

Medicaid Reimbursement Survey, 2007/08

Vermont

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Vermont - 2007/08 AAP Medicaid Reimbursement Survey

Survey Summary :

As part of its effort to monitor the impact of the Medicaid program on pediatrics, the American Academy of Pediatrics (AAP) conducts its Medicaid Reimbursement Survey periodically.

The Survey, which collects state-administered fee-for-service program payment rates for most commonly reported pediatric Current Procedural Terminology/CPT® codes and dental codes, was most recently mailed to State Medicaid Directors in the 50 states and the District of Columbia during July 2007 to request payment rates effective July 1, 2007, the beginning of the 2007-08 fiscal year for most states.

47 states and the District of Columbia returned this survey. Data for New York and Hawaii are based on a search of the two states' Medicaid websites by AAP staff. Tennessee, which does not have a state-administered fee-for-service Medicaid program, is not included in this report series.

This and earlier AAP Medicaid Reimbursement Survey reports can be found at URL: <http://www.aap.org/research/medreimintro.htm>

Caveats and Notes :

Medicaid fees shown in this report represent fee-for-service payments reported by states for state-administered Medicaid programs only. Nationally, the majority of children enrolled in Medicaid programs are enrolled in managed care plans, which may or may not benchmark provider payment rates to fees shown in this report.

Attempts by the AAP to collect plan-to-provider payment rates in Medicaid managed care plans have been unsuccessful since such information has typically been classified as "confidential and proprietary" by the states and the plans with which they contract. Depending on managed care penetration levels, the impact of state-administered fee-for-service Medicaid payment rates varies by state.

All children enrolled in VT Medicaid were covered by a state-administered FFS program according to state reply to the 2007/8 AAP Medicaid Reimbursement Survey. Note: Pediatric payments for E&M codes are enhanced (20% above regular level, as shown in this report for VT).

Medicare rates in this report are (a) based on non-facility Medicare payment published by the Center for Medicare and Medicaid Services for 2007, and (b) adjusted with Geographic Practice Cost Index (GPCIs) published by CMS. Certain codes are assigned RVUs but not covered by Medicare.

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Abbreviations :

- BC :** Billed charges
- BI / BR / PR :** By invoice/ by report/ per review, i.e., Carrier will establish payment amounts for these services on a case-by-case basis following review of documentation, such as an operative report.
- BO :** Bundled with other services, i.e., Payment for covered services is always bundled into payment for other services not specified. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.
- FFS :** Discounted fee-for-service
- FP :** Facility payment
- MP :** Manually priced, i.e., Carrier will establish payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.
- NA :** Not applicable
- NC :** Not covered
- NL :** Information not found on state Medicaid website or physician fee schedule
- NP :** Information not provided by state in returned AAP survey
- NIS :** RVUs not included in RBRVS or Clinical Diagnostic Lab Fee Schedule
- LFS :** National limit amount per Clinical Diagnostic Lab Fee Schedule
- OM :** Other method used
- RBRVS:** Resource-Based Relative Value Scale, the physician payment schedule for Medicare
- RNE :** Rate not established
- RVU(s) :** Relative Value Unit(s), the numeric value of the resources needed to provide services according to the Resource-Based Relative Value Scale
- VFC :** Vaccines for Children Program. Providers are typically paid a vaccine administration fee for administering vaccines made available through VFC programs.
- MRC :** Maximum regional charge, the maximum amount a provider may charge for the administration of qualified pediatric vaccines to federally vaccine-eligible children under the VFC Program. States with universal purchase programs may establish maximum charges that differ from this level. MRCs were established by federal regulation published October 3, 1994, can be found online at: <http://www.cdc.gov/vaccines/programs/vfc/fee-fedreg.htm>, and have not been updated since initial publication of this regulation.

Contact Information :

Contact Suk-fong Tang, Department of Practice, for questions about this report. Contact Dan Walter, Division of State Government Affairs, for Medicaid questions and advocacy advice. Contact Elizabeth Sobczyk, Division of Pediatric Practice, for pediatric immunization questions and advocacy advice. Contact the Division of Health Care Finance and Quality Improvement at dhcfqi@aap.org for information on child health financing or RBRVS.


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AAP Medicaid Reimbursement Survey: Vermont

2007/08 Medicaid Payments for Commonly Reported Pediatric CPT™ Codes

<u>Preventive Medicine Services</u>	Medicaid	Medicare	%Medicare
99381 - New Patient, under 1 year	\$101.10	\$91.87	110.0%
99382 - New Patient, 1 through 4 years	\$109.01	\$98.07	111.2%
99383 - New Patient, 5 through 11 years	\$106.81	\$97.55	109.5%
99384 - New Patient, 12 through 17 years	\$116.01	\$106.01	109.4%
99385 - New Patient, 18 through 39 years	\$116.01	\$106.01	109.4%
99391 - Established Patient, under 1 year	\$76.85	\$71.66	107.2%
99392 - Established Patient, 1 through 4 years	\$86.06	\$79.74	107.9%
99393 - Established Patient, 5 through 11 years	\$106.81	\$79.00	135.2%
99394 - Established Patient, 12 through 17 years	\$116.01	\$86.89	133.5%
99395 - Established Patient, 18 through 39 years	\$95.07	\$87.63	108.5%
99401 - Individual Counseling, 15 min	\$41.13	\$37.07	110.9%
99402 - Individual Counseling, 30 min	\$69.44	\$62.04	111.9%
<u>Office and Other Outpatient Services</u>			
99201 - New Patient, office visit	\$42.73	\$34.48	123.9%
99202 - New Patient, expanded office visit	\$75.96	\$60.30	126.0%
99203 - New Patient, low complexity	\$112.79	\$89.12	126.6%
99204 - New Patient, moderate complexity	\$159.79	\$135.89	117.6%
99205 - New Patient, high complexity	\$203.29	\$170.63	119.1%
99211 - Established Patient, office visit	\$25.13	\$19.48	129.0%
99212 - Established Patient, expanded office visit	\$44.94	\$35.58	126.3%
99213 - Established Patient, low complexity	\$61.55	\$58.13	105.9%
99214 - Established Patient, moderate complexity	\$96.54	\$88.06	109.6%
99215 - Established Patient, high complexity	\$140.47	\$119.01	118.0%
92551 - Screening test, hearing evaluation	\$15.10	NIS	--
92567 - Tympanometry, hearing evaluation	\$15.22	\$19.90	76.5%
99173 - Screening test, visual acuity	\$4.50	\$2.40	187.7%
<u>Newborn Care</u>			
99431 - Initial newborn care	\$59.25	\$53.62	110.5%
99433 - Subsequent newborn care	\$31.22	\$28.59	109.2%
99435 - Admit and discharge on same day	\$79.66	\$72.90	109.3%
99436 - Physician attendance at delivery	\$72.35	\$68.48	105.7%
99440 - Newborn resuscitation	\$147.49	\$134.33	109.8%
54150 - Circumcision; newborn	\$58.66	\$123.01	47.7%

<u>Immunizations:</u>	Medicaid	Medicare	%Medicare
90465 - One immunization administration, physician counseling < 8 yrs.	\$51.29	\$18.74	273.7%
90466 - Each additional immunization administration, physician counseling < 8 yrs	\$6.80	\$9.90	68.7%
90467 - One immunization administration, oral or intranasal, physician counseling < 8 yrs	\$6.00	\$12.13	49.5%
90468 - Each additional immunization administration, oral or intranasal, physician counseling < 8 yrs	\$6.00	\$9.16	65.5%
90471 - One immunization administration	\$6.00	\$18.74	32.0%
90472 - Each additional immunization administration	\$6.00	\$9.90	60.6%
90473 - One immunization administration, oral or intranasal	\$7.64	\$12.49	61.2%
90474 - Each additional administration, oral or intranasal	PAC 6*	\$8.43	--
90645-8 - Hemophilus Influenza B	\$21.76	 <p>Medicare reimburses for vaccine products using 106% of the product's average sale price (ASP)</p>	
90649 - HPV	PAC 6		
90657 - Influenza virus (6-35 months)	\$9.94		
90658 - Influenza virus (3+ years)	\$9.94		
90660 - Influenza virus, intranasal use	PAC 9*		
90669 - Pneumococcal conjugate vaccine	\$80.46		
90680 - Rotavirus	PAC 6*		
90700 - DTaP (< 7 years)	\$20.05		
90701 - DTP	\$16.67		
90702 - DT (< 7 years)	\$7.53		
90707 - Measles, mumps, rubella	\$34.93		
90713 - IPV	\$23.00		
90715 - Tdap	PAC 6*		
90716 - Varicella	\$57.86		
90718 - Td (>= 7 years)	\$14.99		
90721 - DTaP, HIB	\$43.70		
90723 - DTaP-HepB-IPV	PAC 6*		
90744 - Hepatitis B, (pediatric/adolescent age)	\$27.05		

Observation

99217 - Observation care discharge, day management	\$82.94	\$64.21 (FP)	129.2% of FP
99218 - Initial observation care, low severity	\$78.98	\$60.54 (FP)	130.5% of FP
99219 - Initial observation care, intermediate severity	\$131.35	\$100.04 (FP)	131.3% of FP
99220 - Initial observation care, high severity	\$184.60	\$141.02 (FP)	130.9% of FP

<u>Prolonged Physician Services</u>	Medicaid	Medicare	%Medicare
99354 - Prolonged service, outpatient, 1st hour, face-to-face	\$96.88	\$88.99	108.9%
99355 - Same as 99354, each additional 30 min	\$70.20	\$88.43	79.4%
99356 - Prolonged service, inpatient, 1st hour, face-to-face	\$88.91	\$81.76	108.7%
99357 - Same as 99356, each additional 30 min	\$89.47	\$81.95	109.2%
99358 - Prolonged service, 1st hour, not face-to-face	PAC 9*	NIS	--
99359 - Same as 99358, each additional 30 min	PAC 9*	NIS	--
<u>Team Medical Conferences</u>			
99361 - Team medical conference, 30 min	PAC 9*	99361-2 had been replaced by new codes 99366-8 prior to publication of this report.	--
99362 - Team medical conference, 60 min	PAC 9*		--
<u>Telephone Care</u>			
99371 - Telephone call, simple or brief	PAC 9*	99371-3 had been replaced by new codes 99441-3 and 98966-8 prior to publication of this report.	--
99372 - Telephone call, intermediate	PAC 9*		--
99373 - Telephone call - complex or lengthy	PAC 9*		--
<u>Care Plan Oversight</u>			
99339 - Supervision of patient in home, 15-29 minutes per month	PAC I*	\$64.91	--
99340 - Same as 99339, 30 minutes or more per month	PAC I*	\$90.67	--
99374 - Supervision of patient under home health agency care, 15-29 minutes per month	PAC 9*	\$62.74	--
99375 - Same as 99374, 30 min or more per month	PAC 9*	\$110.09	--
<u>Hospital Care</u>			
99221 - Initial hospitalization, per day, low complexity	\$79.66	\$83.03	95.9%
99222 - Initial hospitalization, per day, moderate complexity	\$78.98	\$116.28	67.9%
99223 - Initial hospitalization, per day, high complexity	\$131.35	\$169.94	77.3%
99231 - Subsequent hospitalization, per day, low complexity	\$39.94	\$34.80	114.8%
99232 - Subsequent hospitalization, per day, moderate complexity	\$65.42	\$62.47	104.7%
99233 - Subsequent hospitalization, per day, high complexity	\$83.15	\$89.21	93.2%
<u>Hospital Discharge</u>			
99238 - Hospital discharge, day management, 30 min or under	\$47.02	\$64.02	73.4%
99239 - Hospital discharge, day management, more than 30 minutes	NP	\$92.61	--
<u>Consultations</u>			
99241 - Office consultation, problem focused	\$48.71	\$46.83	104.0%
99242 - Office consultation, straightforward decision	\$88.99	\$86.37	103.0%
99243 - Office consultation, low complexity	\$118.71	\$118.37	100.3%
99244 - Office consultation, moderate complexity	\$168.03	\$174.52	96.3%

Consultations <i>(continued)</i>	Medicaid	Medicare	%Medicare
99245 - Office consultation, high complexity	\$217.34	\$216.31	100.5%
99254 - Initial inpatient consultation, moderate complexity	\$138.53	\$152.90	90.6%
99255 - Initial inpatient consultation, high complexity	\$190.98	\$190.24	100.4%
<u>Pathology and Laboratory</u>			
81000 - Urinalysis, non-automated with microscopy	\$7.26	\$4.43 (LFS)	163.9% of LFS
81002 - Urinalysis, non-automated without microscopy	\$4.15	\$3.57 (LFS)	116.2% of LFS
86580 - Tuberculosis, intradermal	\$14.82	\$8.84	167.6%
87081 - Throat culture	\$9.48	\$9.26 (LFS)	102.4% of LFS
87880 - Rapid Streptococcus screen	\$26.68	\$16.76 (LFS)	159.2% of LFS
<u>Mental Health</u>			
90801 - Psychiatric diagnostic interview examination	\$75.99	\$142.60	53.3%
90804 - Individual psychotherapy, 20-30 min face-to-face	\$34.00	\$60.63	56.1%
90806 - Individual psychotherapy, 45-50 min face-to-face	\$60.04	\$88.32	68.0%
90808 - Individual psychotherapy, 75-80 min face-to-face	\$90.80	\$130.83	69.4%
90862 - Pharmacological management	\$44.09	\$49.51	89.1%
90887 - Interpretation or explanation of results	\$49.39	\$79.47	62.1%
<u>Developmental Testing</u>			
96110 - Developmental testing, limited	\$10.44	\$10.06	103.8%
96111 - Developmental testing, extended	\$111.07	\$127.42	87.2%
<i>Specialty Care Codes</i>			
<u>Allergy/Immunology</u>			
95004 - Percutaneous tests with allergenic extracts	\$1.67	\$4.60	36.3%
95010 - Percutaneous tests, sequential and incremental	\$10.55	\$16.51	63.9%
95015 - Intracutaneous tests, with biologicals	\$9.50	\$11.00	86.4%
95024 - Intracutaneous tests with allergenic extracts	\$2.54	\$6.44	39.4%
95115 - Allergenic immunotherapy, single injection	\$7.37	\$13.25	55.6%
95117 - Allergen immunotherapy, two or more injections	\$8.82	\$16.56	53.3%
<u>Cardiology</u>			
32020 - Thoracostomy tube	\$49.99	\$166.36	30.0%
92950 - Cardiopulmonary resuscitation	\$86.53	\$280.16	30.9%
93303 - Transthoracic echocardiography	\$149.56	\$211.62	70.7%
93307 - Echocardiography, real-time with image documentation	\$160.44	\$187.15	85.7%
93320 - Doppler echocardiograph	\$76.15	\$82.28	92.5%
93501 - Right heart catheterization	\$183.75	\$153.79	119.50%
93510 - Left heart catheterization	\$400.13	\$234.77	170.40%

Critical Care	Medicaid	Medicare	%Medicare
99291 - Critical care, first hour	\$132.67	\$249.41	53.2%
99292 - Critical care, additional 30 minutes	\$64.26	\$111.38	57.7%
99293 - Initial pediatric critical care	\$802.04	\$730.71	109.8%
99294 - Subsequent pediatric critical care	\$399.98	\$363.44	110.1%
99295 - Initial neonatal critical care	\$919.91	\$840.25	109.5%
99296 - Subsequent neonatal critical care	\$402.58	\$365.36	110.2%
Procedures			
31500 - Intubation, endotracheal	\$56.17	\$101.95	55.1%
36555 - Insertion of non-tunneled CVC~ ; <5 yrs old	\$42.35	\$289.74	14.6%
36568 - Insertion of peripherally inserted CVC~; <5 yrs old	\$32.58	\$326.09	10.0%
36600 - Arterial puncture, diagnostic	\$12.05	\$29.39	41.0%
36620 - Arterial line placement	\$33.69	\$48.46	69.5%
36510 - Umbilical vein catheterization	\$33.33	\$156.32	21.3%
36660 - Umbilical artery catheterization	\$12.05	\$64.40	18.7%
10120 - Simple surgical removal of foreign body	\$27.28	\$122.30	22.3%
12015 - Simple surgical repair of facial wound(7.6-12.5cm)	\$66.78	\$226.83	29.4%
36400 - Venipuncture necessitating physician skill, < 3 yrs, femoral or jugular vein	\$12.56	\$24.12	52.1%
36410 - Venipuncture necessitating physician skill, >= 3 years	\$19.95	\$17.28	115.5%
36415 - Routine venipuncture	\$8.00	\$3.00(LFS)	266.7% of LFS
36416 - Finger, heel, ear stick	\$4.00	NIS	--
62270 - Lumbar puncture, diagnostic	\$63.83	\$151.81	42.0%
Moderate Sedation			
99143 - Moderate sedation provided by same physician performing the service that sedation supports; younger than 5 years of age, first 30 minutes intra-service time	PAC I*	NIS	--
99144 - Moderate sedation provided by same physician performing the service that sedation supports; age 5 years or older, first 30 minutes intra-service time	PAC I*	NIS	--
99145 - Moderate sedation provided by same physician performing the service that sedation supports; each additional 15 minutes intra-service time	PAC I*	NIS	--

	Medicaid	Medicare	%Medicare
<u>Moderate Sedation</u> (continued)			
99148 - Moderate sedation provided by a physician other than the health care professional performing the service that sedation supports; younger than 5 years of age, first 30 minutes intra-service time	PAC I*	NIS	--
99149 - Moderate sedation provided by a physician other than the health care professional performing the service that sedation supports; age 5 years or older, first 30 minutes intra-service time	PAC I*	NIS	--
99150 - Moderate sedation provided by a physician other than the health care professional performing the service that sedation supports; each additional 15 minutes intra-service time	PAC I*	NIS	--
<u>Emergency Care</u>			
99282 - ED visit, low complexity	\$26.76	\$36.22	73.9%
99283 - ED visit, moderate complexity	\$60.12	\$58.61	102.6%
99284 - ED visit, detailed	\$93.87	\$107.12	87.6%
<u>Gastrointestinal</u>			
43239 - Upper gastrointestinal endoscopy with biopsy	\$160.77	\$314.83	51.1%
44389 - Colonoscopy with biopsy	\$151.64	\$359.44	42.2%
45331 - Sigmoidoscopy with biopsy	\$60.73	\$155.08	39.2%
<u>Ophthalmology</u>			
67311 - Strabismus surgery, horizontal	\$453.95	\$484.65	93.7%
67314 - Strabismus surgery, vertical	\$463.47	\$540.09	85.8%
68810 - Nasolacrimal probing	\$48.87	\$224.80	21.7%
<u>Otolaryngology</u>			
42820 - Tonsillectomy/adenoidectomy, under 12 years	\$192.58	\$262.37	73.4%
42821 - Tonsillectomy/adenoidectomy, 12 years or over	\$179.73	\$275.42	65.3%
69436 - Tympanostomy and tubes	\$123.54	\$150.13	82.3%
<u>Intensive Low Birth Weight Services</u>			
99298 - Subsq intensive care, <1500gm present body weight	\$141.65	\$128.84	109.9%
99299 - Subsq intensive care, 1500-2500gm present body weight	\$129.41	\$119.21	108.6%
99300 - Subsq intensive care, 2501-5000 gm present body weight	PAC I*	\$114.87	--
<u>Plastic Surgery</u>			
40700 - Cleft lip repair	\$494.30	\$829.80	59.6%
42200 - Cleft palate repair	\$499.90	\$804.55	62.1%

	Medicaid	Medicare	%Medicare
<u>Pulmonology</u>			
31622 - Bronchoscopy	\$144.56	\$302.21	47.8%
32000 - Thoracentesis	\$33.33	\$159.34	20.9%
94010 - Spirometry, including graphic record	\$29.90	\$31.62	94.6%
94640 - Inhalation treatment	\$10.41	\$12.15	85.7%
94644 - Continuous inhalation treatment, first hou	PAC 9*	\$34.20	--
94645 - Same as 94644, each additional hour	PAC 9*	\$12.88	--
94664 - Demonstration/evaluation	PAC 9*	\$12.90	--
<u>Radiology</u>			
71010 - Frontal chest x-ray	\$22.82	\$25.02	91.2%
<u>Surgery</u>			
28262 - Extensive clubfoot release	\$617.96	\$1146.81	53.9%
44950 - Appendectomy	\$346.33	\$539.81	64.2%
49500 - Bilateral inguinal hernia, 6 mos to under 5 yrs	\$247.10	\$329.00	75.1%
49505 - Bilateral inguinal hernia, 5 years or over	\$274.86	\$427.36	64.3%
<u>Nephrology</u>			
50200 - Renal biopsy	\$123.54	\$138.46	89.2%
90918 - ESRD (end stage renal disease) services, < 2 years	\$242.93	\$598.75	40.6%
90919 - ESRD, 2 through 11 years	\$242.93	\$434.44	55.9%
90920 - ESRD, 12 through 19 years	\$242.93	\$380.53	63.8%
90945 - Peritoneal dialysis	\$39.28	\$68.61	57.3%
<u>Dental Services</u>			
D0120 - Periodic exam	\$18.00	<div style="border-left: 1px solid black; border-right: 1px solid black; border-bottom: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> NIS </div>	
D1203 - Topical fluoride treatment, child	\$15.00		
D1120 - Prophylaxis, child	\$29.00		
D2150 - Amalgam - two surfaces, primary or permanent	\$67.00		
D2330 - Resin-based composite - one surface anterior	\$65.00		
D1351 - Sealant, per tooth	\$28.00		
D2930 - Stainless steel crown on a primary tooth	\$116.00		
D3220 - Pulpotomy	\$75.00		
D7140 - Extraction	\$75.00		

Dental codes (CDT Codes) are copyright 2006 American Dental Association.

Footnotes: * Request sent to state for clarification of payment method.