Washington State Health Care Authority

Advisory Committee on Primary Care

February 23, 2023

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Advisory Committee on Primary Care

February 23, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Committee Members:					
☐	Judy Zerzan-Thul, Chair				
☐	Kristal Albrecht	☐	Gregory Marchand	☐	Jonathan Staloff
☐	Sharon Brown	☐	Chandra Hicks	☐	Sarah Stokes
☐	Tony Butruille	☐	Meg Jones	☐	Linda Van Hoff
☐	Michele Causley	☐	Sheryll Morelli	☐	Shawn West
☐	Nancy Connolly	☐	Lan H. Nguyen	☐	Staici West
☐	Tracy Corgiat	☐	Kevin Phelan	☐	Ginny Weir
☐	David DiGiuseppe	☐	Eileen Ravella	☐	Maddy Wiley
☐	DC Dugdale	☐	Katina Rue		
☐	Sharon Eloranta	☐	Mandy Stahre		

Time	Agenda Items	Tab	Lead
2:00-2:10 (10 min)	Welcome, roll call, and agenda review	1	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:10-2:15 (5 min)	Approval of December meeting summary	2	AnnaLisa Gellermann, Cost Transparency Board Director Health Care Authority
2:15-2:30 (15 min)	Public comment		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:30-2:45 (15 min)	Presentation on providers, facilities, and primary care services	3	Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
2:45-3:55 (70 min)	Discussion of providers, facilities, and primary care services		Dr. Judy Zerzan-Thul, Chair, Medical Director Washington State Health Care Authority
3:55-4:00 (5 min)	Wrap-up and adjournment		AnnaLisa Gellermann, Committee Facilitator Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Advisory Committee on Primary Care Meeting Summary

January 31, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the Advisory Committee on Primary Care webpage.

Members present

Judy Zerzan-Thul, Chair
Chandra Hicks
David DiGiuseppe
D.C. Dugdale
Ginny Weir
Gregory Marchand
Jonathan Staloff
Katina Rue
Kristal Albrecht
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Michele Causley
Nancy Connolly
Sarah Stokes
Sharon Brown
Sharon Eloranta
Sheryl Morelli
Staici West
Tony Butruille

Members absent

Kevin Phelan
Meg Jones
Shawn West
Tracy Corgiat

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order.

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul provided an overview of the agenda.

Approval of November meeting summary

The committee members present voted to adopt the Meeting Summary from the November 2022 meeting.

Topics for Today

The topics were listed as presentation and discussion of primary care providers and facilities.

Presentation on primary care providers and facilities

Dr. Judy Zerzan-Thul, Health Care Authority (HCA)
Judy Zerzan-Thul presented a proposed list of primary care providers and facilities for the committee to vote on.

Public Comment

No public comment.

Discussion of primary care providers and facilities

Dr. Judy Zerzan-Thul, Health Care Authority
Mandy Stahre asked whether an internal medicine pediatrician would provide primary care services. Sheryll Morelli said they are primarily primary care providers, and they are double boarded. Judy Zerzan-Thul said it's like family medicine with a longer residency. Nancy Connolly asked if there's a separate taxonomy code to account for an internist. What about medical psychiatry? They probably do primary care, too. Judy Zerzan-Thul asked staff to research the internal medical psychiatry. Jonathan Staloff made a motion to include the internal medicine, pediatrics provider in the narrow list. The motion was seconded and approved.
Sharon Eloranta suggested adding obstetricians (OBs) to the narrow list because many women see this provider type but do not have a primary care provider (PCP). Ginny Weir affirmed Sharon's point about women seeing OBs. If the committee is focused on improving population health, OBs should be included in the narrow list. Nancy Connolly suggested that if a relationship is present, all specialties can provide primary care. Dr. Judy Zerzan-Thul agreed and highlighted that it's an overlap of the who, what, and where. Sheryl Morelli disagreed that OBs, advanced practice midwives (APMs), and midwives are primary care providers, even though they sometimes provide services. Mandy Stahre pointed out that for many women, OBs are their only contact with the health care system. For Medicaid, there have been many efforts to expand postnatal care. OB providers aren't just providing services related to pregnancy since they manage other conditions, too. In the broader umbrella of women's health, including this group will help increase primary care services. For OFM's prior work, where both providers and services were considered, some services were excluded while others were included, which is why OBs were included in the broad definition of primary care. David DiGiuseppe noted that other states have benchmarked for spending and asked whether OB was included by those states. Dr. Zerzan-Thul directed staff to research this further. Jean Marie Dreyer, HCA staff, noted that Colorado included OB in their narrow category. Sarah Stokes noted that the Washington Health Care Alliance assigns patients to OBGYN as though they are PCPs. Sheryll Morelli said that the committee's agreed upon primary care definition should serve as the reference for determining whether providers count as primary care. OBs don't coordinate care except for primary OBGYN diagnoses. For spending, OBs shouldn't' be included as PCPs according to the newly formulated definition. Even if patients treat a specialist as a PCP, that doesn't make them a PCP e.g., cardiologists. Lan Nguyen noted that many OBGYNs don't consider themselves as PCPs even when they provide primary care services due to their residency training. OBs shouldn't be included due to scope of practice and not meeting the definition of comprehensive primary care

services. Jonathan Staloff voiced support for retaining the broad definition rather than the narrow using cardiology, OBs, and pediatrics as examples. Cardiologists are often first point of contact for a large subpopulation, but they don't provide comprehensive care. OBs provide care for roughly 50 percent of the population, but they don't provide the same comprehensiveness as pediatrics (for every medical need). Michele Causley suggested retaining OBs, APMs, and midwives in the broad definition and maybe specifically excluding these providers for the Medicare population.

Tony Butruille asked for more clarification between the narrow and broad providers list. In general, states that use both definitions view narrow as definitively primary care and broad captures people and services that are not consistently primary care. Chandra Hicks asked whether the group was working towards one list. Dr. Judy Zerzan-Thul noted that narrow and broad were both used before, which is common with other states. The group could decide to merge and use one list and use an intersection of the who, what, and where to make final decisions. Chandra Hicks said if two buckets are used, it would be helpful to see how that would affect the spending target. Dr. Judy Zerzan-Thul clarified that the two buckets would provide two different ranges with the "true" percentage somewhere in between. It isn't clear which bucket/category is referred to with the 12 percent target in statute. There's also not a date by which to attain 12 percent. Sharon Eloranta expressed confusion and concern about having two lists – it would be harmful to overinflate the target by making the list too inclusive. Nancy Connolly asked how the list would be incentivized to attach patients to primary care doctors. The intention of the statute was to increase continuity. Sharon Eloranta pointed out that the definition used by the Washington Health Care Alliance is close to the narrow list. It's difficult to attribute patients, almost half are unattributed. People don't like being told to have a PCP. Nancy Connolly asked whether the group should consider the narrow or the broad list. Jean Marie Dreyer proposed that the group make a motion to decide on whether to use one or two categories. Tony Butruille expressed agreement and noted a preference for one list rather than two. David DiGiuseppe said that two categories allow for sensitivity analysis. Nancy Connolly asked whether if with two lists, there would be two ranges. Dr. Judy Zerzan-Thul said a range would continue to be reported. David DiGiuseppe suggested discussing behavioral health before deciding on narrow and broad. Michele Causley expressed support for two lists – narrow is useful for benchmarking with other states and the broad list provides a full range, and both need to be trended. Mandy Stahre said it would be helpful to identify what's not primary care. Dr. Judy Zerzan-Thul said that this refinement has already taken place and suggested members show by raise of hands their preference of whether to retain the narrow and broad categories. Nine members voted to retain two categories and nine voted for one category. Chandra Hicks offered to change votes from supporting one to supporting both lists if the purposes for each were clarified – narrow could be used for primary care transformation versus broad for primary care capacity. There need to be limitations outlined for both. Gregory Marchand also voiced changing support to two lists if the purpose for each list is clear. Linda Van Hoff suggested that if things are based on a percentage of primary care activity, the percentage threshold should be used for determining placement on the narrow list. Dr. Judy Zerzan-Thul observed that a majority seemed comfortable with retaining two lists – the narrow would be used for primary care transformation investment and the broad is more inclusive to account for providers who might provide some primary care. Sheryll Morelli, who initially voted for a single, agreed with Dr. Zerzan-Thul's rationale for two lists.

Dr. Judy Zerzan-Thul asked for committee members' feeling on including women's health on the narrow list. Two members voted to include women's health practitioners on the narrow, and all other members voted to retain them on the broad list. Sheryll Morelli proposed that if more than half of what OBs do every day is primary care, they could be moved to narrow list. Dr. Judy Zerzan-Thul concurred. No additional motion was made for OBs and other women's health care practitioners.

Dr. Judy Zerzan-Thul moved to considering registered nurses (RNs) for inclusion on narrow list. Nancy Connolly asked how often RNs are considered the highest level of service. Michele Causley noted that from a claims data perspective, RNs are not often billed on their own, rather they are billed with a supervising physician. Sheryl Eloranta noted that some places like transitional care management (TCM) coding where a step is accomplished by

a licensed professional like an RN, but the full claim is submitted by the physician. Mandy Stahre pointed out that with no way to measure RNs' service provision, it can't be measured, and shouldn't be included. Ginny Weir asked whether RNs should be removed from the broad list.

Dr. Judy Zerzan-Thul asked whether the group wanted to add homeopaths to the narrow list. Sheryll Morelli asked how homeopaths are separate from naturopaths. Dr. Judy Zerzan-Thul clarified that they have different trainings and philosophies. Nancy Connolly asked about where homeopaths trained. Mandy Stahre noted that if they are covered by commercial insurers, they will appear in claims and asked if they are MDs or DOs. Sharon Eloranta highlighted that the tenet of homeopathy is that the less of an active ingredient there is, the more powerful it is. Dr. Judy Zerzan-Thul noted that there isn't a separate program for homeopathy at Bastyr. Mandy Stahre asked if homeopaths have their own taxonomy. Jean Marie Dreyer clarified that homeopaths do have their own taxonomy code. Linda Van Hoff explained that based on a Google search, homeopaths might be a licensed professional, such as a naturopath or nurse in Washington, but they also have a separate homeopath designation. Sarah Stokes clarified that there are no homeopath taxonomies in their system. Sheryl Morelli made a motion to remove homeopaths as a provider type from narrow and broad. This motion was seconded and approved. Katina Rue moved to add Internal Medicine Pediatrics to the narrow list. Dr. Judy Zerzan-Thul added that advanced practice nurses might be added to the list, as could internal medicine psychiatry.

Dr. Judy Zerzan-Thul moved to proposals to amend the broad list. Mandy Stahre pointed out that "accountable" should be further. Dr. Judy Zerzan-Thul clarified that accountable is not attribution. Sharon Eloranta asked who is accountable when it's billed. Sheryl Morelli noted that social workers are not PCPs since they don't provide for physical health. Psychologists don't provide for physical health. None of these can be accountable for all of health or all primary care. Dr. Judy Zerzan-Thul suggested applying "accountable" to narrow providers. The broad provider list includes those that are part of the team that provide primary care. Sheryll Morelli pointed out that most of those in the broad can't be independent providers. Nancy Connolly stated that these providers must be on a team to be considered primary care providers. Michele Causley noted that the group is using claims data to identify primary care spend. If providers don't match the exact definition of physical primary care but primary care physicians are required to add those services, then that's the only way to capture those pieces. Sheryll Morelli asked whether cognitive behavioral therapy would be included in the primary care spend? Michele Causley responded that other states put behavioral health providers on a broad list and acknowledged some services would be captured that aren't primary care but mental health is important for physical health. Nancy Connolly noted that social workers and pharmacists bill independently but are part of primary care physicians' practice. Jean Marie Dreyer noted that most states put these providers in the broad category and emphasized the statute's direction to integrate behavioral health. Katina Rue asked how the next step of identifying the "where" would intersect with the discussion e.g., if someone goes across town to a separate practice versus a shared practice that's part of a network. Dr. Judy Zerzan-Thul noted that a psychologist could be at the same address as another primary care clinician. Tony Butruille asked if social workers, pharmacists, or others could be linked with another traditional primary care practitioner on the narrow list.

Dr. Judy Zerzan-Thul noted that most of the broad providers would remain and asked for committee members' view on additional providers to include, like perinatal. Karie Nicholas asked for clarification on whether the emphasis was on whole-person care. Dr. Judy Zerzan-Thul responded this was part of the definition. Sheryll Morelli asked what broad providers could count as primary care in a traditional setting. Some of the specialists, addiction medicine, etc., wouldn't be provided in a primary care setting. Dr. Judy Zerzan-Thul asked for feedback on adding perinatal providers and neonatologists. Sheryl Morelli expressed skepticism for including neonatologists since they are specialty and only a small subset performs post-natal intensive care unit (NICU) care. D.C. Dugdale pointed out that neonatal specialists most often practice in hospitals. Sheryll Morelli pointed out that most neonatal providers work in a hospital setting. Neonatologists represent a big spend that would skew the data. Katina Rue agreed with Sheryll's point regarding adding too much spend. Dr. Judy Zerzan-Thul noted that based on feedback, perinatal specialists would be excluded. Sheryll Morelli proposed removing psychologist rehab and psychologist mental

retardation/developmental from the broad list. For family medicine, it would be helpful to hear from family medicine providers on the committee. Should addiction medicine, bariatric, and palliative be included? Do these providers maintain a general family practice scope? Katina Rue responded that many family doctors work with addiction as part of their scope of practice and are board certified in addiction medicine. For other family docs, they work in sports medicine but no primary care. There are providers who fit both. There's not a huge spend associated with including these types of providers. Jonathan Staloff agreed with Katina's points and noted that there are dedicated fellowships for these family practitioners – some have just a niche and some have a broad practice in family medicine. Dr. Judy Zerzan-Thul noted that this happens with internal medicine providers, too, who are double boarded. Sheryll Morelli noted that pediatrics (peds) has these same specialties but were excluded. Katina Rue suggested that maybe peds providers dedicate more time to specialty. D.C. Dugdale noted that most internists continue to practice primary care and often serve as informal consultants for colleagues in a primary care group. Sheryll Morelli asked D.C. whether all of the specialties in family medicine should be included. D.C. Dugdale noted that sleep and sports medicine are different from addiction and bariatric. Nancy Connolly suggested that a setting is more important for making a determination rather than double boarding. Sheryll Morelli noted that if the facility addition clarifies primary care provision, it would be fine to retain the specialists on the list. Mandy Stahre pointed out that place of service is difficult to clarify. It's not possible to pinpoint place of service for measurement. Looking at services will also help weed out providers as well. It's both what is being billed and what the place of service is. Dr. Judy Zerzan-Thul proposed making no changes to the broad list. Krystal Albrecht noted that allopathic codes were missing. Linda Van Hoff noted that the APM and midwife are on the broad list but that ARNPs would likely get included on the narrow list. Dr. Judy Zerzan-Thul proposed sorting the NPs and PAs into narrow and broad. Sharon Eloranta asked about the school social worker. Jean Marie Dreyer replied that it does have its own code. Dr. Judy Zerzan-Thul noted that the school social worker could work elsewhere and Katina Rue agreed and noted that they could practice a school-based clinic practicing primary care.

Nancy Connolly made a motion to accept the broad list in its current form. The motion passed.

Dr. Judy Zerzan-Thul discussed next steps for future discussions. At the next meeting, NPs and PAs will be sorted into narrow and broad. Facilities will also be discussed. A list of primary care services to include will be emailed to the committee. There will also be several presentations to other groups, the Advisory Committee of Providers and Carriers and the Cost Board on the primary care committee's progress.

Adjournment

The meeting adjourned at 3:50 p.m.

Next meeting

March 30, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Public comment

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Tab 3

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Claims-based payments discussion: primary care providers, facilities, and services

Dr. Judy Zerzan-Thul, Chair, Advisory Committee on Primary Care

Washington State Health Care Authority

Definition of primary care

- **"Team -based** care led by an **accountable** primary care clinician that serves as a person's source of **primary contact** with the larger healthcare system. Primary care includes a **comprehensive** array of **equitable**, **evidence-informed** services to create and maintain a **continuous** relationship over time. This array of services is **coordinated** by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

January 31 meeting recap

- Motions approved to:
  - Retain narrow and broad provider list
  - Add internal medicine pediatrics to narrow list
  - Remove homeopath from narrow and broad list
- Proposal to add OB and midwife to narrow declined
- Suggestion made to add internal medicine psychiatry

Tasks for Today: Make Progress on

- Nurse practitioners (NPs) and physician assistants (PAs)
- Facilities
- Start on primary care services

NPs and PAs

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Reminder: NPs and PAs

- NP
- NP, acute care
- NP, community health
- NP, family
- NP, gerontology
- NP, pediatrics
- NP, primary care
- NP, psychiatric/mental health
- NP, women's health
- PA
- PA, medical

Feedback: NPs and PAs

- Add:
  - All categories to narrow.
  - Add PA/APRN, Pediatrics.
  - Add PA/APRN, Family Health.
  - Add PA/APRN, Adult Health.
  - Add PA/APRN, Women's Health.
  - NP, Psychiatric/mental health to broad.
  - PA/APRN.
  - PA/APRN, Psychiatric/mental health, child & adolescent.
  - PA/APRN, Psychiatric/mental health, child & family.
  - PA/APRN, Psychiatric/mental health, chronically ill.
  - PA/APRN, Psychiatric/mental health, community.
  - PA/APRN, Psychiatric/mental health, geropsychiatric.
  - NP, OBGYN.
- Remove:
  - Psychiatric/mental health.
  - If NP acute care is hospital care.
- For NP, PA, and PA, medical, only include if provider practiced at a primary care facility.

Decision

- Motion to approve finalized NPs and PAs list

Facilities

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Reminder: facilities

- Primary care clinic (including on-site at hospitals)
- Multi-specialty clinic/center
- Rural health clinic (RHC)
- Federally qualified health center (FQHC)
- Ambulatory health clinic/center
- Community health clinic/center
- Critical access hospital (CAH)
- School-based health center
- Indian health service facility
- Long-term care facilities

Feedback: facilities

- Add:
  - Primary care clinics within Hospital Outpatient Departments (HOPDs) that have primary care providers.
  - Urgent care clinics with primary care providers.
  - Virtual care.
  - 193200000X – Group/Multi-Specialty.
  - 193400000X – Group/Single-Specialty.
- Remove:
  - Critical access hospitals (CAHs) (if they do not provide primary care).
- Clarify:
  - Will only facilities using Method II for professional billing be included?

Decision

- Motion to approve finalized facilities list

Primary care services

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Recap of Claims

- Primary Care Collaborative made an Excel sheet comparing states
- WA is only state that divided into narrow and broad
- WA had more codes covered than most states

Decision

- Motion to approve finalized primary care services list

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Final check-in and next steps

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Questions: final check-in

- Do the lists in the previous slides reflect our recommended definition of primary care?
  - Accountable
  - Continuous
  - Coordinated
  - Equitable

- Is everything captured in the All-Payer Claims Database?

Next steps

- March 7 - Advisory Committee of Providers and Carriers meeting
  - Present claims-based measurement recommendations for feedback
- March 30 - Advisory Committee on Primary Care meeting
  - Continue primary care services discussion
  - Presentation from Oregon on non-claims-based measurement
- June 6 - Joint meeting: Advisory Committee of Providers and Carriers and Advisory Committee on Data Issues
  - Present claims-based recommendation for feedback
  - Begin discussion of non-claims-based measurement
- June 21 - Health Care Cost Transparency Board meeting
  - Present final claims-based recommendation (includes feedback from providers and carriers and data committees)

Thank you for attending the Advisory Committee on Primary Care meeting!

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Comparison of Primary Care Investment Definition Code Sets

Code	Description	Washington
11055	Trim Skin Lesion Single	Y
11056	Trim Skin Lesions 2 To 4	Y
11200	Removal Of Skin Tags <W/15	Y
11201	Remove Skin Tags Add-On	Y
11719	Trimming Nondystrophic Nails Any Number	Y
11720	Debride Nail 1-5	Y
11721	Debride Nail 6+	Y
11740	Evacuation Subungual Hematoma	Y
11900	Inject Skin Lesions </W 7	Y
11976	Remove Contraceptive Capsule	Y
11981	Insert Drug Implant Device	Y
11982	Remove Drug Implant Device	Y
11983	Remove W/ Insert Drug Implant	Y
15851	Removal Sutures Under Anesthesia Other Surgeon	Y
16020	Dressings&/Dbrdmt Prtl-Thkns Burns 1St/Sbsq Small	Y
17110	Destroy B9 Lesion 1-14	Y
17111	Destroy B9 Lesion 15 Or More	Y
24640	Closed Treat Radial Head Sublx Child	Y
30300	Removal Foreign Body Intranasal Office Procedure	Y
36415	Routine Venipuncture	Y
36416	Capillary Blood Draw	Y
51702	Insj Temp Indwellg Bladder Catheter Simple	Y
54150	Circumcision W/Clamp/Oth Dev W/Block	Y
57170	Fitting Of Diaphragm/Cap	Y
58300	Insert Intrauterine Device	Y
59400	Obstetrical Care	Y - B
59410	Veginal Delivery + Postpartum Care	Y - B
59425	Antepartum Care Only 4-6 Visits	Y - B
59426	Antepartum Care Only 7< Visits	Y - B
59430	Postpartum Care Only	Y - B
59510	Routine Ob Care	Y - B
59515	Cesarean Delivery Only + Postpartum Care	Y - B
59610	Routine Obstetric Care After Prevs C-Section	Y - B
59614	Vaginal Delivery Only After Prevs C-Section + Postpartum Care	Y - B
59618	Routine Ob Care Post Vaginal Delivery After Prev C-Section	Y - B
59622	C-Section Only, After Attempted Vaginal Delivery After Prev C- Section + Postpartum Care	Y - B
69200	Clear Outer Ear Canal W/Out Anesthesia	Y
69210	Remove Impacted Ear Wax Instruments	Y
81000	Urinalysis Dip Stick/Tablet Reagnt Non-Auto Micrscpy	Y
81001	Urinalysis Dip Stick/Tablet Reagent Auto Microscopy	Y
81025	Urine Pregnancy Test Visual Color Comparison	Y
82044	Urine Albumin Semiquantitative	Y
82270	Blood Occult Peroxidase Actv Qual Feces 1 Determination	Y
82272	Blood Occult Peroxidase Actv Qual Feces 1-3 Spec Determination	Y
82465	Cholesterol Serum/Whole Blood Total	Y
82947	Glucose Quantitative Blood Xcpt Reagent Strip	Y
82948	Glucose Blood Reagent Strip	Y
82950	Glucose Post Glucose Dose	Y
82962	Gluc Bld Glucouse Device Spec Home Use	Y
83655	Assay Of Lead	Y
83718	Lipoprotein Dir Meas High Density Cholesterol	Y
85013	Blood Count Spun Microhematocrit	Y
85014	Blood Count Hematocrit	Y
85018	Blood Count Hemoglobin	Y
86580	Skin Test Tuberculosis Intradermal	Y
87205	Smr Prim Src Gram/Giemsa Stain Bct Fungi/Cel	Y
87880	Immunoassay Streptococcus Group A	Y
90460	Immunization Admin 1St/Only Component 18 Years<	Y - N
90461	Immunization Admin Each Addl Component 18 Years<	Y - N
90471	Immunization Admin 1 Vaccine Single/Combo	Y - N
90472	Immunization Admin Each Add-On Single/Combo	Y - N
90473	Immunization Admin Oral/Nasal Single/Combo	Y - N
90474	Immunization Admin Oral/Nasal Addl Single/Combo	Y - N

92551	Pure Tone Hearing Test Air	Y
92567	Tympanometry	Y
93000	Ecg Routine Ecg W/Least 12 Lds W/I&R	Y
93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only W/O I&R	Y
93010	Ecg Routine Ecg W/Least 12 Lds I&R Only	Y
93040	Rhythm Ecg 1-3 Leads W/Interpretation & Report	Y
93268	Xtrnl Pt Activ Ecg Transmis W/R&I </30 Days	Y
93784	Ambl Bld Press W/Tape&/Disk 24/> Hr Alys I&R	Y
94010	Spirometry	Y
94060	Bronchodilation Responsiveness	Y
94640	Pressurized/Nonpressurized Inhalation Treatment	Y
94664	Demo&/Eval Of Pt Utiliz Aersl Gen/Neb/Inhlr/Ip	Y
94760	Noninvasive Ear/Pulse Oximetry Single Deter	Y
94761	Noninvasive Ear/Pulse Oximetry Multiple Deter	Y
95115	Prof Services Allergen Immutherapy Single Injection	Y
95117	Prof Services Allergen Immutherapy Multiple Injection	Y
96160	Pt-Focused Hlth Risk Assmt	Y - N
96161	Caregiver Health Risk Assmt	Y - N
96372	Ther/Proph/Diag Inj Sc/Im	Y
97597	Debridement Open Wound 20 Sq Cm/<	Y
97602	Rmvl Devital Tiss N-Slctv Dbrdmt W/O Anes 1 Sess	Y
98925	Osteopath Manj 1-2 Regions	Y
98926	Osteopath Manj 3-4 Regions	Y
98927	Osteopath Manj 5-6 Regions	Y
98928	Osteopath Manj 7-8 Regions	Y
98929	Osteopath Manj 9-10 Regions	Y
98966	Hc Pro Phone Call 5-10 Min	Y
98967	Non-Physician Telephone Services 11-20 Min	Y
98968	Non-Physician Telephone Services 21-30 Min	Y
98969	Online Service By Hc Pro	Y
99000	Specimen Handling Office-Lab	Y
99050	Medical Services After Hrs	Y
99051	Med Serv Evening/Wkend/Holiday	Y
99058	Office Emergency Care	Y
99078	Phys/QHP Education Materials for Pts In Group Setting	Y - N
99173	Visual Acuity Screen	Y
99202	Office/OutPt Visit New 15-29 Min	Y
99203	Office/OutPt Visit New 30-44 Min	Y
99204	Office/OutPt Visit New 45-59 Min	Y
99205	Office/OutPt Visit New 60-74 Min	Y
99211	Office/OutPt Visit Est	Y
99212	Office/OutPt Visit Est 10-19 Min	Y
99213	Office/OutPt Visit Est 20-29 Min	Y
99214	Office/OutPt Visit Est 30-39 Min	Y
99215	Office/OutPt Visit Est 40-54 Min	Y
99241	Office Or Other OutPt Consultations 15 Min	Y - N
99242	Office Or Other OutPt Consultations 30 Min	Y - N
99243	Office Or Other OutPt Consultations 40 Min	Y - N
99244	Office Or Other OutPt Consultations 60 Min	Y - N
99245	Office Or Other OutPt Consultations 80 Min	Y - N
99304	Initial Nursing Facility Care/Day 25 Min	Y - B
99305	Initial Nursing Facility Care/Day 35 Min	Y - B
99306	Initial Nursing Facility Care/Day 45 Min	Y - B
99307	Sbsq Nursing Facility Care/Day E/M Stable 10 Min	Y - B
99308	Sbsq Nursing Facil Care/Day Minor Complj 15 Min	Y - B
99309	Sbsq Nursing Facil Care/Day New Problem 25 Min	Y - B
99310	Sbsq Nurs Facil Care/Day Unstabl/New Prob 35 Min	Y - B
99315	Nursing Facility Discharge Management 30 Min<	Y - B
99316	Nursing Facility Discharge Management 30 Min>	Y - B
99318	E/M Annual Nursing Facility Assess Stable 30 Min	Y - B
99324	Domiciliary Or Rest Home Custodial Care 20 Min	Y - N
99325	Domiciliary Or Rest Home Custodial Care 30 Min	Y - N
99326	Domiciliary Or Rest Home Custodial Care 45 Min	Y - N
99327	Domiciliary Or Rest Home Custodial Care 60 Min	Y - N
99328	Domiciliary Or Rest Home Custodial Care 75 Min	Y - N
99334	Domiciiary Or Rest Home Evaluation 15 Min	Y - N
99335	Domiciliary Or Rest Home Evaluation 25 Min	Y - N

99336	Domiciliary Or Rest Home Evaluation 40 Min	Y - N
99337	Domiciliary Or Rest Home Evaluation 60 Min	Y - N
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min	Y - N
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min	Y - N
99341	Home Visit New Pt 20 Min	Y - N
99342	Home Visit New Pt 30 Min	Y - N
99343	Home Visit New Pt 45 Min	Y - N
99344	Home Visit New Pt 60 Min	Y - N
99345	Home Visit New Pt 75 Min	Y - N
99347	Home Visit Established Pt 15 Min	Y - N
99348	Home Visit Established Pt 25 Min	Y - N
99349	Home Visit Established Pt 40 Min	Y - N
99350	Home Visit Established Pt 60 Min	Y - N
99354	Prolonged Service OutPt 60 Min	Y - N
99355	Prolonged Service OutPt Add 30 Min	Y - N
99356	Prolonged Service Requiring Unit/Floor 60 Min	Y - N
99357	Prolonged Service Requiring Unit/Floor Add 30 Min	Y - N
99358	Prolong Service W/O Contact	Y - N
99359	Prolong Serv W/O Contact Add 30 Min	Y - N
99360	Standby Service	Y - N
99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician	Y - N
99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician	Y - N
99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician	Y - N
99374	Home/Nursing Facility Visits 15-29 Min	Y - N
99375	Home/Nursing Facility Visits 30 Min	Y - N
99377	Supervision Hospice Patient/Month 15-29 Min	Y - B
99378	Supervision Hospice Patient/Month 30 Minutes/>	Y - B
99379	Supervision Nurs Facility Pt Mo 15-29 Min	Y - B
99380	Supervision Nurs Facility Pt Month 30 Min/>	Y - B
99381	Init Pm E/M New Pat Infant	Y
99382	Init Pm E/M New Pat 1-4 Yrs	Y
99383	Prev Visit New Age 5-11	Y
99384	Prev Visit New Age 12-17	Y
99385	Prev Visit New Age 18-39	Y
99386	Prev Visit New Age 40-64	Y
99387	Office Visit - New Pt 65+ Yrs	Y
99391	Periodic Pm Reeval Est Pat Infant 1>	Y
99392	Prev Visit Est Age 1-4	Y
99393	Prev Visit Est Age 5-11	Y
99394	Prev Visit Est Age 12-17	Y
99395	Prev Visit Est Age 18-39	Y
99396	Prev Visit Est Age 40-64	Y
99397	Per Pm Reeval Est Pat 65+ Yr	Y
99401	Preventive Counseling Indiv 15 Min	Y - N
99402	Preventive Counseling Indiv 30 Min	Y - N
99403	Preventive Counseling Indiv 45 Min	Y - N
99404	Preventive Counseling Indiv 60 Min	Y - N
99406	Behav Chng Smoking 3-10 Min	Y - N
99407	Behav Chng Smoking > 10 Min	Y - N
99408	Audit/Dast 15-30 Min	Y - N
99409	Alcohol/Substance Screen & Intervention >30 Min	Y - N
99411	Preventive Counseling Group 30 Min	Y - N
99412	Preventive Counseling Group 60 Min	Y - N
99429	Unlisted Preventive Service	Y - N
99441	Phys/Qhp Telephone Evaluation 5-10 Min	Y - N
99442	Phone E/M Phys/Qhp 11-20 Min	Y - N
99443	Phys/Qhp Telephone Evaluation 21-30 Min	Y - N
99446	Interprofessional Electronic Health Assessment 5-10 Min	Y - N
99447	Interprofessional Electronic Health Assessment 11-20 Min	Y - N
99448	Interprofessional Electronic Health Assessment 21-30 Min	Y - N
99449	Interprofessional Electronic Health Assessment 31 Min <	Y - N
99450	Basic Life And/Or Disability Exam	Y
99451	Interprofessional Electronic Health Assessment 5 Min >	Y - N
99452	Interprofessional Electronic Health Record Referral Service(S) Provided By A Treating Physician Health Care Professional, > 16 Min	Y - N

99453	Remote Monitoring Physiologic Parameters Initial	Y
99454	Remote Monitoring Physiologic Parameters Programed Transmission	Y
99455	Work Related Disability Exam	Y
99456	Disability Examination	Y
99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min	Y
99460	Initial Evaluation And Management Of Newborn At Hospital	Y - N
99461	Initial Evaluation And Management Of Newborn Outside Of Hospital	Y - N
99462	Evaluation And Menagement Of Normal Newborn At Hospital	Y - N
99463	Evaluation And Menagement Of Normal Newborn Hospital Same Day Admittance And Discharge	Y - N
99464	Attendance At Delivery And Initial Stabilization Of Newborn	Y - B
99465	Delivery/Birthing Resuscitation	Y - B
99483	Assmt & Care Planning Pt W/Cognitive Impairment	Y - N
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min	Y - B
99487	Complex Care W/O Pt Vsit 60 Min	Y - N
99489	Complex Chronic Care Addl 30 Min	Y - N
99490	Chron Care Mgmt Srvc 20 Min	Y - N
99494	1St/Sbsq Psyc Collab Care	Y - B
99495	Trans Care Mgmt 14 Day Disch	Y - N
99496	Trans Care Mgmt 7 Day Disch	Y - N
99497	Advncd Care Plan 30 Min	Y - N
99498	Advncd Care Plan Addl 30 Min	Y - N
A4627	Spacr Bag/Resrvor W/Wo Mask W/Metrd Dose Inhal	Y
A6448	Light Comprs Bandge Elast Wdth < 3 In Per Yard	Y
A6449	Light Comprs Bandge Elast Wdth >/= 3 & <5 In Per Yd	Y
A7003	Admn Set Sm Vol Nonfiltr Pneumat Nebulizr Dispbl	Y
A7015	Areo Mask Used W/ Dme Neb	Y
G0008	Admin Influenza Virus Vaccine	Y
G0009	Admin Pneumococcal Vaccine	Y
G0010	Admin Hepatitis B Vaccine	Y
G0101	Cancer Screen; Pelvic/Breast Exam	Y
G0102	Prostate Cancer Screening; Digital Rectal Examination	Y
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd	Y - N
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd	Y - N
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved	Y - N
G0182	Hospice Facility Visits Medicare Approved	Y - B
G0396	Alcohol/Subs Misuse Intervention 15-30 Min	Y
G0397	Alcohol/Subs Misuse Intervention 30 Min <	Y
G0402	Welcome to Medicare visit	Y - N
G0403	Ekg For Initial Prevent Exam	Y
G0404	Ekg Tracing For Initial Prev	Y
G0405	Ekg Interpret & Report Preve	Y
G0438	Ppps, Initial Visit	Y - N
G0439	Ppps, Subseq Visit	Y - N
G0442	Annual Alcohol Screen 15 Min	Y
G0443	Brief Alcohol Misuse Counsel	Y
G0444	Depression Screen Annual 15 Min	Y
G0463	Hospital Outpt Clinic Visit	Y - N
G0466	FQHC Visit, New Pt	Y - N
G0467	FQHC Visit, Established Pt	Y - N
G0468	FQHC Preventive Visit	Y - N
G0469	FQHC Visit, Mh New Pt	Y - B
G0470	FQHC Visit, Mh Estab Pt	Y - B
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services	Y
G0513	Prolong Preventative Services, First 30 Min	Y
G0514	Prolonged Preventive Service Addl 30 Min	Y
J1050	Injection Medroxyprogesterone Acetate 1 Mg	Y
Q0091	Obtaining Screen Pap Smear	Y
S8100	Holding Chamb/Spacr W/Inhal/Nebulizr; W/O Mask	Y
S8101	Holding Chamb/Spacr W/An Inhal/Nebulizr; W/Mask	Y
T1015	Clinic Service All-Inclusive	Y - N