall report the average reimbursement paid for a specific service. The survey shall be managed by the department of banking, insurance, securities, and health care administration, and any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. When published, survey data will be at least 90 days old. Only the department will have access to the underlying survey responses. The department shall provide a copy of the survey results to the house committee on health care and the senate committee on health and welfare. (Added 2007, No. 71, § 9; amended 2009, No. 42, § 31.)

Appendix 2—Primary Care Reimbursement Survey - Instructions

General

Introduction: - Per Sec. 31. 18 V.S.A. § 9409a

HEALTH CARE INSURANCE REIMBURSEMENT SURVEY

In order to understand the impact of reimbursement on access to health care, the cost shift, the workforce shortages and recruitment and retention of healthcare professionals, the commissioner shall annually survey health insurers to determine the reimbursement paid for the ten most common billing codes for primary care health services within the current procedural terminology category of Evaluation and Management Services and the ten most common billing codes outside the category of Evaluation and Management, excluding routine venipuncture. Each insurer shall report the average reimbursement paid for a specific service. The survey shall be managed by the department of banking, insurance, securities, and health care administration, and any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. When published, survey data will be at least 90 days old. Only the department will have access to the underlying survey responses. The department shall provide a copy of the survey results to the house committee on health care and the senate committee on health and welfare.

Lines of Business - include all business for which you have a direct contractual relationship with providers. Exclude any business for which you do not have a contractual relationship with providers. Exclude Catamount Health.

Self-Insured Business - include any self-insured business where reimbursement was based on the same contracts as fully insured business.

Data Survey Period - include all claims incurred (dates of service) between January 1, 2010 and June 30, 2010 and paid through September 30, 2010. Paid dates should be as current as possible. Do not include IBNR estimates. (Any reports based on these data will be at least 90 days old at the time of publication.)

Allowed Charges - report fees as established in all provider contracts or fee schedules, for claims incurred (dates of service) between January 1, 2010 and June 30, 2010 and paid through September 30, 2010. The allowed charge is the amount reimbursed prior to any reductions for cost sharing (deductibles, coinsurance, or co-payments). Exclude any pay-for-performance or other quality-based reimbursement.

Allowed charges should be calculated at the CPT and modifier combination level. For example:

- 99213
- 99213-25

The results should be reported for 99213 as an aggregate of the two codes above.

Calculation of Average Payment - averages are to be computed across all provider contracts and all lines of business that use fee-for-service reimbursement. In cases where services are paid at different reimbursement levels, report the average payment rate using one of the methods below.

Calculations of Averages for a specific CPT code.

Contract	Claims Paid	Allowed	Total Allowed	% of Claims	% of Dollars
1	500	\$70	\$35,000	17.9%	22.2%
2	800	\$60	\$48,000	28.6%	30.4%
3	1500	\$50	\$75,000	53.6%	47.5%
Totals	2800		\$158,000	100.0%	100.0%

Acceptable Calculations

Result

1 Summation	$158,000 / 2800$	\$56.43
2 Weighted Average	$\frac{((500 * \$70) + (800 * \$60) + (1500 * \$50))}{(500+800+1500)}$	\$56.43

The CPT code listing shall include the top 20 codes in category (1) Evaluation and Management Services and the top 30 codes in category (2) the common codes outside of the category of Evaluation and Management, excluding venipuncture. Include the total count of services by CPT code that was used in the calculation of each average. Counts will be used only to determine the top 10 CPT codes within each category and across payers and will not be included in any reports.

Data Universe - include all paid claims incurred by Vermont residents for primary care health services within the current procedure terminology code category of Evaluation and Management Services (see Table 1 as an example) and the common codes outside of the category of Evaluation and Management, excluding venipuncture. Include claims paid to Vermont providers (individual/group practices, tertiary clinics, PHOs etc.) and non-Vermont providers.

Data Exclusions List - Exclude Catamount Health line of business.

Exclude any pay-for-performance or other quality-based reimbursement.

Exclude HCPCS Level II – J/J9-Codes.

Exclude routine venipuncture and collection of capillary blood specimen.

Reimbursement/ Service Payments - include services that were reimbursed under any form of aggregate agreements such as a per-member-per-month target and a settlement contract. Exclude any services for which no fee-for-service payment is made, such as a capitation payment.