Appendix A: All Payer Claims Database report

AUDIO-ONLY TELEMEDICINE EVALUATION WORK

2023

Executive Summary

ESHB 1196 (2021) directed the Office of the Insurance Commissioner (OIC), in collaboration with the Washington State Telehealth Collaborative and the Health Care Authority to undertake a study related to audio-only telemedicine and report findings of the study to the legislature by November 1, 2023. To complete this directive, OIC contracted with the Value & Systems Science Lab to prepare a health claims data analysis report, conduct a literature search, and field a survey of health carriers and Medicaid managed care organizations in Washington state. This report contains information and findings from a descriptive analysis of telemedicine utilization trends.

The utilization analysis was conducted using claims data from the Washington All-Payer Claims Database. There were five notable findings based on measuring utilization using information from health service claims for audio-only telemedicine during the period of January 1 to November 30, 2022. This period was chosen for analysis in order to describe the utilization of audio-only telemedicine services during a period least affected by the COVID-19 pandemic, as compared to earlier periods (2020 and 2021). In addition, certain audio-only billing codes were first implemented in 2022.

Finding 1: Audio-only telemedicine utilization remained stable overall but varied by beneficiary population. Audio-only telemedicine utilization remained stable over the time period studied in 2022. Utilization varied by beneficiary age, gender, payer type, and urban/rural residence, with older, female, Medicaid-insured, and urban-dwelling beneficiaries exhibiting higher proportions of utilization than might be expected based on their representation in the overall evaluation population. Utilization also varied slightly

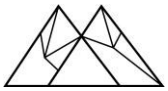
by the extent of social vulnerability in beneficiaries' areas of residence.

Finding 2: Audio-only telemedicine was used most commonly for mental health conditions. Conditions most commonly associated with audio-only telemedicine were post-traumatic stress disorder, generalized anxiety disorder, unspecified anxiety disorder, and major depressive disorder. These findings may reflect the importance of audio-only services for behavioral health and/or the emergence of new claims-based methods to identify audio-only telemedicine use for behavioral health needs.

Finding 3: Over time, the amount of audio-only telemedicine delivered by physicians and advanced practice providers was surpassed by the amount delivered by other providers. Over the evaluation period, the amount of audio-only telemedicine delivered by providers such as psychologists and licensed independent clinical social workers exceeded the amount delivered by physicians and advanced practice providers (e.g., nurse practitioner, physician assistant). Together with Finding 2 (audio-only telemedicine being commonly utilized for behavioral health conditions), this trend may have reflected a growing number of behavioral health providers delivering audio-only telemedicine.

Finding 4: Audio-only telemedicine was rarely delivered by telemedicine-only providers. Telemedicine-only providers – those who delivered all services through telemedicine modalities exclusively – comprised a small percentage of all providers and provided a low proportion of audio-only telemedicine services.

Finding 5: Audio-only telemedicine use varied geographically, with certain areas



demonstrating low use compared to others. Several counties in the southeastern part of Washington exhibited low levels of audio-only telemedicine. Higher use areas were more geographically dispersed across the state.

This analysis also included two alternative approaches of capturing audio-only telemedicine utilization. These approaches were adopted to reflect other ways that audio-only telemedicine services could have been indicated in claims (as pandemic-related services; inadvertently as audio-video telemedicine services) and yielded several exploratory findings that are further detailed in the body of the report.

Introduction

In 2021, the Legislature enacted ESHB 1196, which required that audio-only telemedicine be a covered service reimbursed at parity with health services provided in person. Section 8 of ESHB 1196 directs the Office of the Insurance Commissioner (OIC), in collaboration with the Washington State Telehealth Collaborative (WSTC) and the Health Care Authority (HCA), to study and make recommendations related to audio-only telemedicine. The OIC and collaborators engaged the Value & Systems Science Lab (VSSL) at the University of Washington School of Medicine to assist with this directive.

In collaboration with the OIC, WSTC, and HCA, VSSL (1) performed a literature review on regulatory experiences, costs, and clinical effectiveness of audio-only telemedicine, (2) conducted a web-based survey of commercial carriers and Medicaid Managed Care Organizations to evaluate specific domains relevant to coverage of audio-only telemedicine services, (3) conducted an audio-only telemedicine utilization analysis of audio-only telemedicine utilization trends in Washington state between January 2022 and November 2022, and (4) developed a set of proposed methods for future evaluations to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas. This report contains information and findings from the third component (audio-only telemedicine utilization analysis).

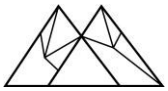
Audio-Only Telemedicine Utilization Trends Report

Evaluation Approach/Methodology

Data Source

We analyzed data from the Washington All-Payer Claims Database (WA-APCD). The dataset included data from 30 commercial health care payers (including the HCA Public Employees Benefits Board Program and School Employees Benefits Board Program), Medicaid, and Medicare Advantage plans (State of Washington Office of Financial Management, 2019; Washington Health Care Compare (a), 2023) but excluded claims from Medicare and Medicaid Fee-for-Service, most self-funded plans, Indian Health Service, and the Veterans Health Administration.

We analyzed three data tables within the WA-APCD containing information about beneficiaries and providers (defined as individual clinicians providing health care services) (Washington Health Care Compare (b), 2023). The first was the Eligibility Table, which included records documenting each beneficiary's enrollment in each health plan and product, and dates of enrollment. The second table was the Medical Claim Detail Table, which included variables on all medical services received by health plan beneficiaries. This table contained outpatient records containing data on individual demographics, and information on encounters including dates, providers of care, diagnosis codes, and service procedure codes. Specifically, both Current Procedural Terminology (CPT) codes and code modifiers were analyzed in order to identify audio-only telemedicine services (described in greater detail below). The third table was the Provider Master Table, which included identifying information of individual providers such as location, National Provider Identifiers (NPI), and taxonomy codes that specify providers' clinical specialty.



Audio-Only Telemedicine Services

The evaluation acknowledged the fact that claims could be an imperfect measure of audio-only telemedicine utilization, particularly in the context of COVID-19 (e.g., if audio-only telemedicine services could have been billed as audio-video services; services intended to be audio-video could have been converted to audio-only due to technological difficulties). Therefore, several approaches were used to evaluate audio-only telemedicine services.

Our primary (*base case*) approach was to identify audio-only telemedicine services as those meeting one of the two following criteria based on billing claims:

1. Claims that included dedicated CPT modifiers designating audio-only telemedicine: FQ (behavioral health) and 93 (physical health), irrespective of CPT code. These new code modifiers FQ and 93 were implemented in 2022 to more reliably identify situations in which audio-only telemedicine is used for physical and behavioral health services given that audio-only telemedicine services designation was initially limited to six CPT codes previously (#2) but expanded in scope during the course of the COVID-19 pandemic.

2. Claims that included CPT codes denoting telephone services provided by physicians (CPT 99441-99443) or non-physician health care professionals (98966-98968).

   > CPT 99441-99443. Telephone evaluation and management (E/M) service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a

related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

99441. 5-10 minutes of medical discussion.

99442. 11-20 minutes of medical discussion.

99443. 21-30 minutes of medical discussion.

CPT 98966-98968. Telephone E/M service by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

98966. 5-10 minutes of medical discussion.

98967. 11-20 minutes of medical discussion.

98968. 21-30 minutes of medical discussion.

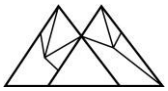
Upon the recommendation and input from OIC, WSTC, and HCA leadership, as well as input from interested parties (e.g., carriers), several additional approaches were adopted. These approaches were used as alternative ways to capture utilization of audio-only telemedicine services – measures that were helpful to counterbalance the newly adopted 93 and FQ audio-only telemedicine CPT code modifiers used in the primary (*base case*) approach.

A secondary (*expanded case*) approach identified claims with the CR catastrophe/disaster modifier appended to CPT codes identified by Centers for Medicare & Medicaid Services (CMS) as meeting the requirements for audio-only telemedicine services (*Appendix B*). A tertiary (*max case*) approach captured claims that included the GT or 95 modifiers—modifiers that denote care delivered via interactive audio-video telemedicine, appended to the CPT codes meeting the requirements for audio-only telemedicine services (*Appendix B*). The tertiary approach was adopted to address the possibility that audio-only telemedicine services could have been inadvertently billed as audio-video telemedicine services (i.e., due to changes from audio-video to audio-only telemedicine visits due to technological issues). These three approaches – base, expanded, and max cases – were created to be mutually exclusive in order to understand distinctions between services identified by each (*Table 1*).

Table 1. Approaches to Identify Audio-Only Telemedicine

Approach	Definition
Primary Approach (Base Case)	FQ or 93 modifiers; CPT 99441-99443; CPT 98966-98968
Secondary Approach (Expanded Case)	CR modifier appended to audio-only telemedicine CPT codes
Tertiary Approach (Max Case)	GT or 95 modifiers appended to audio-only telemedicine CPT codes

Using these approaches, two measures of audio-only telemedicine services were generated. The first was a raw count of services per month. This measure was assessed both overall and stratified by certain variables of interest (see *Variables Used in Stratification* below). The second measure was the proportion of services represented by audio-only telemedicine among certain subgroups defined by stratification of variables of interest.



Evaluation Period

Trends in utilization of audio-only telemedicine services were evaluated over an 11-month period from January 2022 to November 2022. This period coincided with implementation of the new CPT code modifiers dedicated to audio-only telemedicine services in January 1, 2022. Data from December 2022 were not included due to incomplete data (insufficient time to enable full claims run out and data capture).

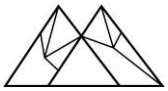
Trends involving provider-level variables were evaluated from January 2022 to September 2022. It was not feasible to accurately assess trends through November 2022 due to data reliability issues identified in the Provider Master Table – that is, concerns discussed and confirmed about reliability of WA-APCD data for records in those months.

Evaluation Cohort

We examined utilization of 4,295,382 Washington State beneficiaries with health insurance coverage who were tracked in the WA-APCD during the evaluation period (Washington State Health Care Authority, 2022). We excluded beneficiaries enrolled in a health plan for less than six months out of the prior calendar year (2021).

Variables Used in Stratification

We examined trends across a number of beneficiary- and provider-level variables (*Table 2*) that could potentially influence beneficiaries' use of audio-only telemedicine and which have been identified as areas of disparities in audio-only telemedicine use in prior literature (Benjenk et al.,

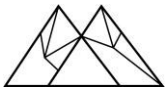


2021; Rodriguez et al., 2021). These included age, gender, race and ethnicity, payer type, rurality, county, and county-level Social Vulnerability Index.

Data on race and ethnicity were reported as available and existing in the WA-APCD – that is, the VSSL team did not conduct steps for re-categorization or otherwise change race or ethnicity categories. Data was missing considerably for several variables, including race (54% missing) and ethnicity (50% missing); thus, the analyses for these variables should be heavily caveated and interpreted with particular attention to data availability.

The Social Vulnerability Index (SVI) is a composite measure of socioeconomic disadvantage developed by the Centers for Disease Control and Prevention. It includes Census-based measures of income, employment, education, housing quality, and percentages of minoritized individuals and those with limited English proficiency (Agency for Toxic Substances and Disease Registry, 2022). SVI scores capture social vulnerability in beneficiary's county of residence and range from 0 (lowest vulnerability) to 100 (highest vulnerability). SVI was analyzed by grouping beneficiaries into categories based on national SVI score quartiles. The first quartile represents beneficiaries residing in areas with the lowest social vulnerability. Correspondingly, the fourth quartile represents beneficiaries residing in areas with the highest social vulnerability.

Provider-level variables included type of provider (MD/DO-trained physicians, advanced practice providers [APPs], or other), primary care provider or not (based on provider taxonomy codes), provider rurality, and telemedicine-only provider or not (based on outreach to carriers identified by OIC and the provider lists generated by those carriers).



Analysis

Analysis involved several steps. First, an overall trend in audio-only telemedicine service utilization for all beneficiaries was generated by aggregating visits for each month in the evaluation period. Additional stratified trends were generated by variables in *Table 2*. Utilization was aggregated within each month and reported both raw, monthly service counts and the proportion of services by variables of interest (listed above).

For example, for categorical variables (e.g., sex), we (a) aggregated services for each month separately for each value (e.g., respective service counts for female and male groups) and (b) tabulated the monthly proportion of services provided to beneficiaries in subgroups, defined by variables of interest (e.g., percent of services received by female and male groups, summing to 1). For continuous variables (e.g., age), we constructed categories based on examination of data distribution.

Audio-only telemedicine utilization was also examined by diagnosis and service types. In particular, utilization was assessed based on the ten most common conditions (defined by the International Classification of Diseases-10 [ICD-10] diagnostic codes) and the five most common service types (defined by CPT codes). Condition and service types with the highest total volume from January to November 2022 were defined as the most common.

Findings

A total of 4,295,382 beneficiaries met criteria for inclusion in the evaluation. Characteristics of this population are shown in *Table 3.* The mean age was 37 years (SD=23 years), and 52% of beneficiaries were female. For race, 30% were White, 4% were Black or African American, 3% were Asian, 2% were American Indian or Alaska Native, 7% were categorized in the Other category, and 54% had missing data. For ethnicity, 7% were Hispanic, 43% were non-Hispanic, and 50% had missing data.

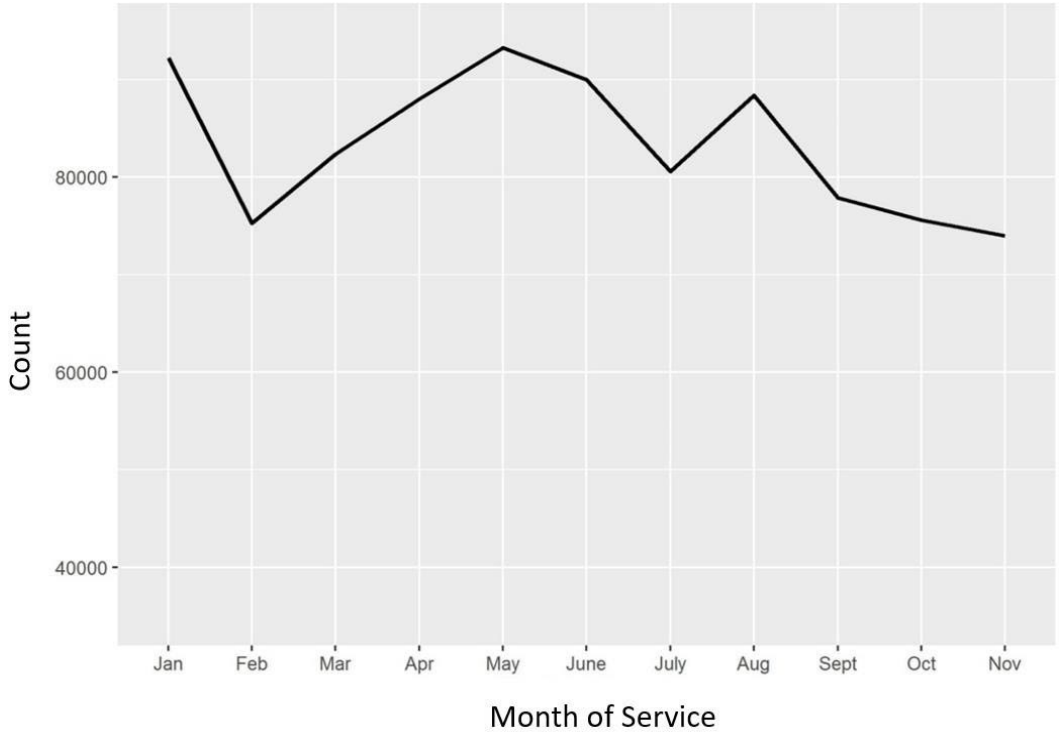
Nearly half of the population (45%) was insured through commercial insurers or Medicaid (44%), and fewer were insured by Medicare (11%). The majority of beneficiaries (87%) resided in urban areas. Six percent resided in lowest vulnerability areas; 54% in the low-medium vulnerability areas; 29% in medium-high vulnerability areas; and 12% in the highest vulnerability areas. The average number of days of insurance coverage for the cohort was 350 days (SD=44 days).

Audio-Only Telemedicine Services Utilization

Base Case

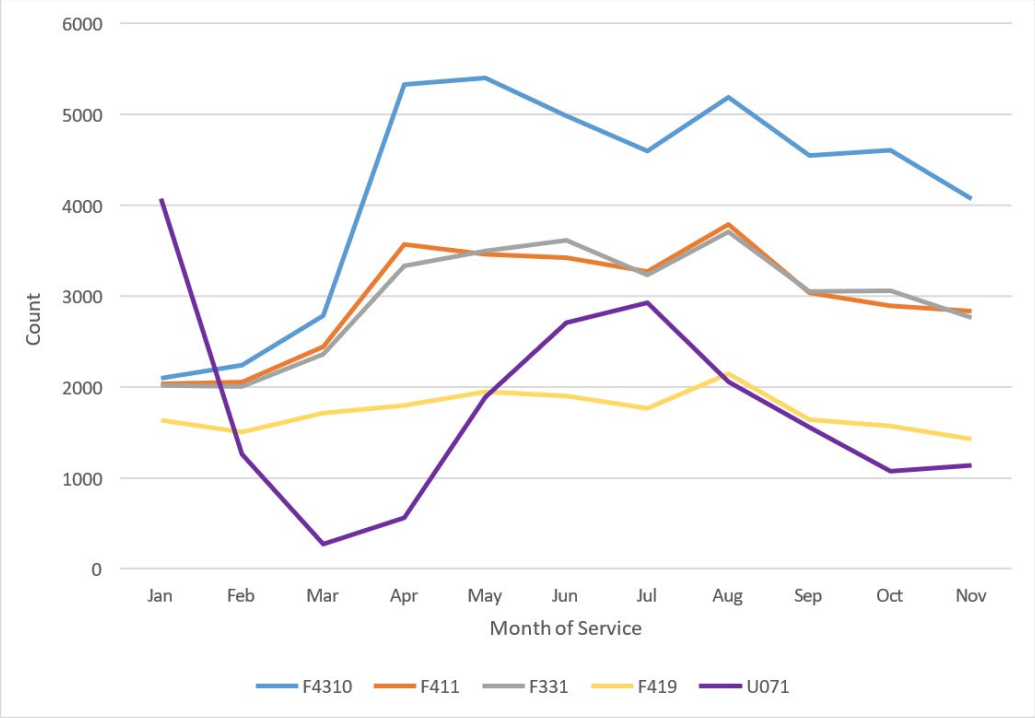
From January to November 2022, there were a total of 917,589 total audio-only telemedicine services generated across the evaluation population. Per month utilization ranged between 74,000-90,000 services without a clear trajectory of increase or decrease (*Figure 1*).

Figure 1. Audio-Only Telemedicine Services Over Time (Base Case)



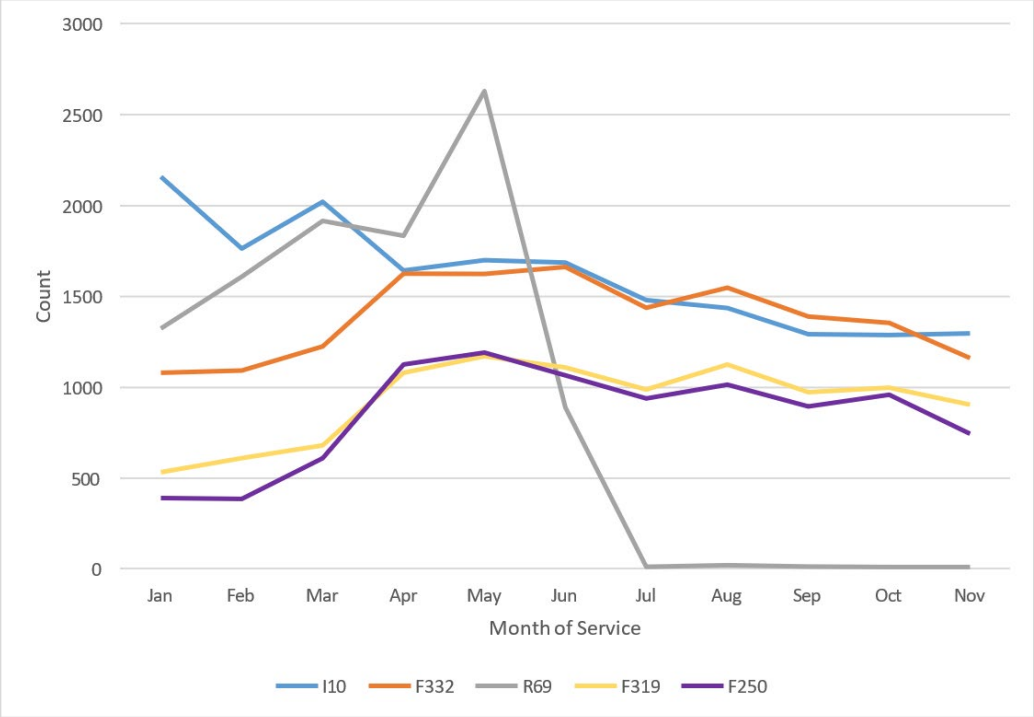
The five most common conditions for which audio-only telemedicine services were utilized were: post-traumatic stress disorder (PTSD; ICD-10 code F4310), generalized anxiety disorder (F411), major depressive disorder (F331), unspecified anxiety disorder (F419), and asymptomatic individuals who tested positive for COVID-19 (U071) (*Figure 2*). The sixth to tenth most common conditions are displayed in *Figure 3*.

Figure 2. Audio-Only Telemedicine Services Over Time, By Top Five Most Common Conditions (Base Case)



ICD-10	Condition
F4310	PTSD, unspecified
F411	Generalized anxiety disorder
F331	Major depressive disorder, recurrent, moderate
F419	Anxiety disorder, unspecified
U071	Asymptomatic individuals who test positive for COVID-19

Figure 3. Audio-Only Telemedicine Services Over Time, By Other Common Conditions (Base Case)



ICD-10	Condition
I10	Essential (primary) hypertension
F332	Major depressive disorder, recurrent severe without psychotic features
R69	Illness, unspecified
F319	Bipolar disorder, unspecified
F250	Schizoaffective disorder, bipolar type

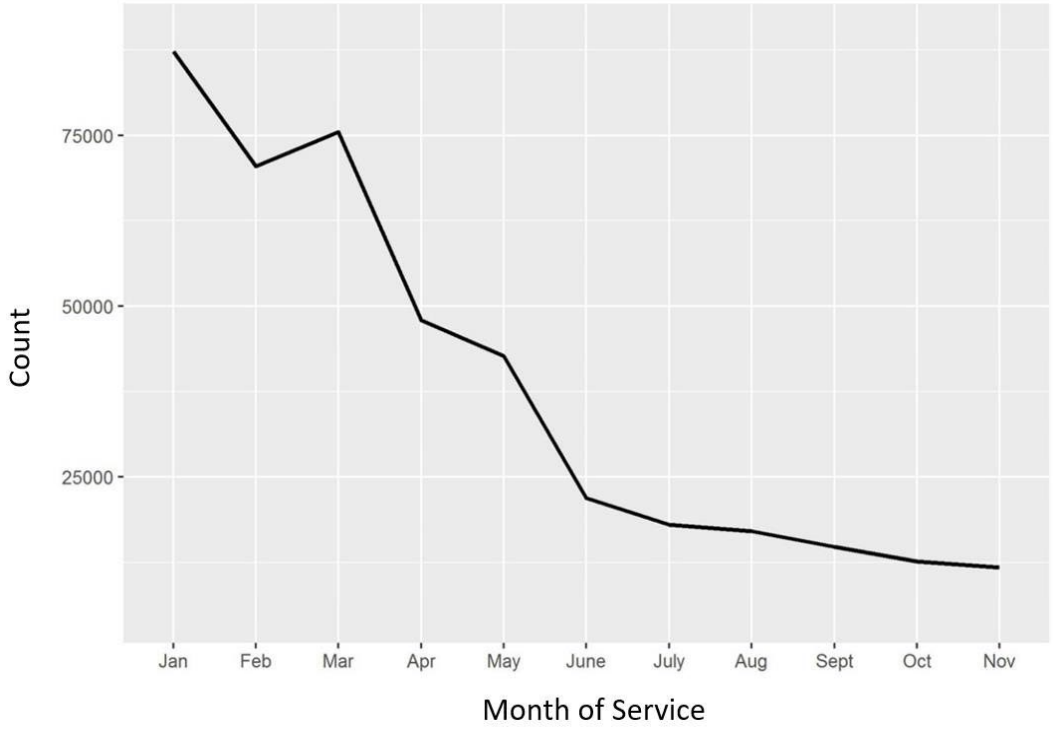
The five most common service types were telephone E/M codes 99441-99443, behavioral health counseling and therapy (H0004), and psychotherapy (90837) (*Table 4*).

Expanded Case

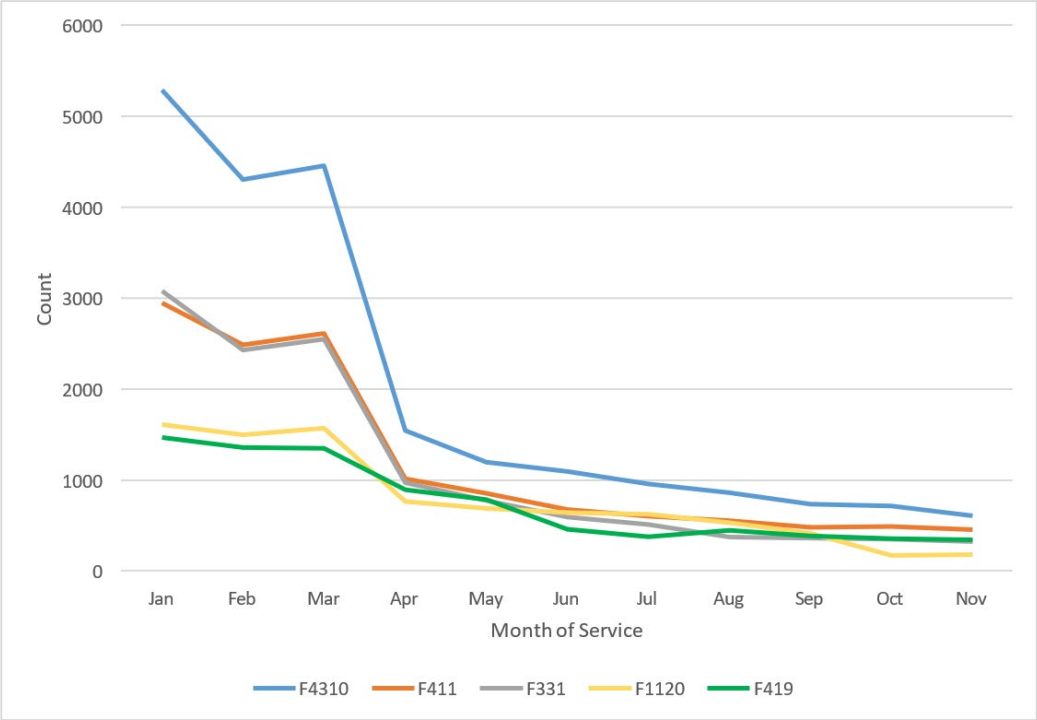
Over the evaluation period, there were a total of 420,119 audio-only telemedicine services. Services steadily decreased over time from 87,000 in January to 12,500 in November 2022 (*Figure 4*). The five most common conditions involving audio-only telemedicine services were PTSD (F4310), generalized anxiety disorder (F411), major depressive disorder (F331), opioid

dependence (F1120), and unspecified anxiety disorder (F419) (*Figure* 5). The five next most common conditions are displayed in *Figure 6.*

Figure 4. Audio-Only Telemedicine Services Over Time (Expanded Case)

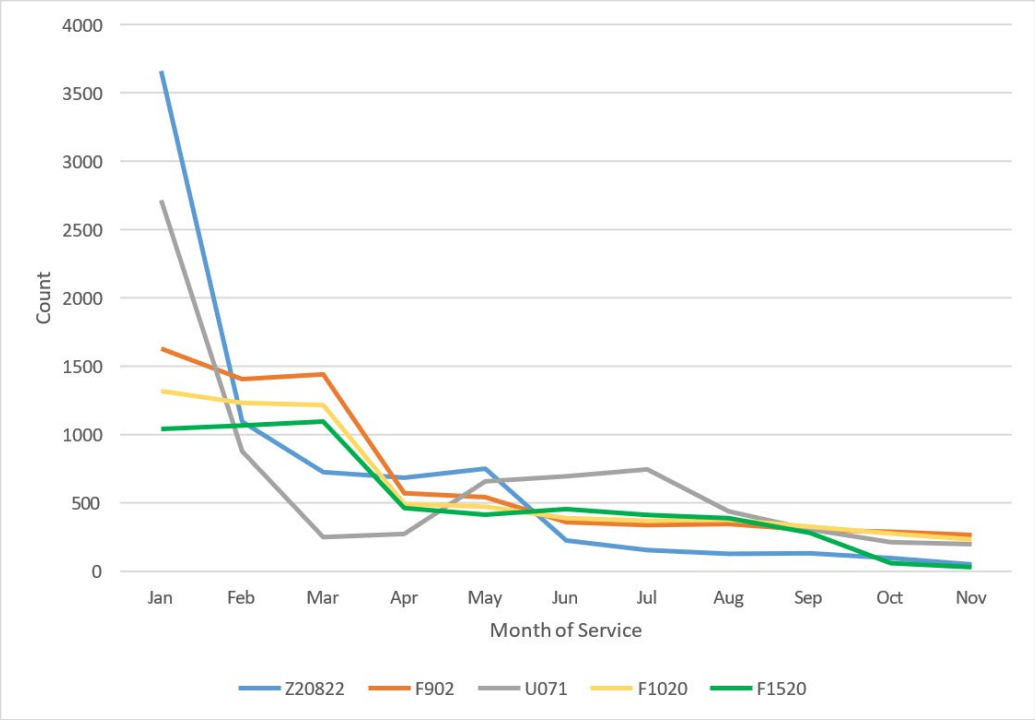


Figures 5. Audio-Only Telemedicine Services Over Time, By Top Five Most Common Conditions (Expanded Case)



ICD-10	Condition
F4310	PTSD, unspecified
F411	Generalized anxiety disorder
F331	Major depressive disorder, recurrent, moderate
F1120	Opioid dependence, uncomplicated
F419	Anxiety disorder, unspecified

Figure 6. Audio-Only Telemedicine Services Over Time, By Other Common Conditions (Expanded Case)



ICD-10	Condition
Z20822	Contact with and suspected exposure to COVID-19
F902	Attention-deficit hyperactivity disorder, combined type
U071	Asymptomatic individuals who test positive for COVID-19
F1020	Alcohol dependence, uncomplicated
F1520	Other stimulant dependence, uncomplicated

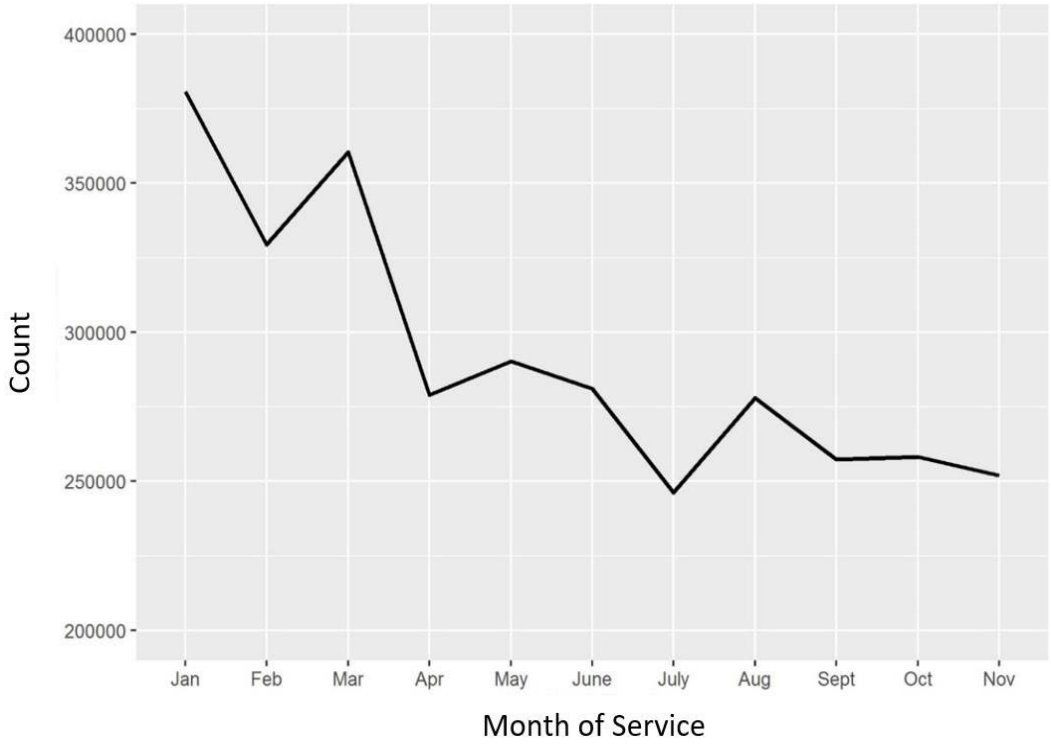
The five most common service types were E/M of an established patient (99213-99214), telehealth originating site facility fee (Q3014), psychotherapy (90837), and behavioral health counseling and therapy (H0004) (*Table 4*).

Max Case

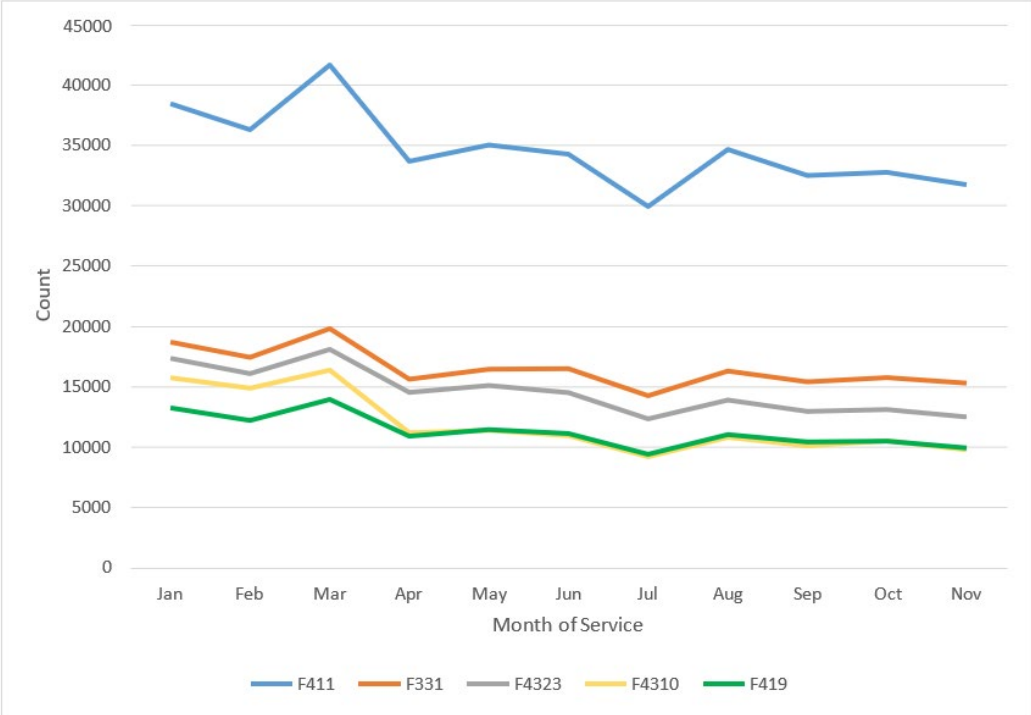
3.2 million total services were generated for audio-only telemedicine services defined according to the max case (specific CPT codes with the GT or 95 modifier). Monthly services decreased

from over 375,000 in January to 250,000 in November 2022 with brief spikes in March and August (*Figure 7*). The five most common conditions involving audio-only telemedicine services were generalized anxiety disorder (F411), major depressive disorder (F331), adjustment disorder (F4323), PTSD (F4310), and unspecified anxiety disorder (F419) (*Figure 8*). The five next most common conditions are displayed in *Figure 9*.

Figure 7. Audio-Only Telemedicine Services Over Time (Max Case)

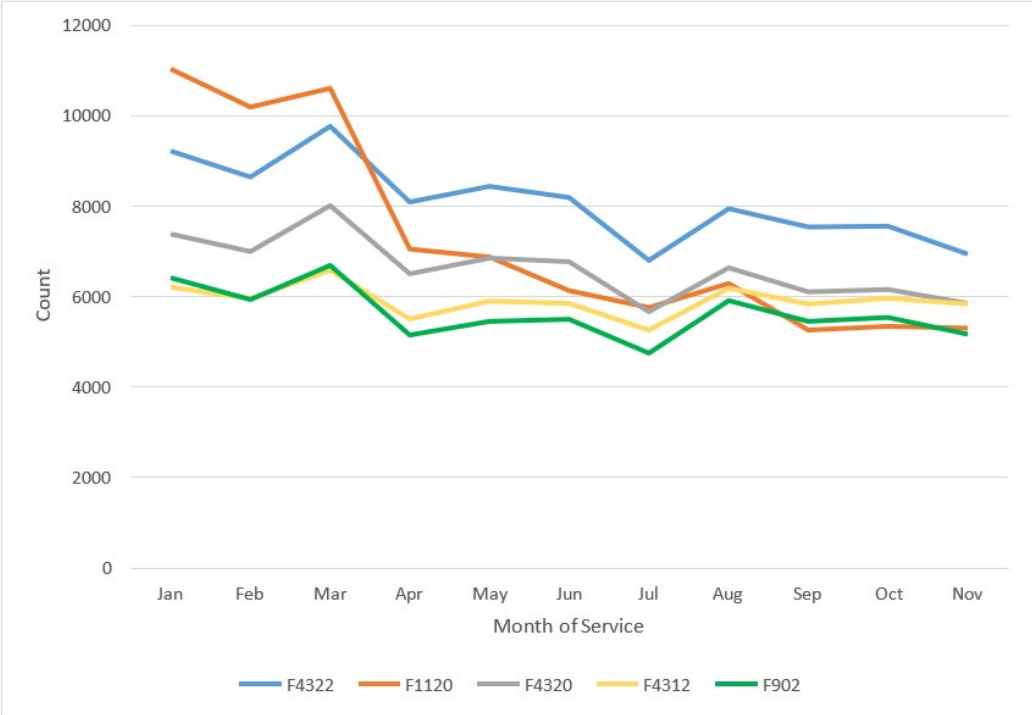


Figures 8. Audio-Only Telemedicine Services Over Time, By Top Five Most Common Conditions (Max Case)



ICD-10	Condition
F411	Generalized anxiety disorder
F331	Major depressive disorder, recurrent, moderate
F4323	Adjustment disorder (AD) with mixed anxiety and depressed mood
F4310	PTSD, unspecified
F419	Anxiety disorder, unspecified

Figure 9. Audio-Only Telemedicine Services Over Time, By Other Common Conditions (Max Case)



ICD-10	Condition
F4322	Adjustment disorder with anxiety
F1120	Opioid dependence, uncomplicated
F4320	Adjustment disorder, unspecified
F4312	Post-traumatic stress disorder, chronic
F902	Attention-deficit hyperactivity disorder, combined type

Psychotherapy (90834, 90837) and E/M services for established patients (99213-99215) were the five most common service types (*Table 4*).

Stratified Analyses

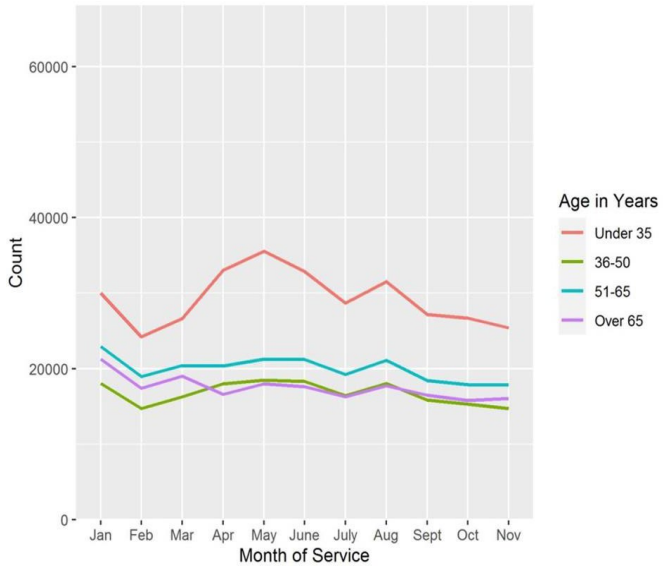
Beneficiary-Level Variables

Age. In the overall evaluation population, 50% of beneficiaries were less than or equal to 35

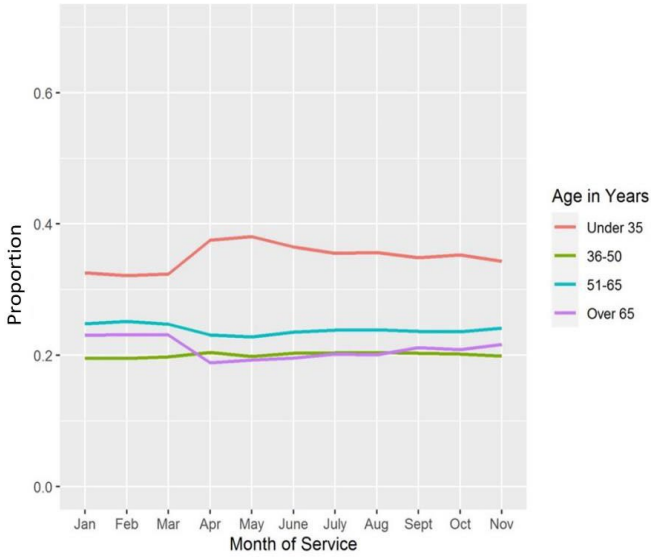
years of age. The proportion of audio-only telemedicine services under the base case received by this age group ranged from 33% in January to 34% in November 2022 (*Figure 10*). While beneficiaries over age 65 years represented 14% of the overall population, they represented 20-22% of audio-only telemedicine services under the base case.

Figure 10. Audio-Only Telemedicine Services Over Time, By Age (Base Case)

Panel A. Service Counts



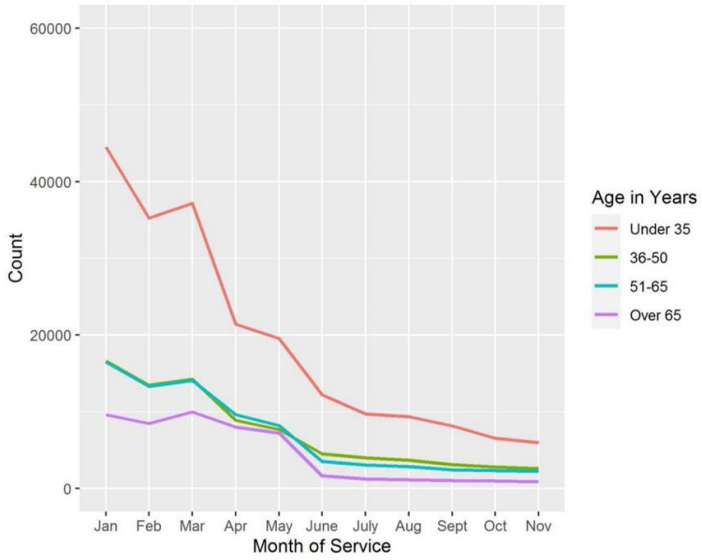
Panel B. Proportion of Services



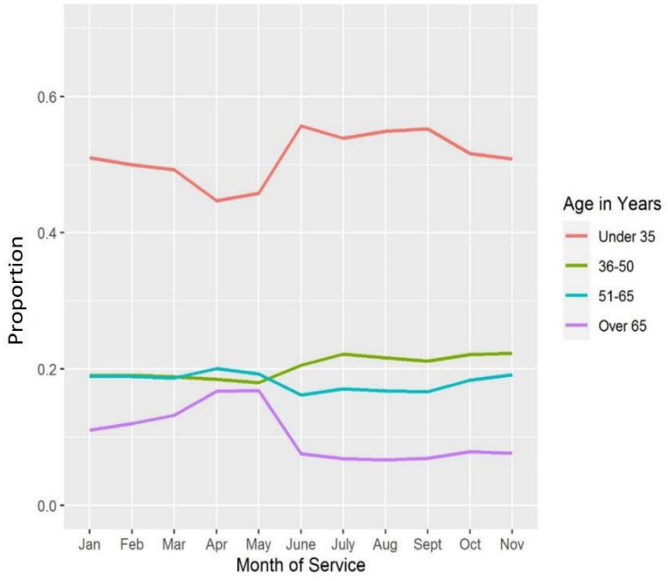
In comparison, under the expanded case, 51% of audio-only telemedicine services were received by beneficiaries less than or equal to 35 years of age, a proportion that remained relatively stable over the evaluation period (*Figure 11*). In turn, 11% of audio-only telemedicine services under the expanded case were received by beneficiaries over age 65 years.

Figure 11. Audio-Only Telemedicine Services Over Time, By Age (Expanded Case)

Panel A. Service Counts



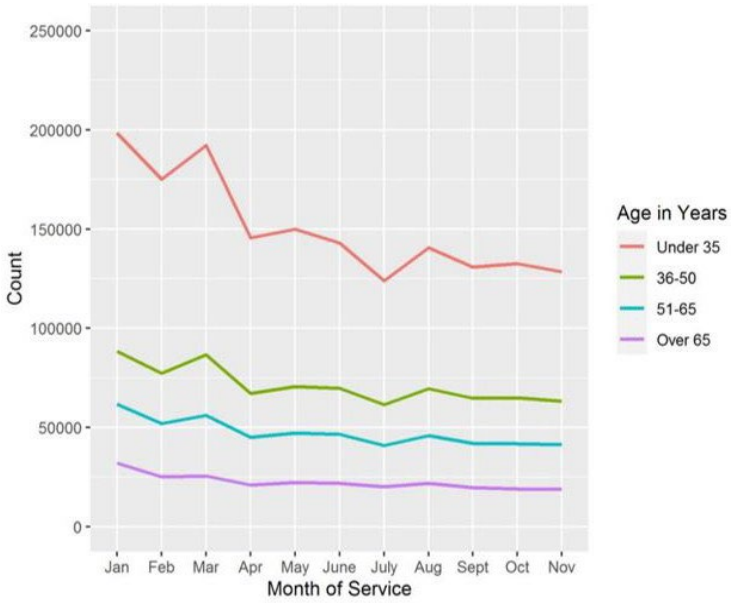
Panel B. Proportion of Services



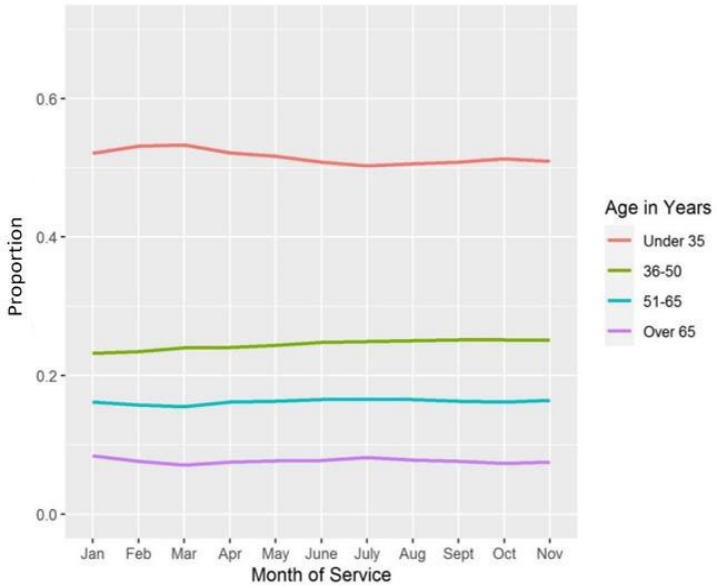
Under the max case, a stable proportion of services were received by beneficiaries 35 years old or younger (51-52%), a proportion that was comparable to that of the overall cohort (*Figure 12*). Under the max case, the proportion of services received by beneficiaries over age 65 years was low at approximately 7% across all months.

Figure 12. Audio-Only Telemedicine Services Over Time, By Age (Max Case)

Panel A. Service Counts



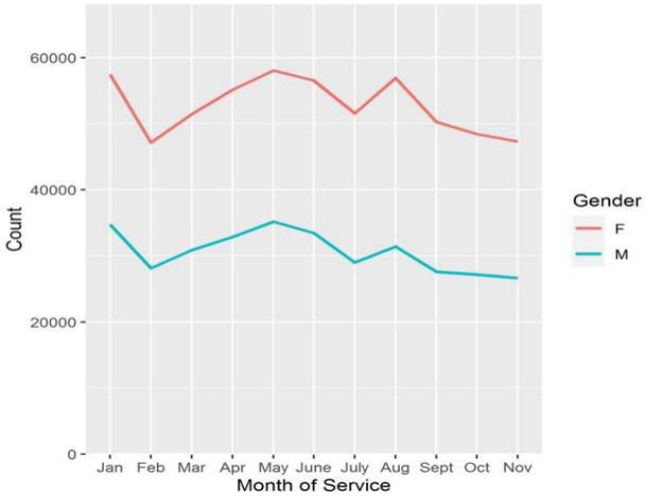
Panel B. Proportion of Services



Gender. Compared to the proportion of female individuals in the overall evaluation population (52%), the proportion of audio-only telemedicine services received by females (versus males) under the base case ranged from 62 to 64%, which was largely stable over the evaluation period (*Figure 13)*. The proportion of audio-only telemedicine services received by females under the expanded case was 59-62% (*Figure 14*). The proportion of audio-only telemedicine services received by females under the max case increased slightly from 66% in January 2022 to 69% in November 2022 (*Figure 15*).

Figure 13. Audio-Only Telemedicine Services Over Time, By Gender (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

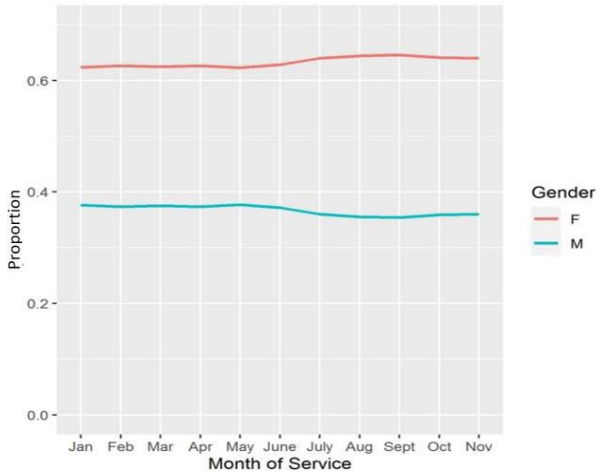
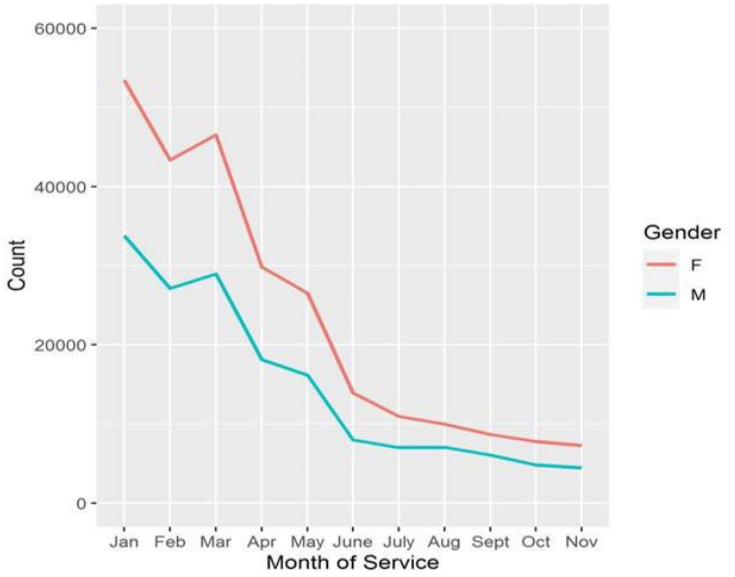


Figure 14. Audio-Only Telemedicine Services Over Time, By Gender (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

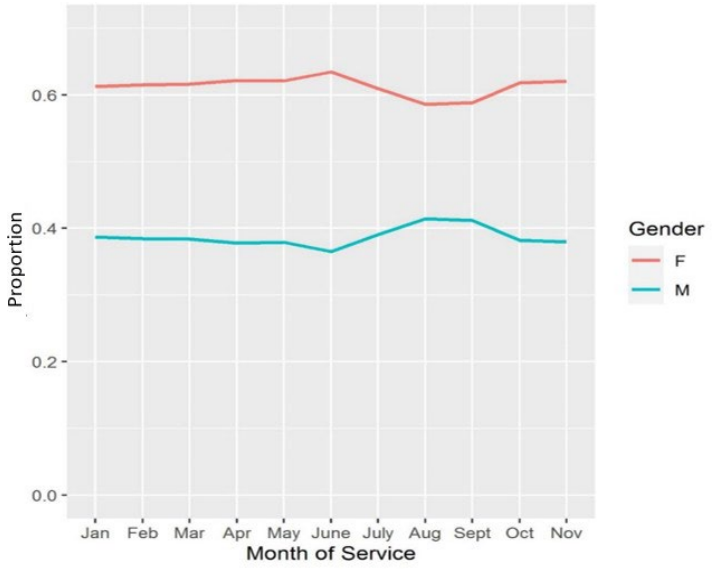
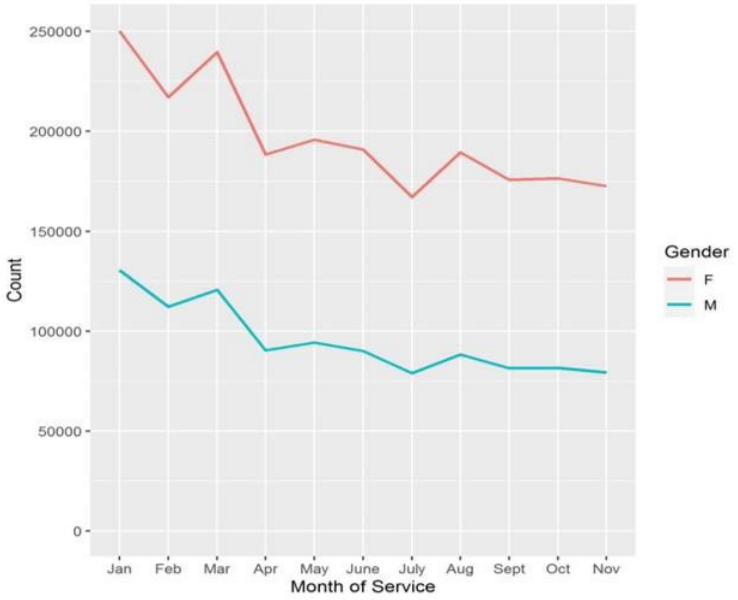
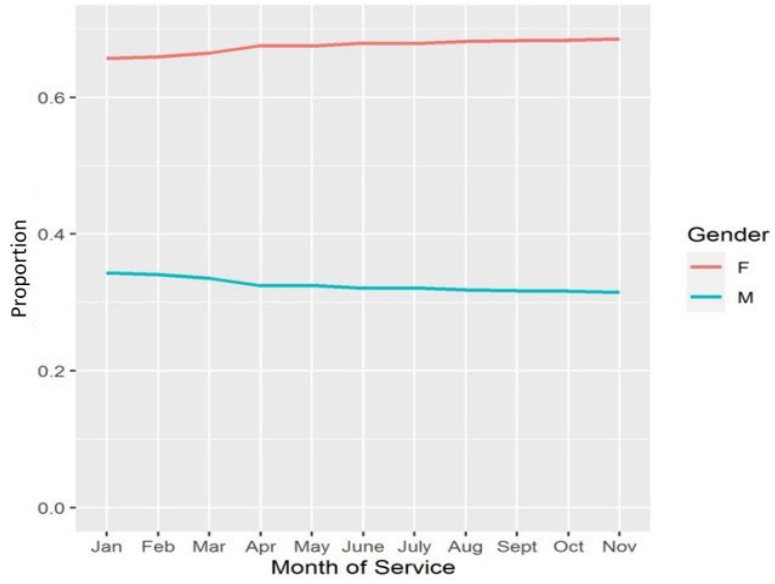


Figure 15. Audio-Only Telemedicine Services Over Time, By Gender (Max Case)

Panel A. Service Counts



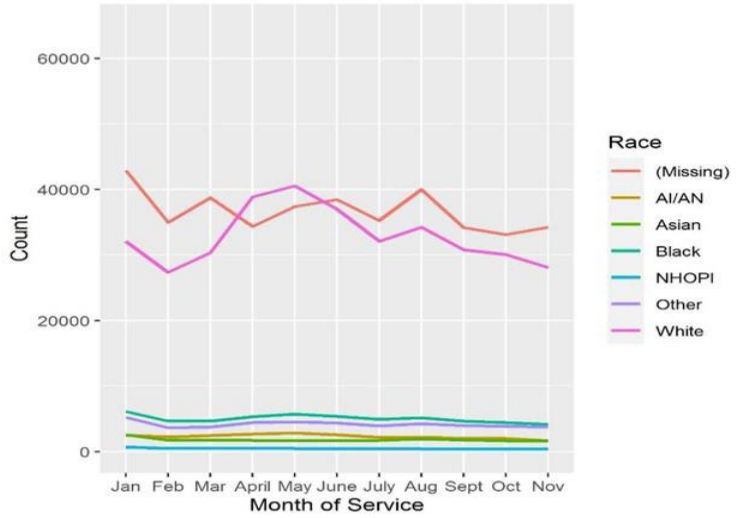
Panel B. Proportion of Services



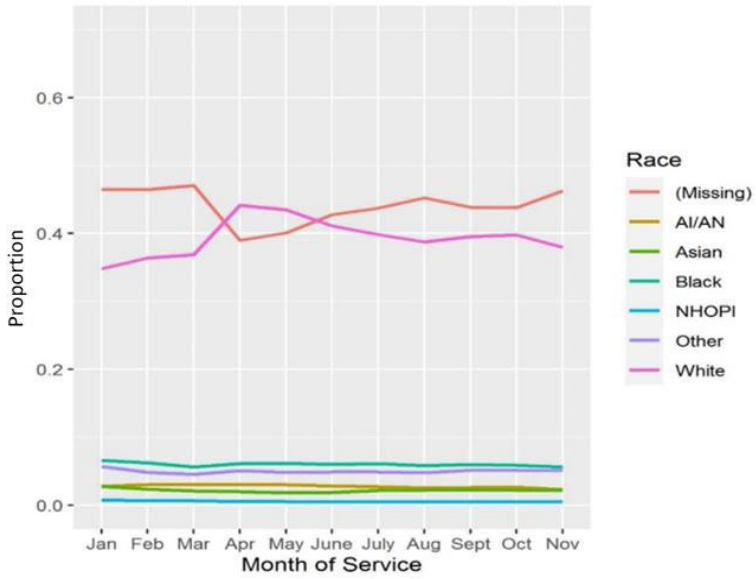
Race. Over half (54%) of the overall evaluation population had missing race data. White beneficiaries comprised 30% of the overall evaluation population. In comparison, under the base case, White beneficiaries received 35-44% of audio-only telemedicine services under the base case while other racial groups received less than 7% (*Figure 16*).

Figure 16. Audio-Only Telemedicine Services Over Time, By Race (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

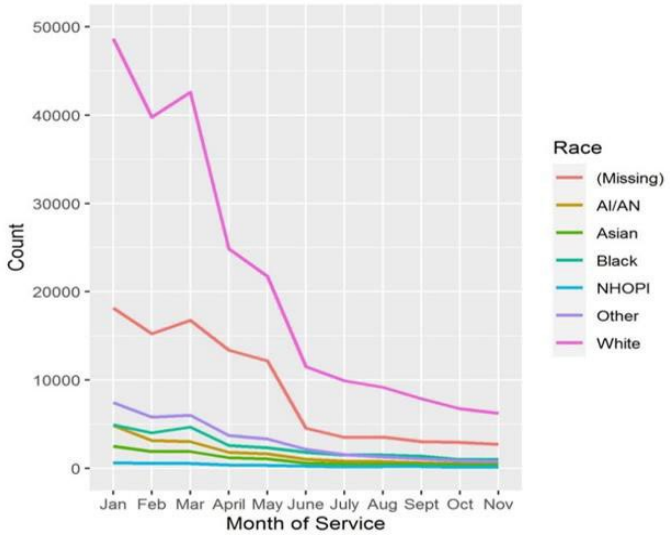


AI/AN=American Indian/Alaska Native, NHOPI=Native Hawaiian or Pacific Islander

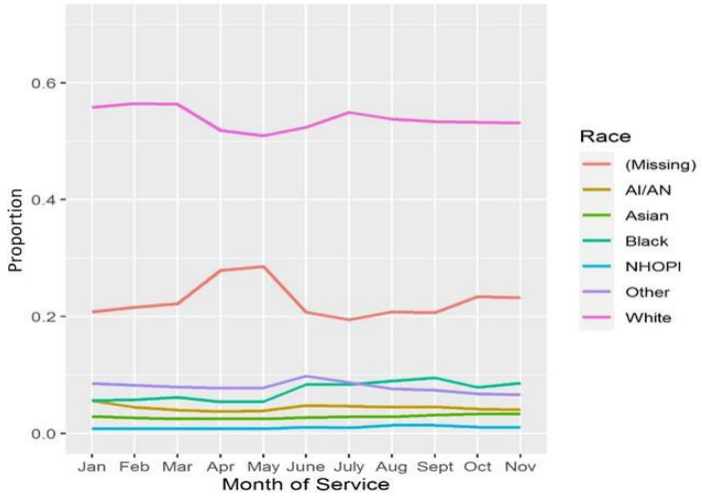
Under the expanded case, the proportion of audio-only telemedicine services received by White beneficiaries was 51-56% (*Figure 17*). The proportions were lower for beneficiaries identified as "Other" (7-10% across the evaluation period), Black (6-10% across the evaluation period), and American Indian/Alaska Native (AI/AN; 4-6% across the evaluation period). The proportion of audio-only telemedicine services with missing race was 19-29% across the evaluation period.

Figure 17. Audio-Only Telemedicine Services Over Time, By Race (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

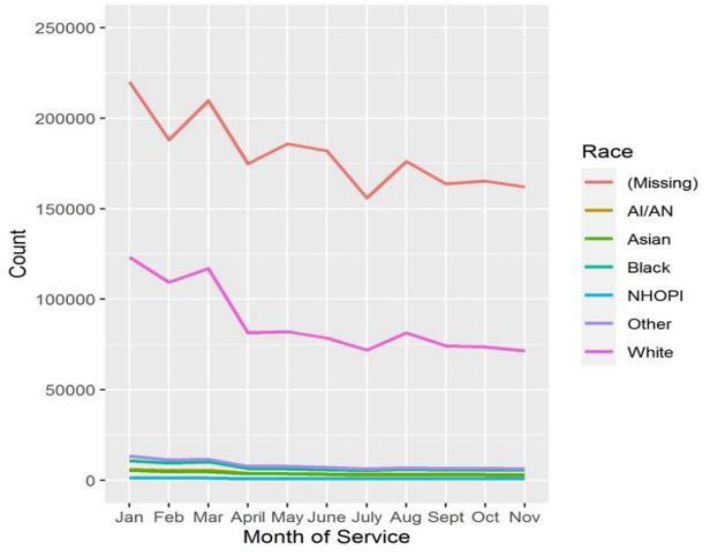


AI/AN=American Indian/Alaska Native, NHOPI=Native Hawaiian or Pacific Islander

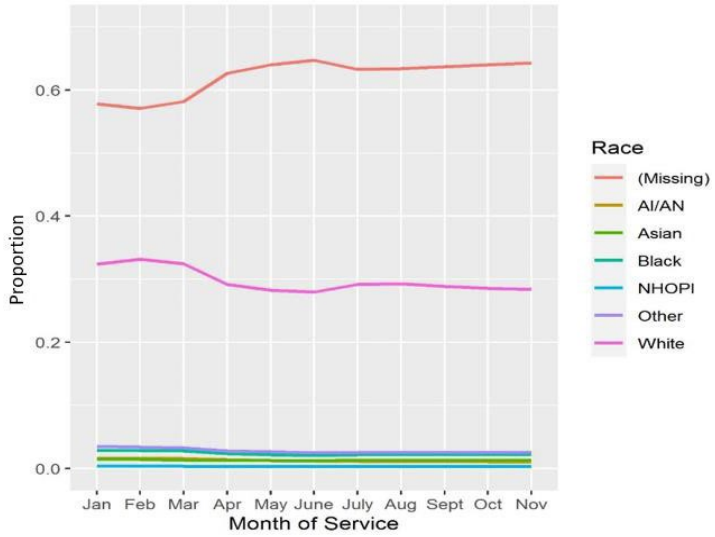
Under the max case, White beneficiaries represented 28-33% of all audio-only telemedicine services (*Figure 18*). The proportions for beneficiaries identifying as Black, Asian, AI/AN, and "Other" races were 2-3%, 1%, 1-2%, and 3-4%, respectively. Race was missing in 57-65% of audio-only telemedicine services identified under the max case.

Figure 18. Audio-Only Telemedicine Services Over Time, By Race (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services

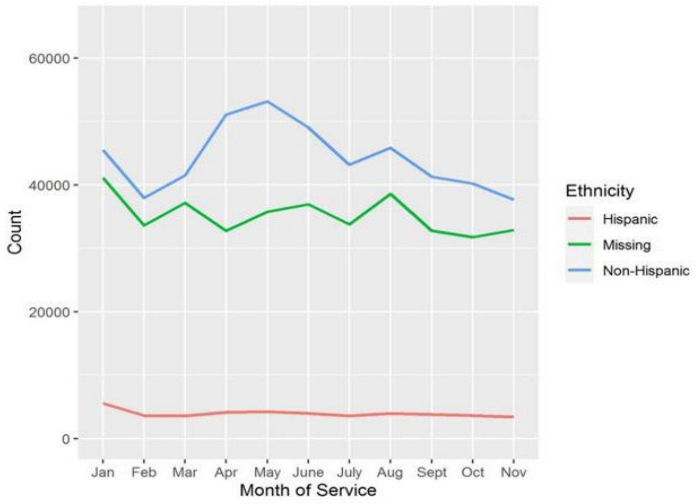


AI/AN=American Indian/Alaska Native, NHOPI=Native Hawaiian or Pacific Islander

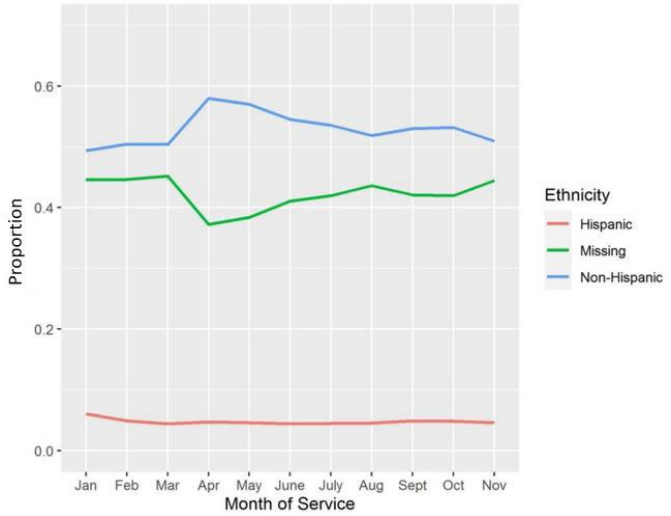
Ethnicity. Half (50%) of the overall evaluation population had missing ethnicity data. Under the base case, the proportion of audio-only telemedicine services received by Hispanic beneficiaries was stable over the evaluation period at a level (4-6%) that was slightly lower than the proportion observed in the evaluation population (7%) (*Figure 19*). In comparison, the proportion of audio-only telemedicine services received by non-Hispanic beneficiaries ranged from 49-58%, without clear trend over time.

Figure 19. Audio-Only Telemedicine Services Over Time, By Ethnicity (Base Case)

Panel A. Service Counts



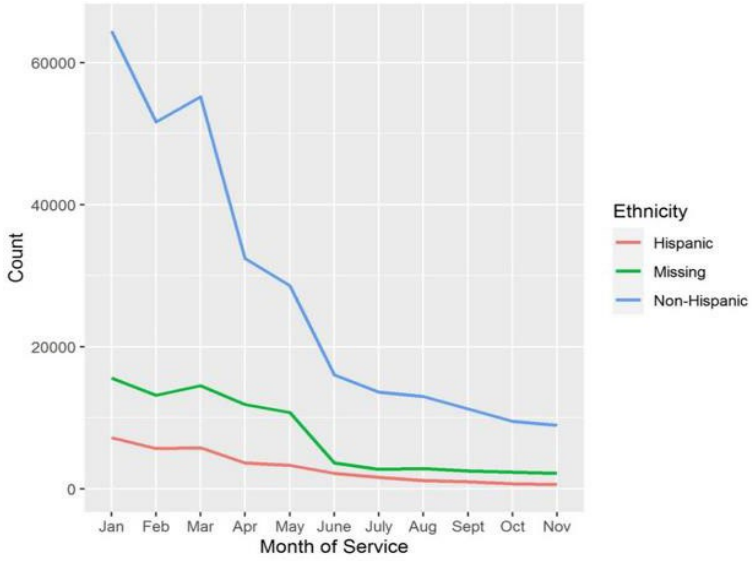
Panel B. Proportion of Services



Under the expanded case, the proportion of audio-only telemedicine received by Hispanic beneficiaries ranged from 5-10% without clear trend (*Figure 20*), and under the max case, ranged from 2-3% (*Figure 21*). The proportion of services with missing ethnicity data ranged from 15-25% under the expanded case and 54-61% under the max case.

Figure 20. Audio-Only Telemedicine Services Over Time, By Ethnicity (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

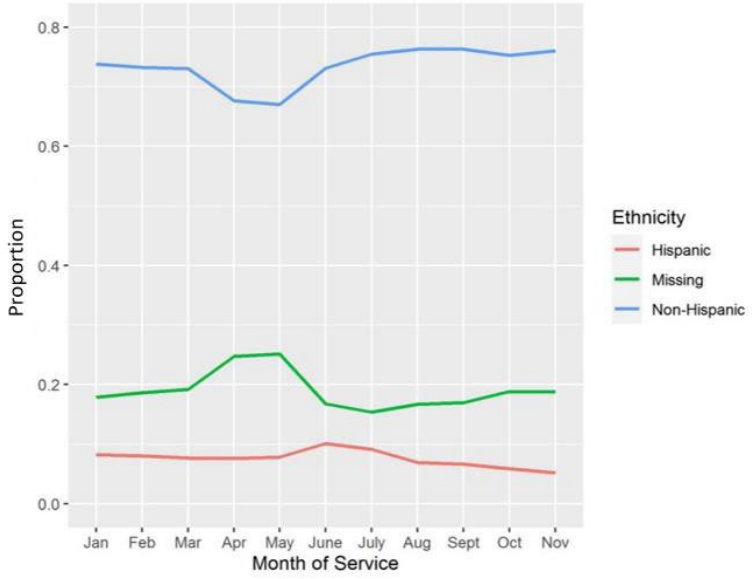
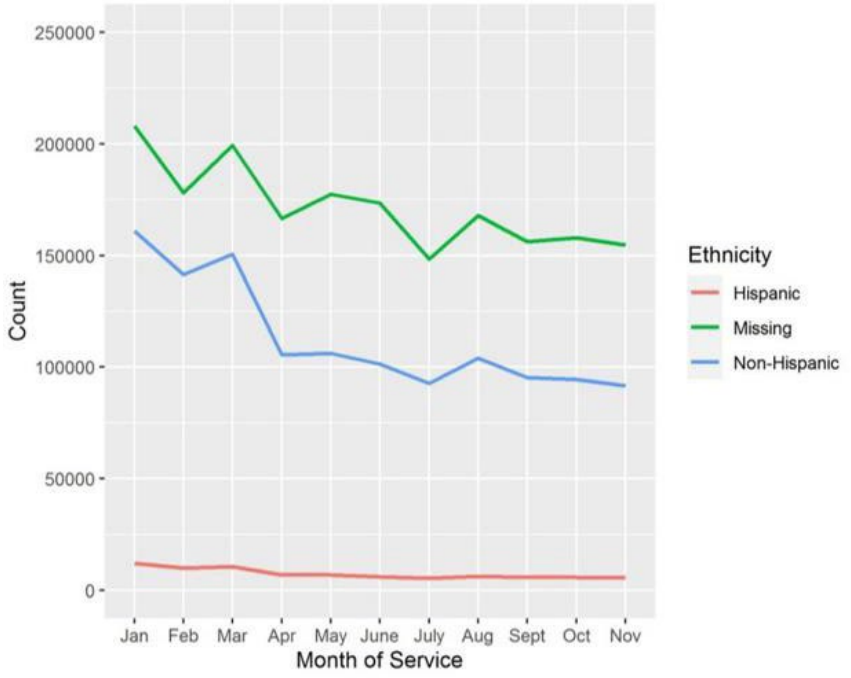
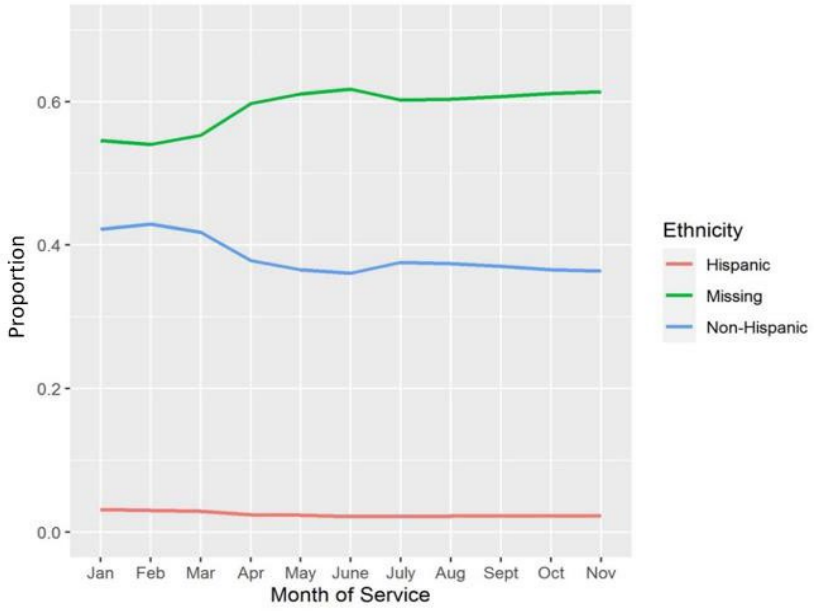


Figure 21. Audio-Only Telemedicine Services Over Time, By Ethnicity (Max Case)

Panel A. Service Counts



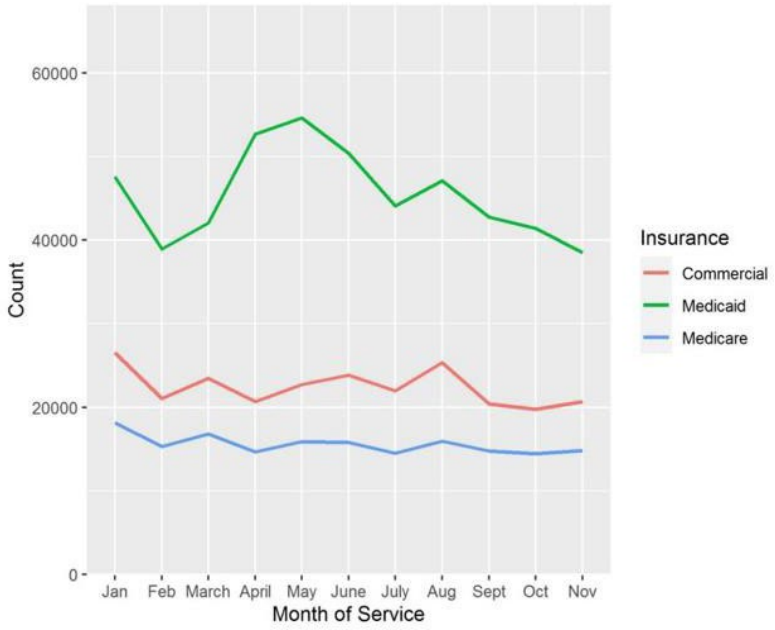
Panel B. Proportion of Services



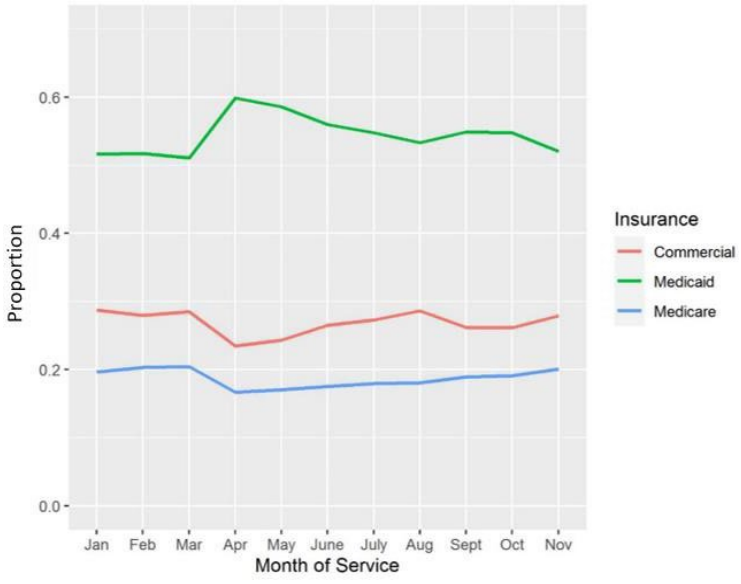
Payer Type. In the overall evaluation population, 44% of beneficiaries were insured by Medicaid. Under the base case, 52-60% of audio-only telemedicine services were received by Medicaid beneficiaries. Medicare beneficiaries received 11% of audio-only telemedicine services, and commercially insured beneficiaries received 23-29% of services (*Figure 22*).

Figure 22. Audio-Only Telemedicine Services Over Time, By Payer Type (Base Case)

Panel A. Service Counts



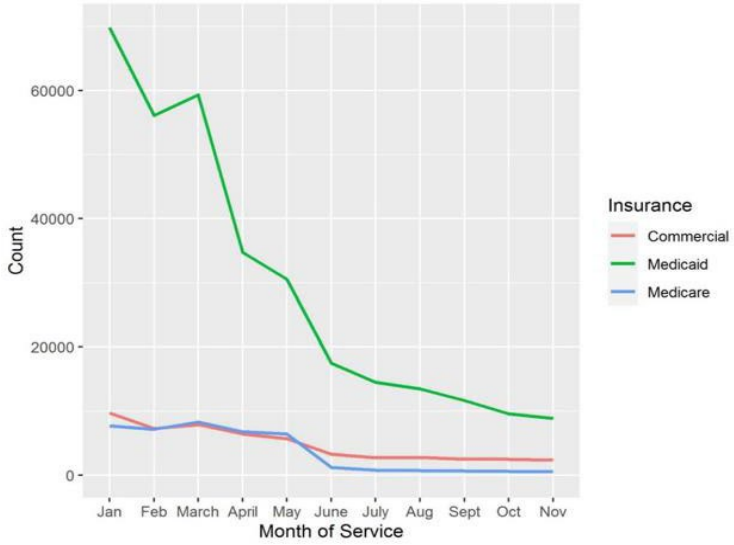
Panel B. Proportion of Services



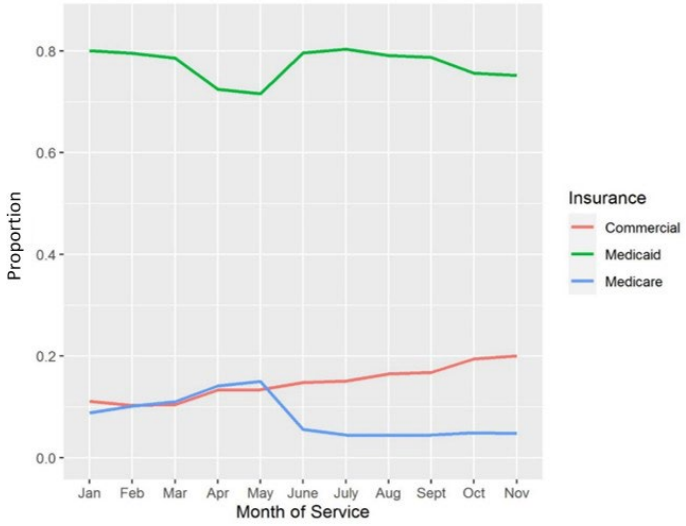
Under the expanded case, Medicaid beneficiaries received 72-80% of audio-only telemedicine services, without clear trend over time. Medicare beneficiaries received 9% of audio-only telemedicine services in January 2022, which increased to 15% in May 2022, before declining to 5% in November. For commercially insured beneficiaries, their proportion of audio-only telemedicine services increased from 4% in January 2022 to 15% in November 2022 (*Figure 23*).

Figure 23. Audio-Only Telemedicine Services Over Time, By Payer Type (Expanded Case)

Panel A. Service Counts



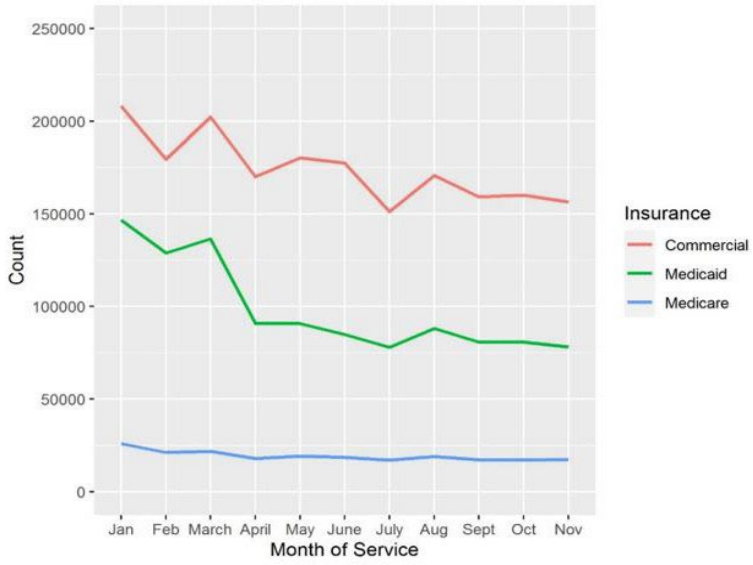
Panel B. Proportion of Services



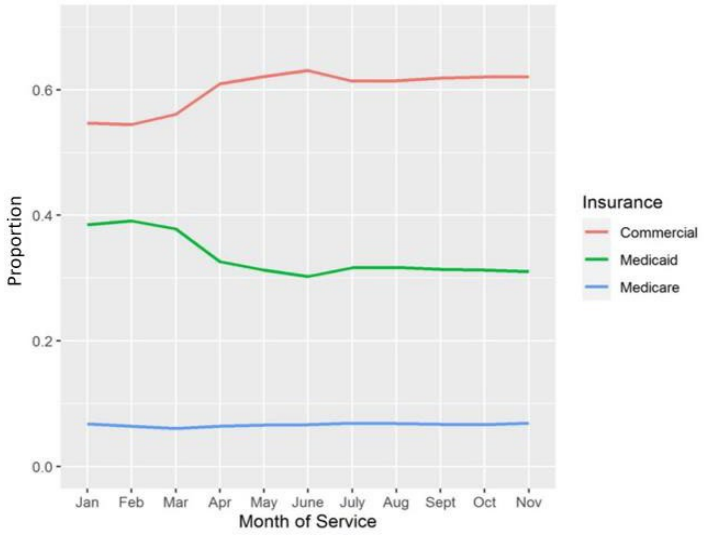
Under the max case, the proportion of audio-only telemedicine services received by Medicaid beneficiaries decreased from 39% in January 2022 to 31% in November 2022. For Medicare, the trend was stable at 6-7% of services. Utilization was high among commercially insured beneficiaries, with these beneficiaries receiving 55% of audio-only telemedicine services in January 2022 and increasing to 62% in November 2022 (*Figure 24*).

Figure 24. Audio-Only Telemedicine Services Over Time, By Payer Type (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services



County. Under the base case, audio-only telemedicine services per 1,000 beneficiaries varied by county. In particular, services per 1,000 beneficiaries ranged from a low of 55 in Columbia County to a high of 561 in Cowlitz County, with a mean of 177 (*Figure 25*). There was also variation in services per 1,000 beneficiaries under the expanded and max cases: from 14 in Asotin County to 379 in Whatcom County with a mean of 101 under the former (*Figure 26*); and from 170 in Adams County to 1092 in Skamania County with a mean of 542 under the latter (*Figure 27*).

Figure 25. Audio-Only Telemedicine Services Per 1,000 Beneficiaries, By County (Base Case)

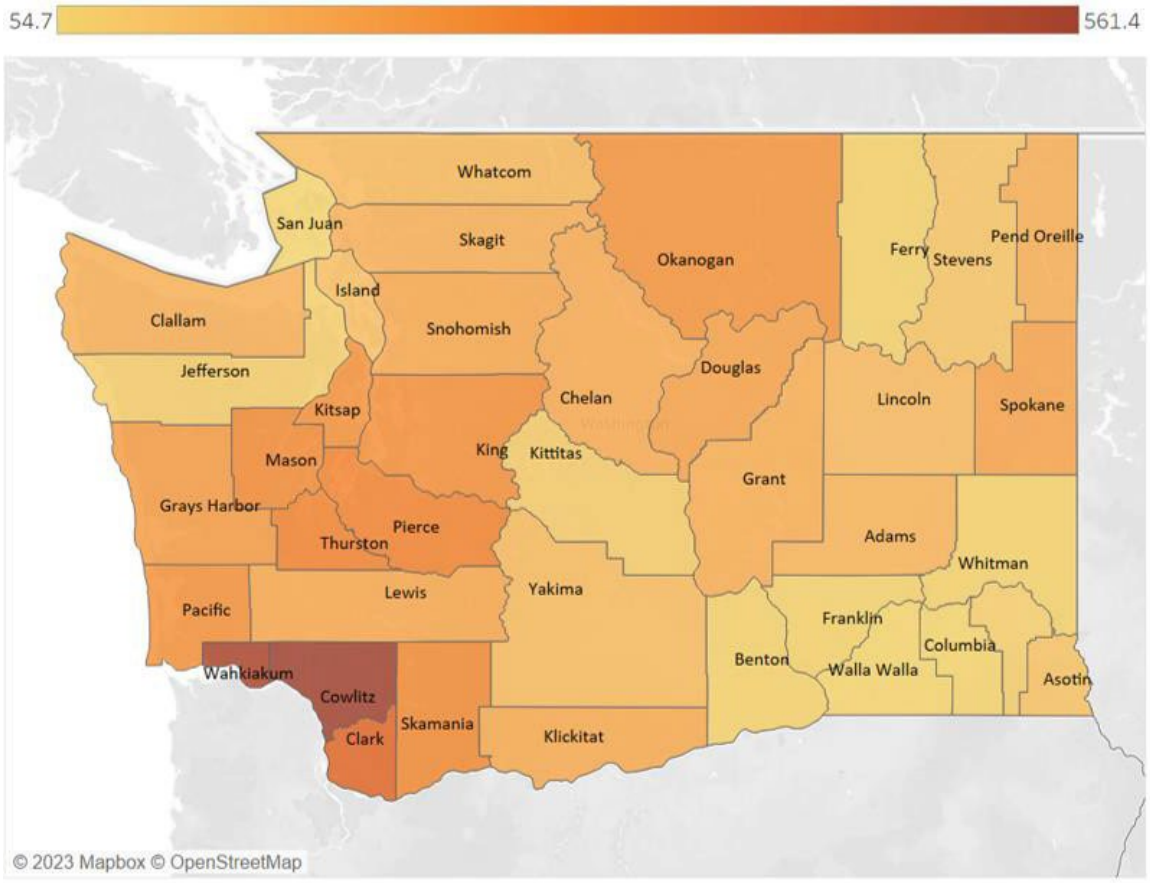


Figure 26. Audio-Only Telemedicine Services Per 1,000 Beneficiaries, By County (Expanded Case)

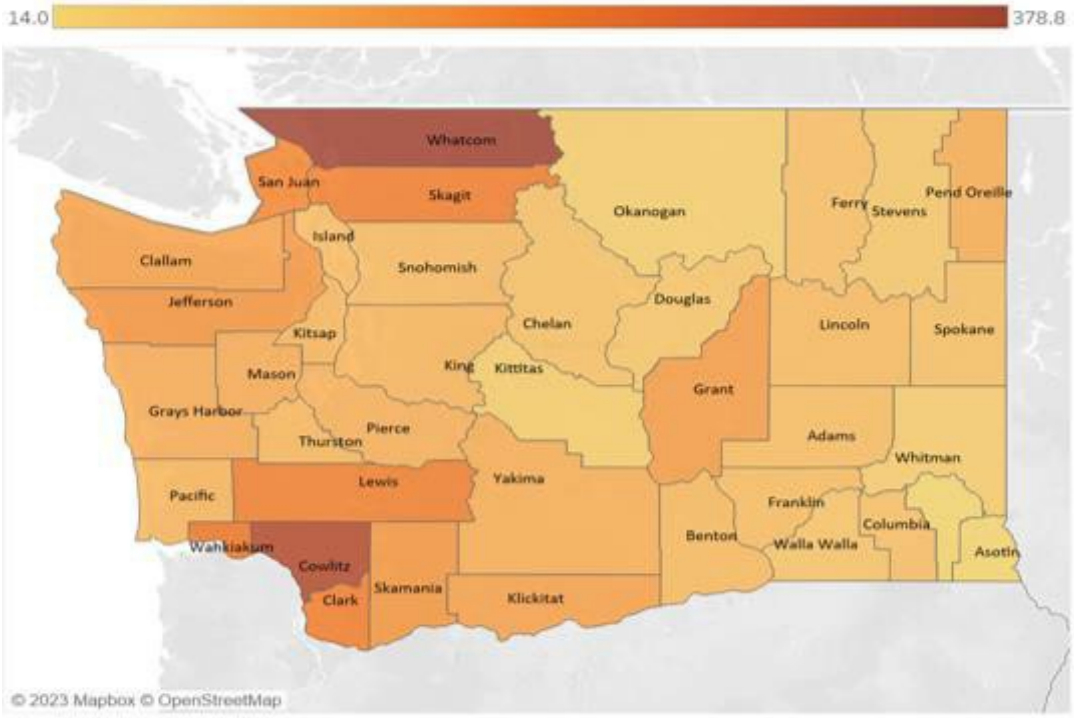
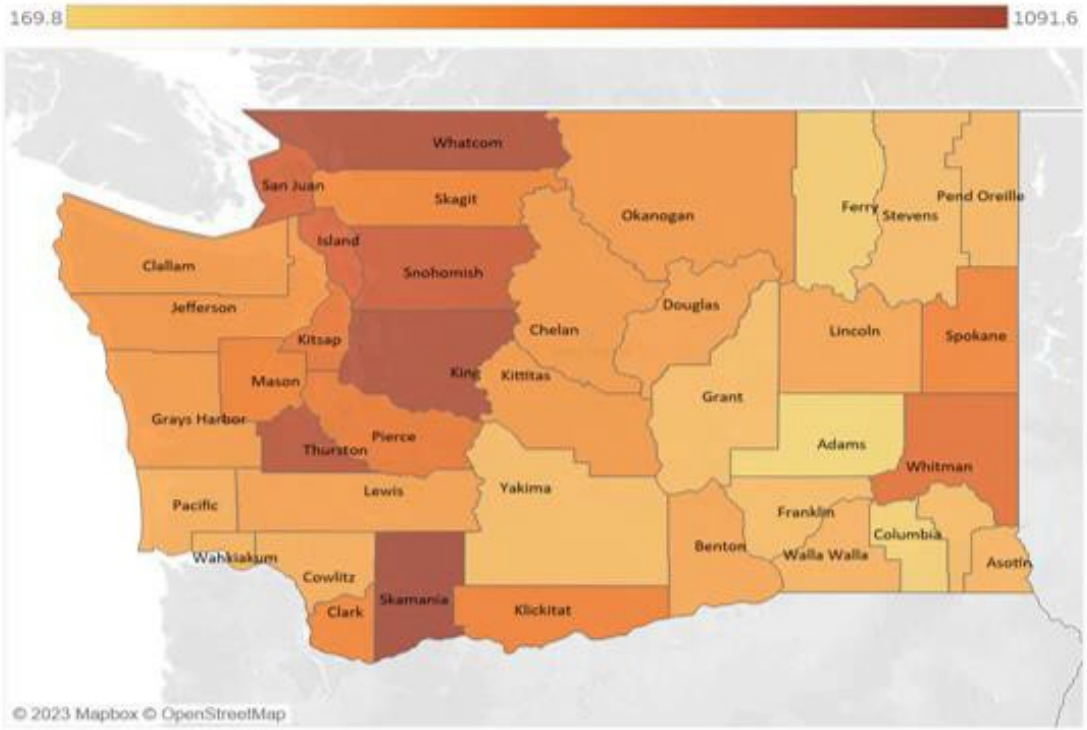


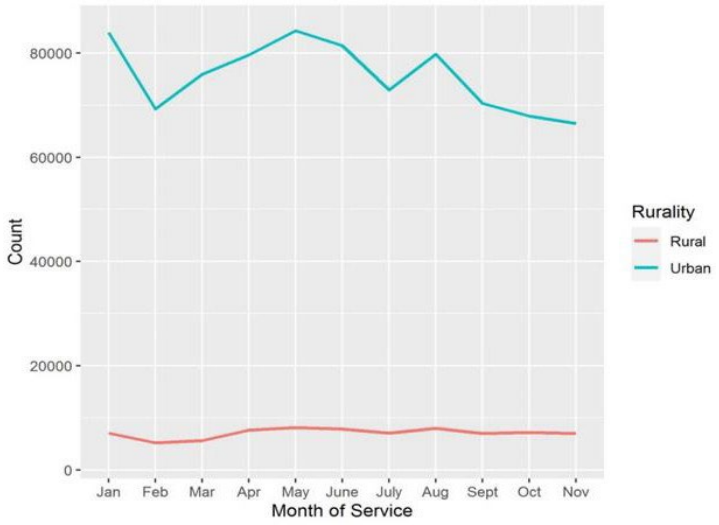
Figure 27. Audio-Only Telemedicine Services Per 1,000 Beneficiaries, By County (Max Case)



Beneficiary Rurality. The proportion of audio-only telemedicine services received by urban-dwelling beneficiaries under the base case was stable over time at 90-93%, which was slightly higher than their representation in the overall evaluation population (87%) (*Figure 28*). The proportion of audio-only telemedicine services received by beneficiaries residing in rural areas under the expanded and max cases was 83-88% (*Figure 29*) and 92% (*Figure 30*), respectively.

Figure 28. Audio-Only Telemedicine Services Over Time, By Beneficiary Rurality (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

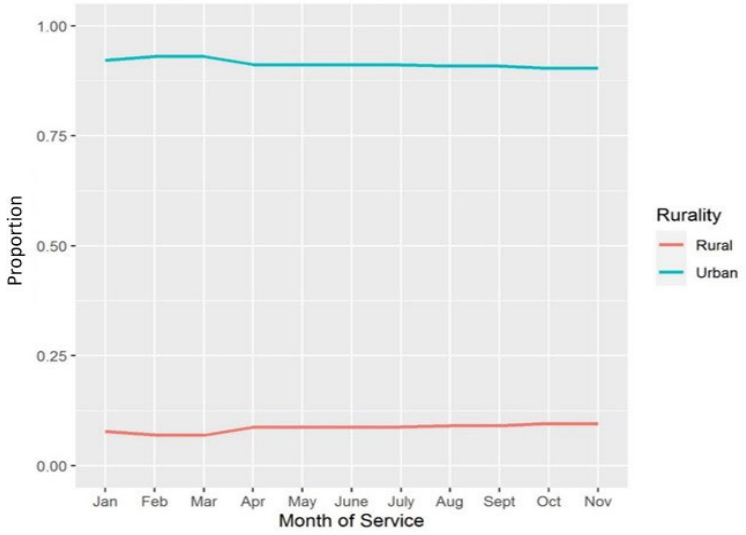
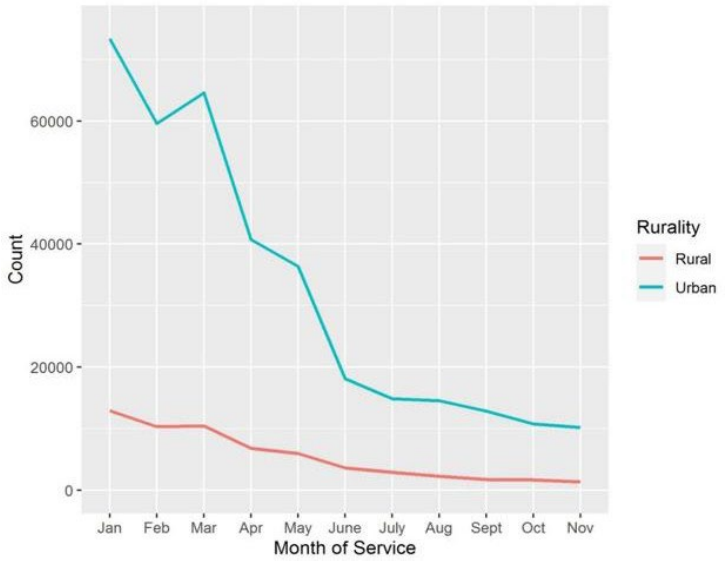


Figure 29. Audio-Only Telemedicine Services Over Time, By Beneficiary Rurality (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

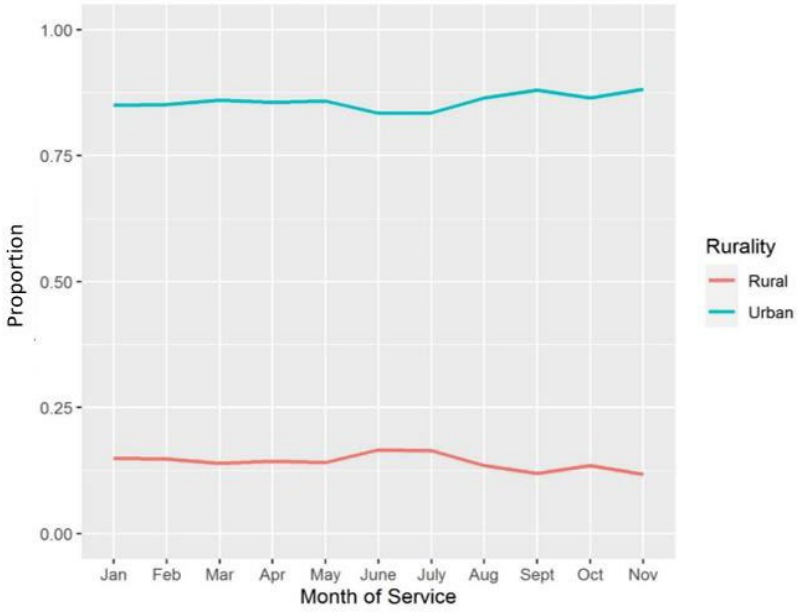
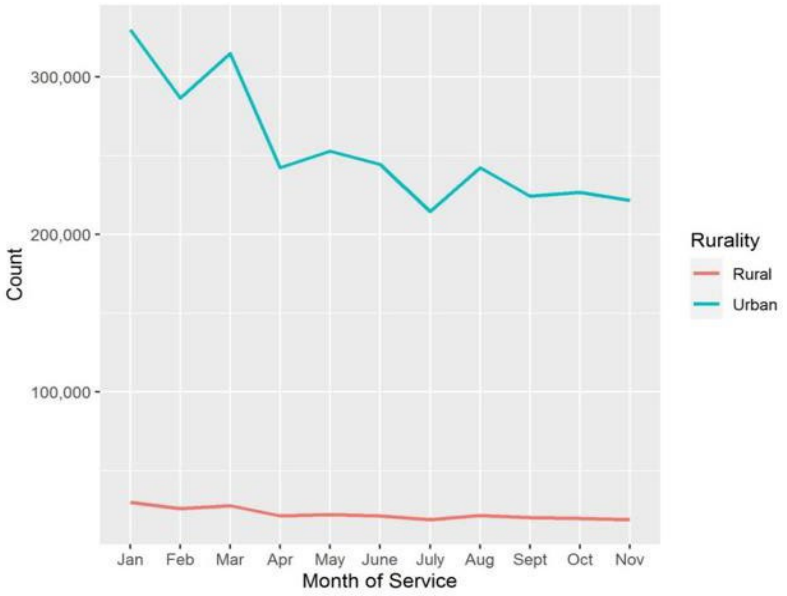
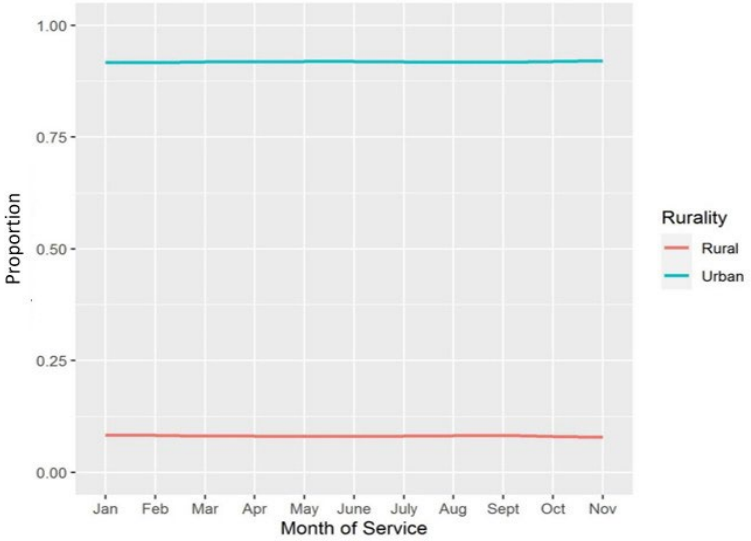


Figure 30. Audio-Only Telemedicine Services Over Time, By Beneficiary Rurality (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services

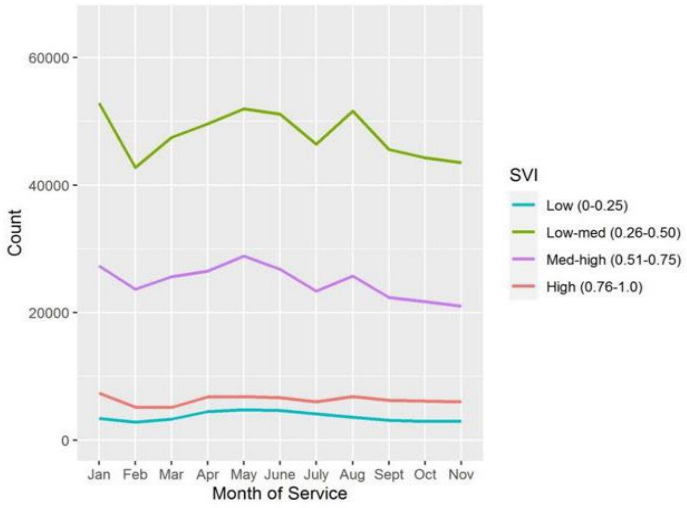


SVI. The majority of the overall evaluation population (54%) resided in areas with an SVI score in the low-medium quartile of national SVI. Under the base case, beneficiaries residing in low-medium SVI quartile areas received 56-59% of audio-only telemedicine services (*Figure 31*).

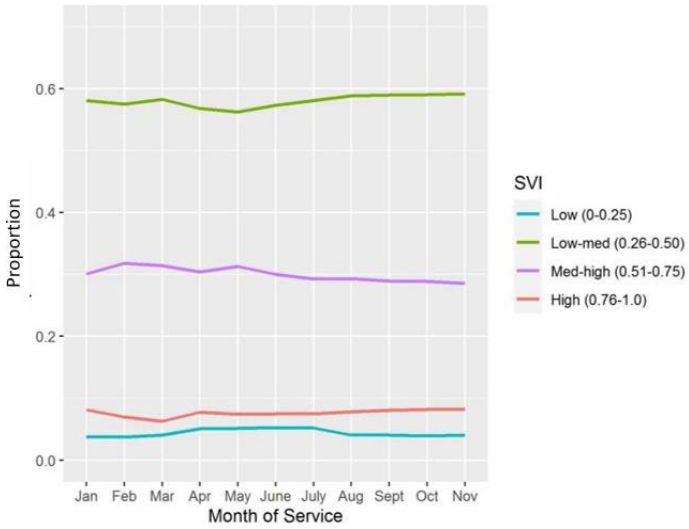
Correspondingly, beneficiaries residing in low, medium-high, and high SVI quartiles received 4-5%, 29-32% and 6-8% of all audio-only telemedicine services, respectively. These beneficiaries represented 6%, 29% and 12% of the evaluation population, respectively. Trends in the proportion of services were stable over time across all SVI quartiles.

Figure 31. Audio-Only Telemedicine Services Over Time, By SVI (Base Case)

Panel A. Service Counts



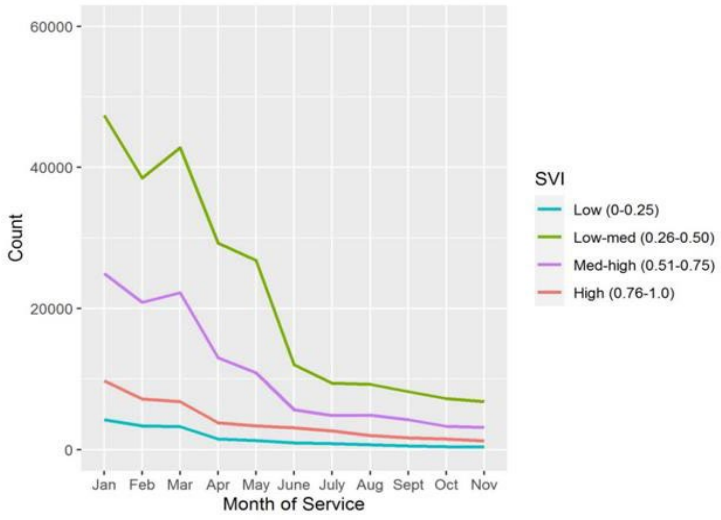
Panel B. Proportion of Services



Under the expanded case, the proportion of audio-only telemedicine services received by beneficiaries in the low, low-medium, medium-high, and high SVI quartiles ranged from 3-5%, 55-63%, 26-30%, and 8-15%, respectively (*Figure 32*). Under the max case, the proportion of services received by beneficiaries in the low, low-medium, medium-high, and high SVI quartiles was 5%, 64-68%, 22-24%, and 5-7%, respectively (*Figure 33*). Trends in these proportions were largely stable over time.

Figure 32. Audio-Only Telemedicine Services Over Time, By SVI (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

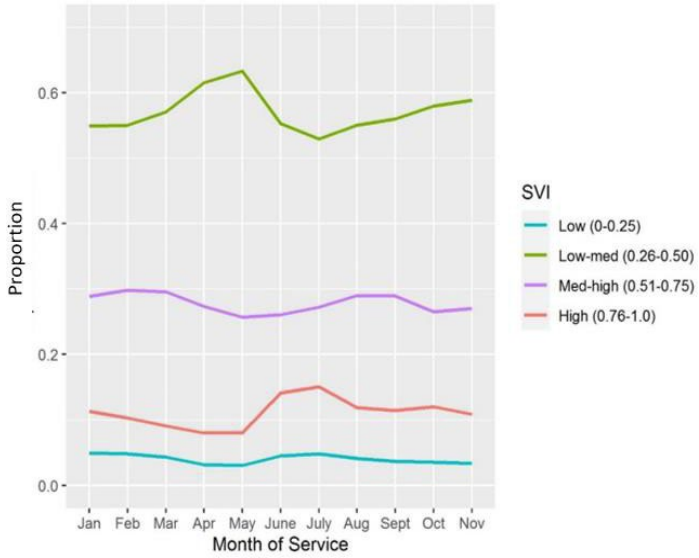
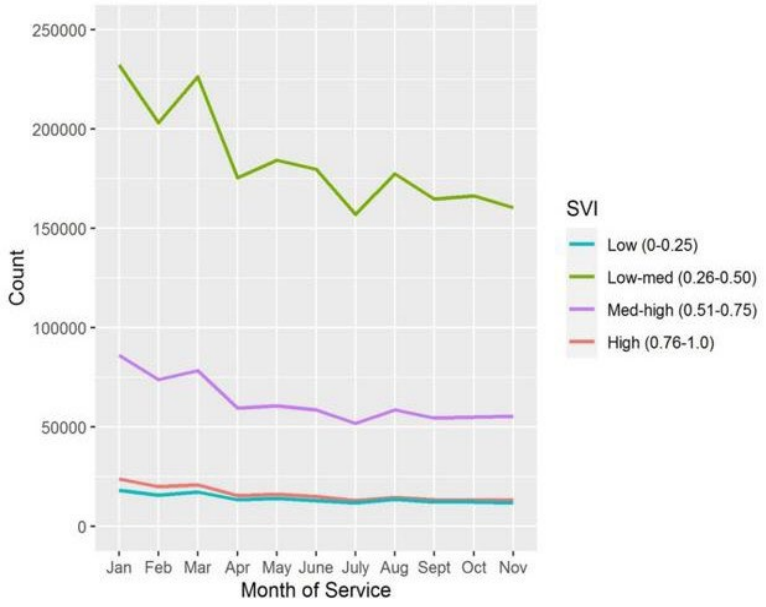
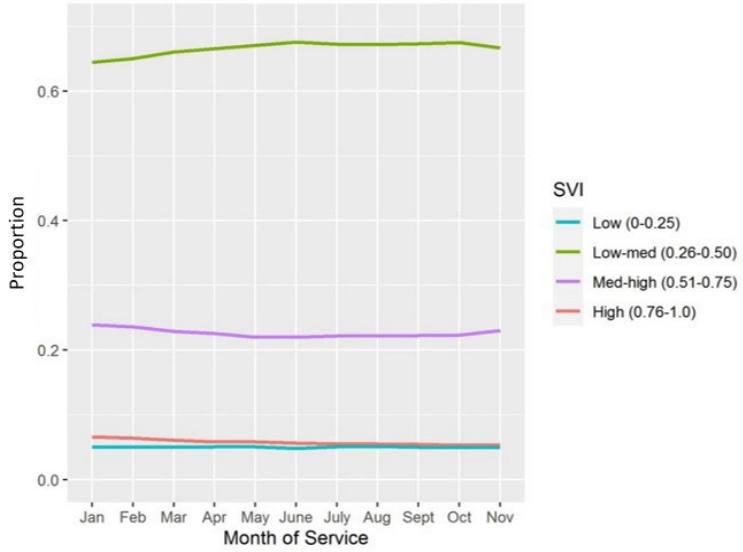


Figure 33. Audio-Only Telemedicine Services Over Time, By SVI (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services



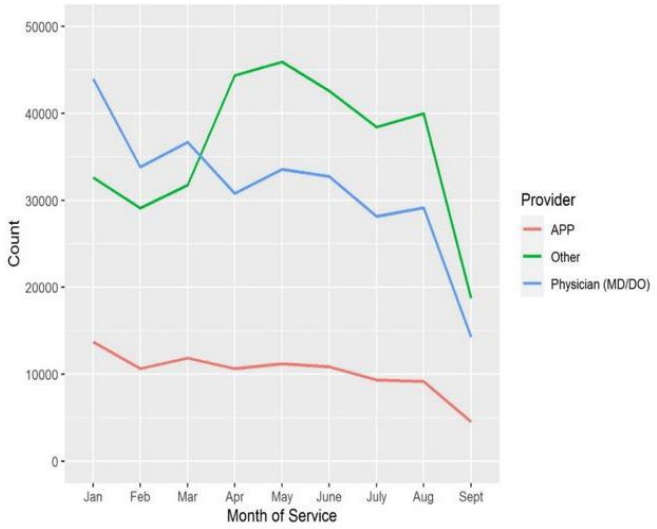
Provider-Level Variables

Provider Type. Under the base case, from March to April 2022, the provider type most frequently delivering audio-only telemedicine services shifted from physicians (MD/DO training) to other providers (*Figure 34*). Other providers consisted of clinicians (e.g., psychologists, licensed

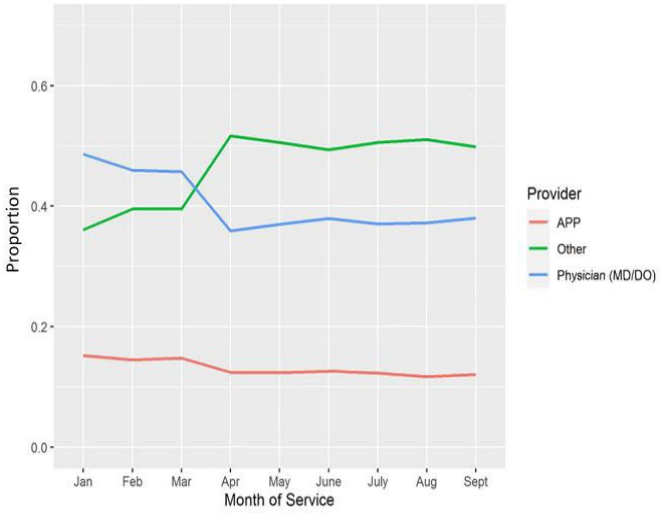
independent clinical social workers) but excluded APPs. Specifically, the proportion of services from physicians decreased from 49% in January 2022 to 36% in April 2022, and then increased slightly to 38% in September 2022. In contrast, the proportion of services from other providers increased from 36% in January 2022 to 52% in April 2022 and then decreased slightly to 50% in September 2022. For APPs, the proportion of services steadily decreased from 15% in January 2022 to 12% in September 2022.

Figure 34. Audio-Only Telemedicine Services Over Time, By Provider Type (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

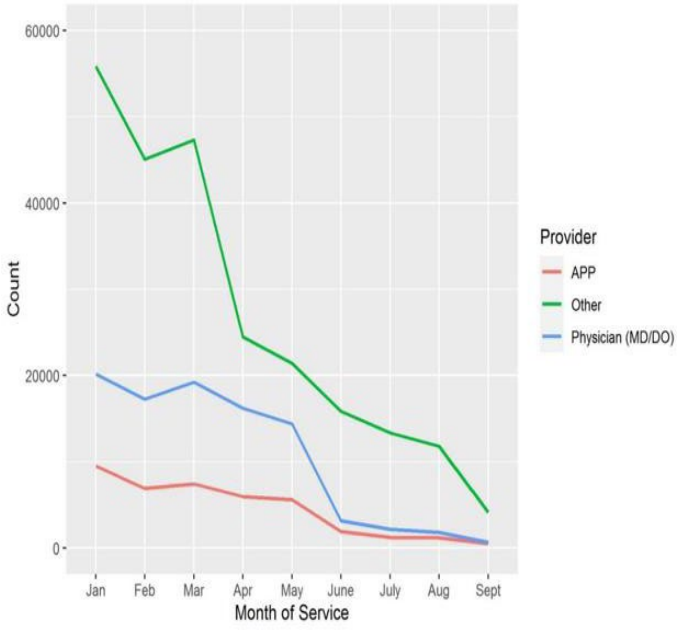


APP=Advanced Practice Provider

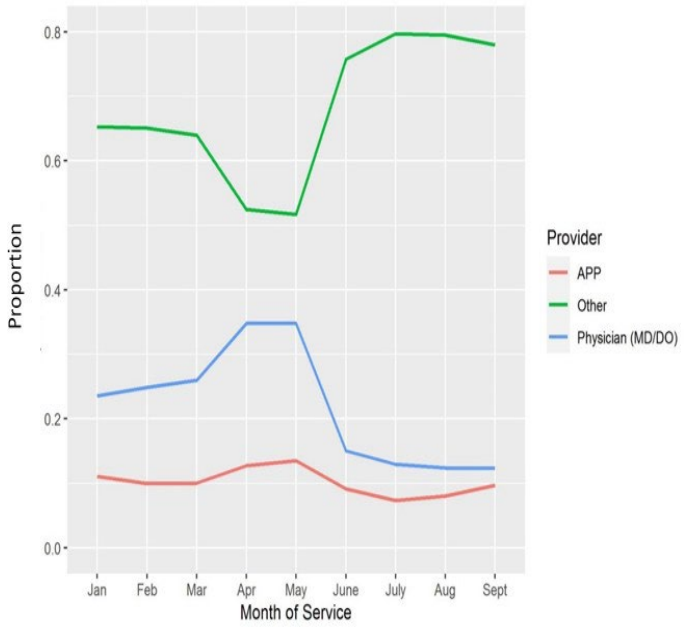
Under the expanded definition, the proportion of services from other providers decreased from 65% in January 2022 to 52% in May 2022, and subsequently increased to 78% in September 2022 (*Figure 35*). The proportion of services from physicians increased from 24% in January to 35% in May, and then decreased to 12% in September 2022. The proportion of services from APPs ranged from 7-13%. The proportion of services defined by the max case was 68-72% from other providers, 18-22% from physicians, and 9-11% from APPs (*Figure 36*). Each of these trends was stable over time.

Figure 35. Audio-Only Telemedicine Services Over Time, By Provider Type (Expanded Case)

Panel A. Service Counts



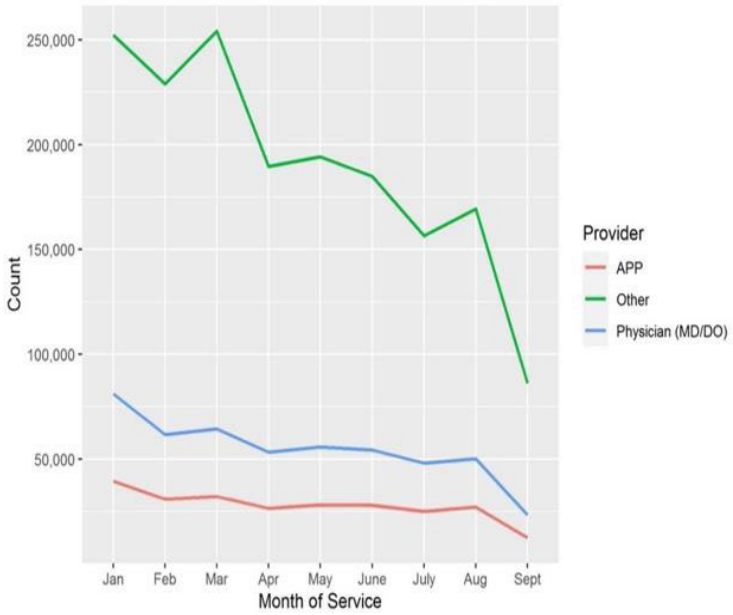
Panel B. Proportion of Services



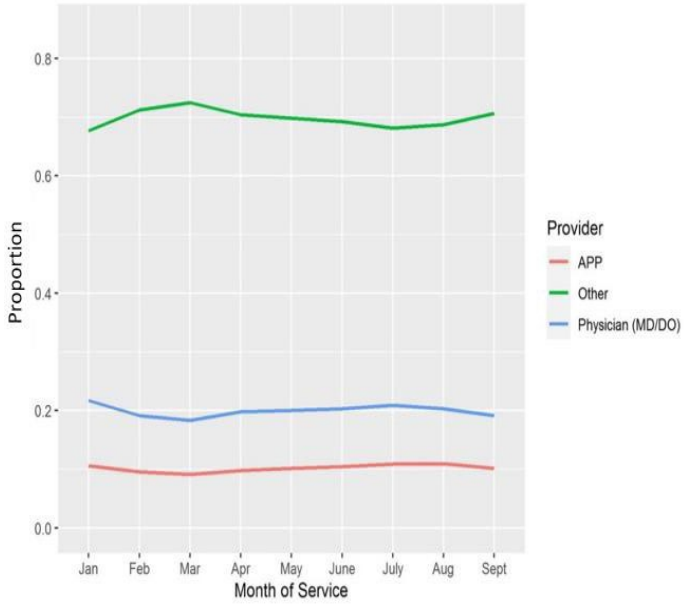
APP=Advanced Practice Provider

Figure 36. Audio-Only Telemedicine Services Over Time, By Provider Type (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services

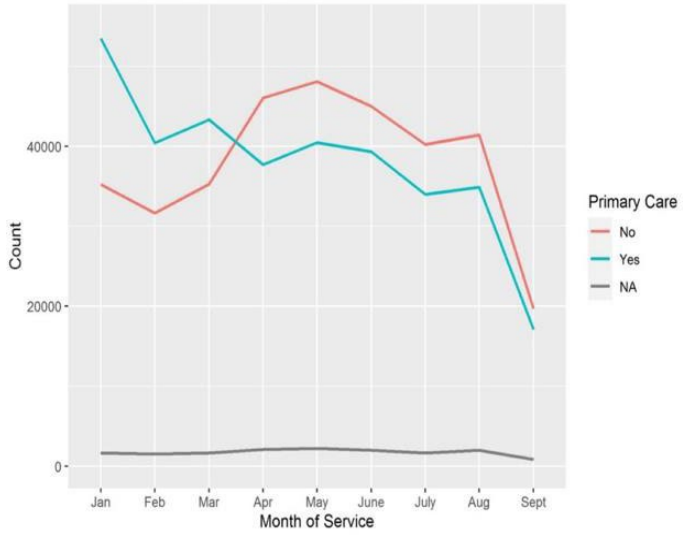


APP=Advanced Practice Provider

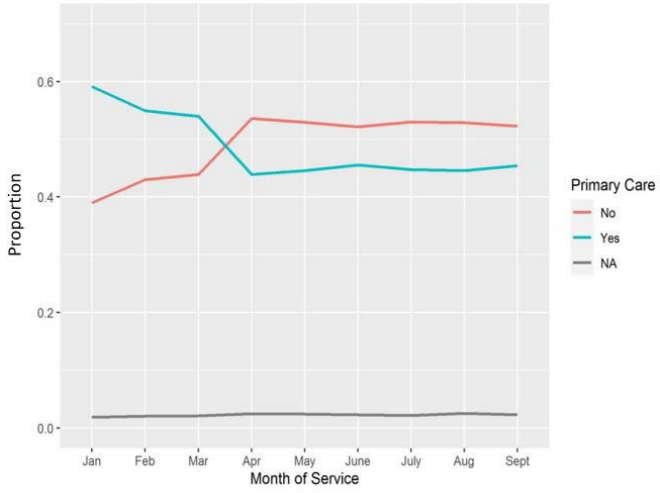
Primary Care Designation. Similar to provider type, we identified a shift in audio-only telemedicine services under the base case with fewer services delivered by primary care providers over time (*Figure 37)*. Between January 2022 and May 2022, the proportion of services from primary care providers decreased from 60% to 45% and remained steady through September 2022. In contrast, the proportion of services from non-primary care providers increased from 39% to 54% between January 2022 and April 2022 and remained steady at 52-53% through September 2022.

Figure 37. Audio-Only Telemedicine Services Over Time, By Primary Care Designation (Base Case)

Panel A. Service Counts



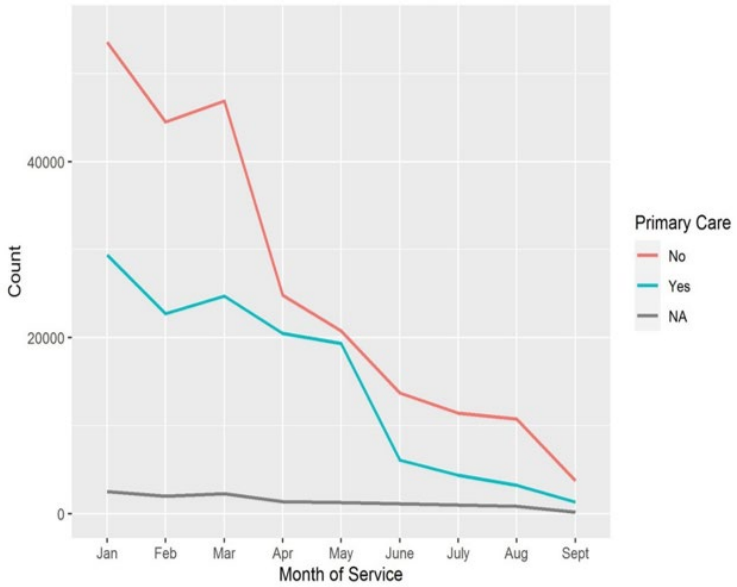
Panel B. Proportion of Services



Under the expanded case, the proportion of services from non-primary care providers decreased from 63% to a low of 50% in May 2022 and then increased to 71% in September 2022 (*Figure 38*). In contrast, the proportion of services from primary care providers increased from 34% in January 2022 to a peak of 47% in May 2022 before declining to 25% in September 2022. The majority of services under the max case were also generated by non-primary care providers (63-68%), which remained stable over time (*Figure 39*).

Figure 38. Audio-Only Telemedicine Services Over Time, By Primary Care Designation (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

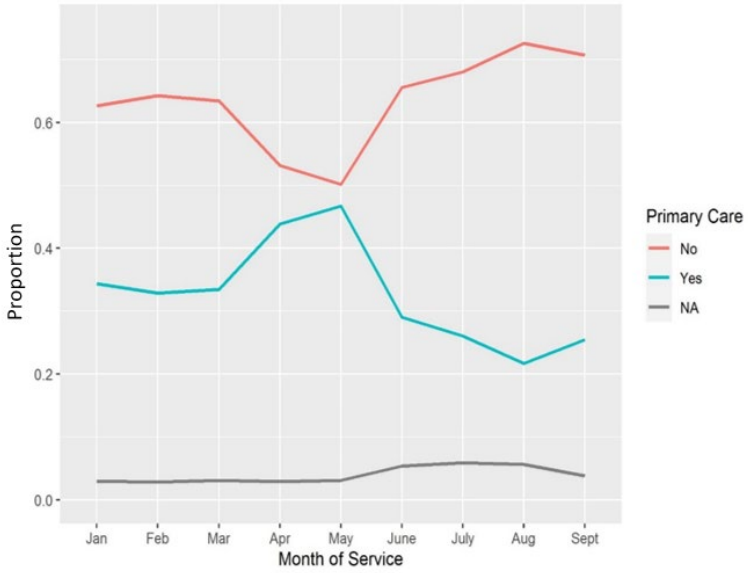
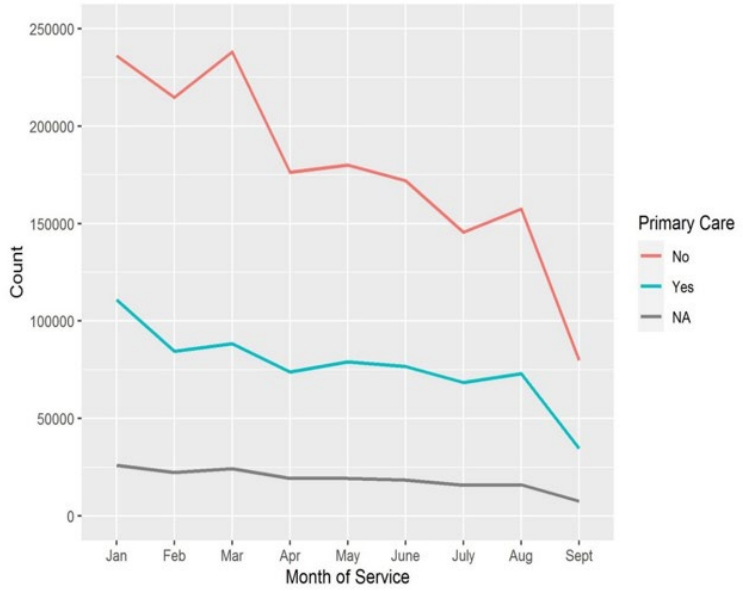
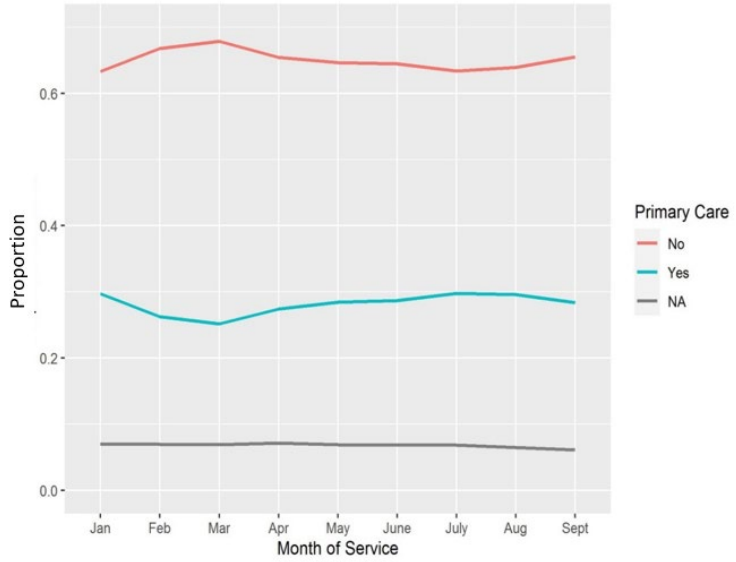


Figure 39. Audio-Only Telemedicine Services Over Time, By Primary Care Designation (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services

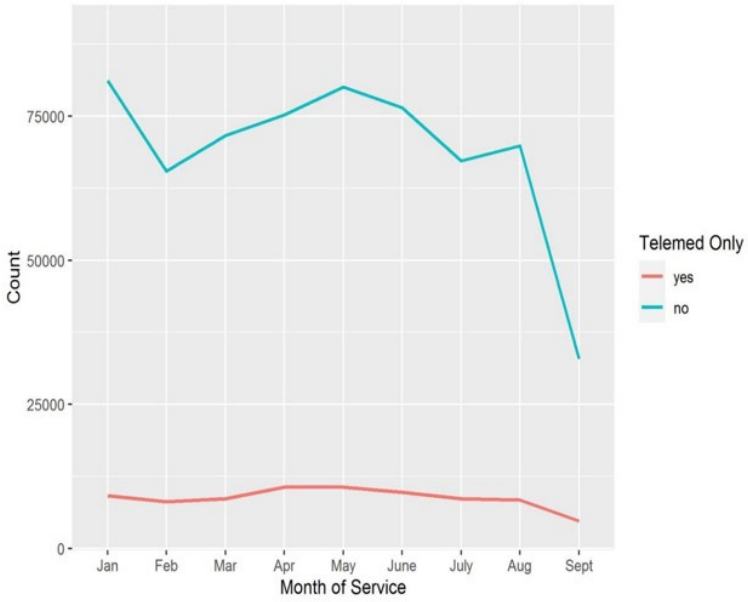


Telemedicine Only. Telemedicine-only providers rendered a small proportion of audio-only telemedicine services over the nine-month period from January through September 2022, generating 10-13% of monthly services under the base case without a clear trend over time (*Figure 40*). The proportion of services under the expanded case provided by telemedicine-only

providers was even lower at 2-6%, also without a clear trend over time (*Figure 41*). The proportion of services under the max case provided by telemedicine-only providers increased from 16% in January 2022 to 23% in September 2022 (*Figure 42*).

Figure 40. Audio-Only Telemedicine Services Over Time, By Provider Classification as Telemedicine-Only (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

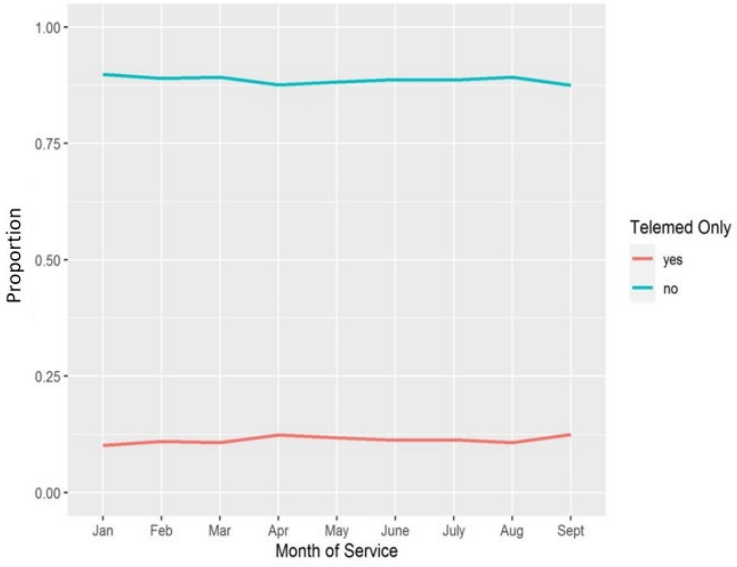
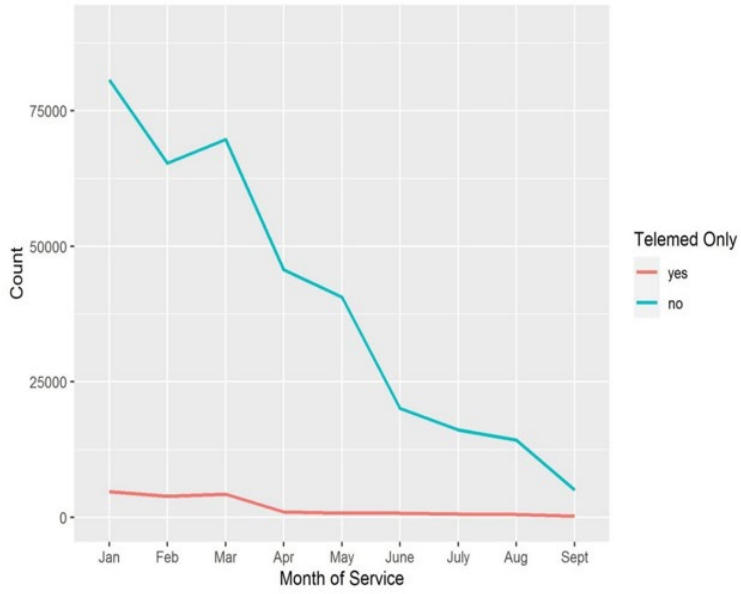


Figure 41. Audio-Only Telemedicine Services Over Time, By Provider Classification as Telemedicine-Only (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

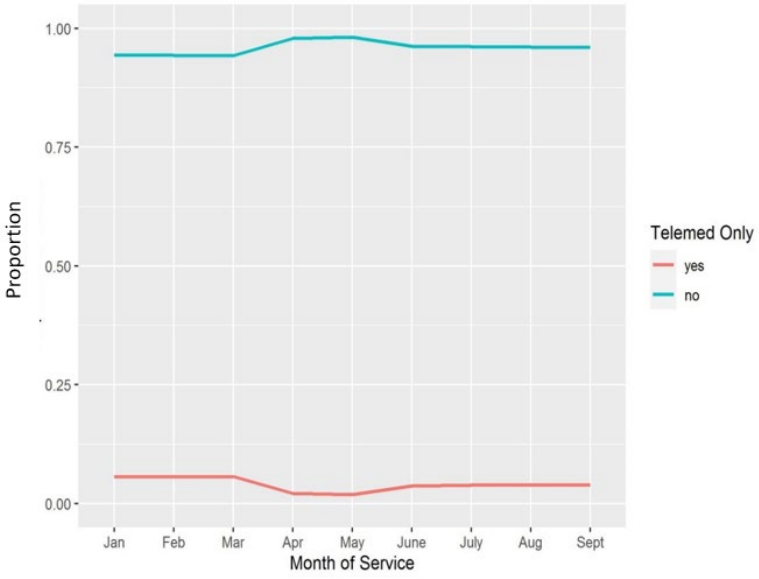
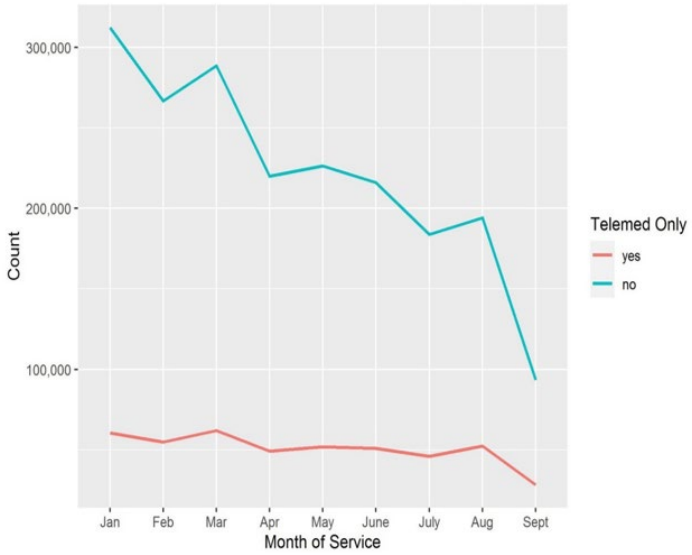
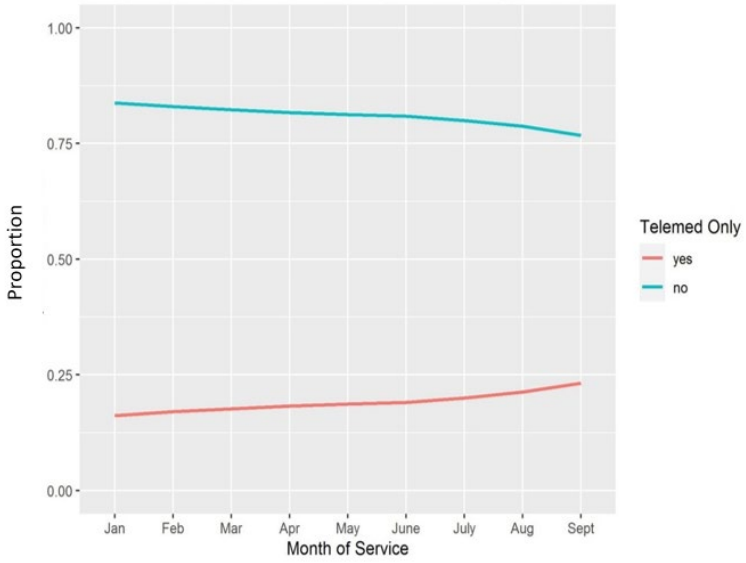


Figure 42. Audio-Only Telemedicine Services Over Time, By Provider Classification as Telemedicine-Only (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services

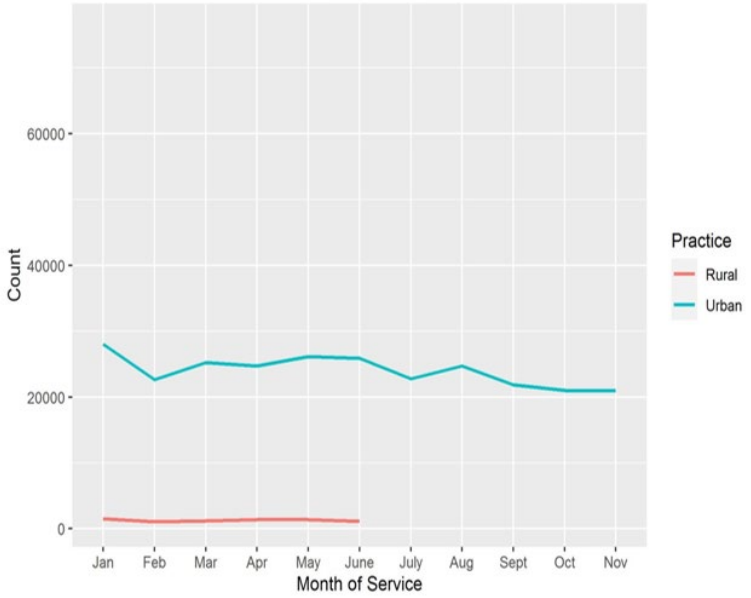


Provider Rurality. Under the base case, audio-only telemedicine services generated from rurally located practices comprised a small fraction, representing a stable 4-6% of all services in each month (*Figure 43*). The proportion of services under the expanded case from rurally located practices was 8-13%, without a clear trend over time (*Figure 44*). The proportion of services

under the max case from rurally located practices was 4% each month and remained stable over time (*Figure 45*).

Figure 43. Audio-Only Telemedicine Services Over Time, By Provider Rurality (Base Case)

Panel A. Service Counts



Panel B. Proportion of Services

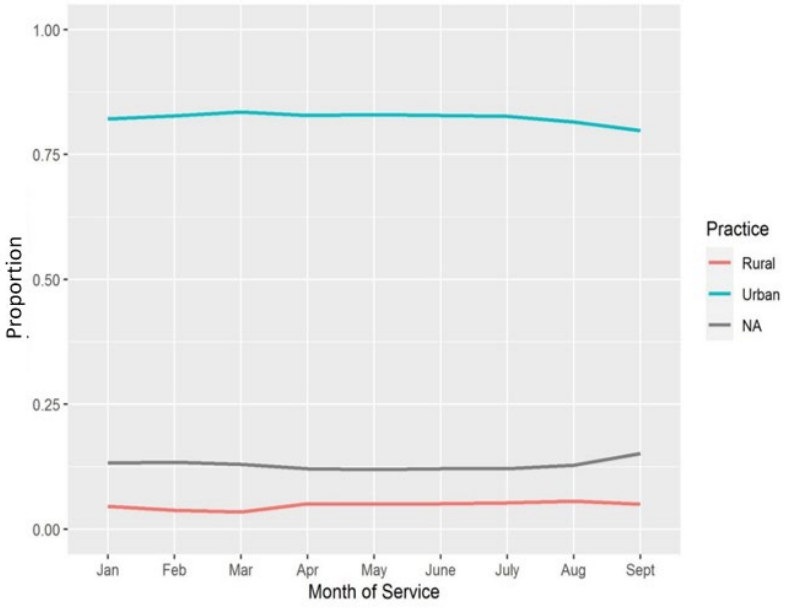
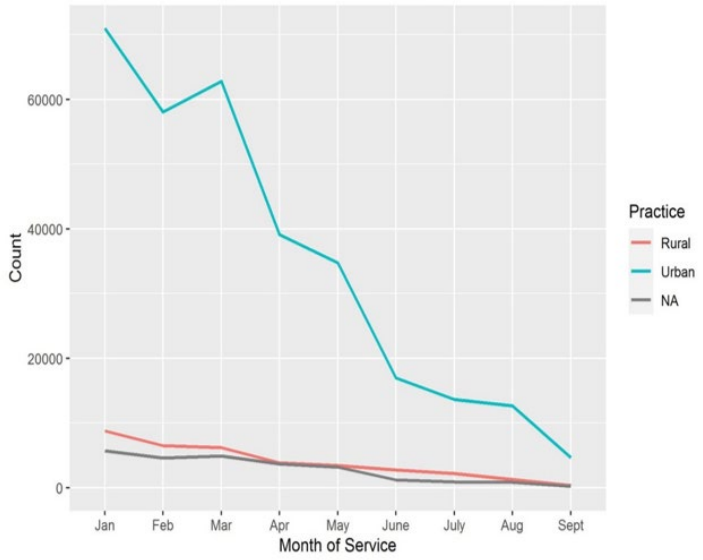


Figure 44. Audio-Only Telemedicine Services Over Time, By Provider Rurality (Expanded Case)

Panel A. Service Counts



Panel B. Proportion of Services

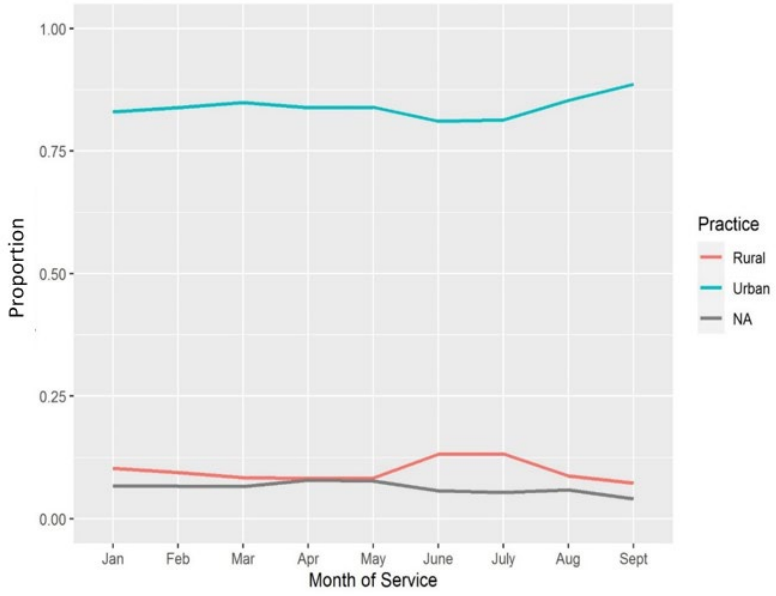
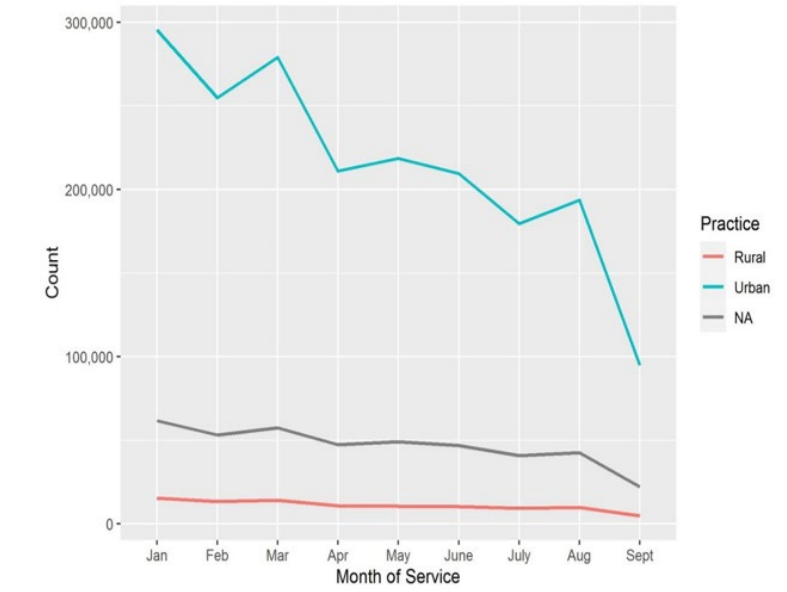
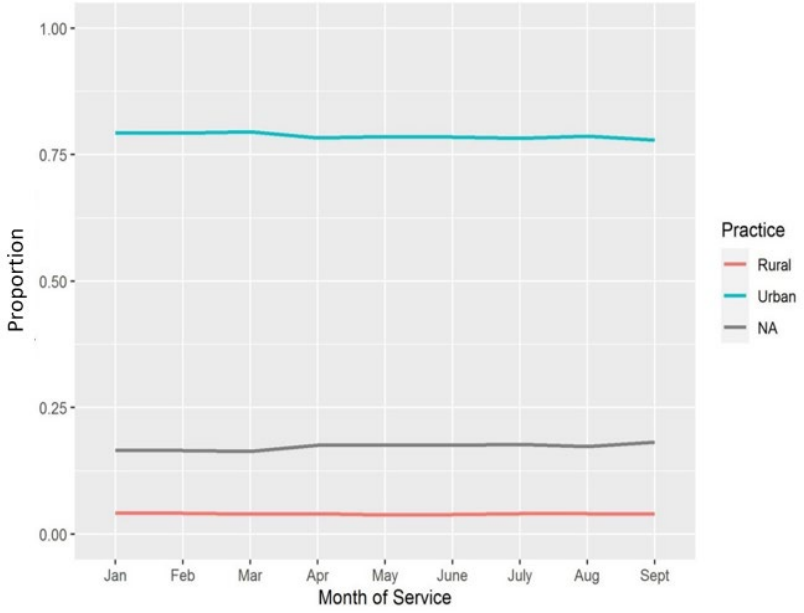


Figure 45. Audio-Only Telemedicine Services Over Time, By Provider Rurality (Max Case)

Panel A. Service Counts



Panel B. Proportion of Services



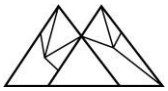
Discussion

Base Case

Between January and November 2022, audio-only telemedicine services remained largely stable under the base case, which provided the most conservative but concise definition of audio-only telemedicine. Under this primary approach, utilization varied by beneficiary age, gender, payer type, and urban/rural residence, with older, female, Medicaid-insured, and urban-dwelling beneficiaries exhibiting higher proportions of utilization than might be expected based on their representation in the overall evaluation population.

Additionally, audio-only telemedicine use was slightly less common among beneficiaries residing in the areas with the lowest and highest extent of social vulnerability than their representation in the overall evaluation population. This dynamic may reflect (a) preferences for and access to other forms of care, such as audio-visual telemedicine or in-person care, among beneficiaries residing in areas with less social vulnerability; or (b) barriers to or limited acceptability of audio-only telemedicine among beneficiaries residing in areas with greater social vulnerability.

Notably, audio-only telemedicine was most commonly used in the care of PTSD, generalized anxiety disorder, unspecified anxiety disorder, and major depressive disorder. On one hand, these findings reflect the importance of audio-only telemedicine in the care of beneficiaries with behavioral health needs – conclusions that align with results from other prior work (Lo et al., 2022; Uscher-Pines et al., 2023). On the other hand, use of audio-only telemedicine for behavioral health conditions should also be interpreted in the context of Medicaid being the only insurer in Washington to require use of the modifiers 93 and FQ in 2022, and behavioral health

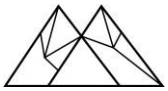



needs among Medicaid populations (Medicaid.gov, 2023).

Moreover, audio-only telemedicine services were increasingly provided by non-physician and other providers over time. Together with the fact that audio-only telemedicine was used commonly for behavioral health conditions, this trend in provider type may have reflected a growing number of behavioral health providers utilizing audio-only telemedicine. These changes coincided with shifts toward the majority of audio-only telemedicine services being provided by non-primary care providers (55%), versus primary care providers (45%). That this occurred as of April 2022 could have reflected increases in audio-only telemedicine code modifier use by non-primary care providers.

Audio-only telemedicine was rarely delivered by providers offering care through telemedicine modalities exclusively, as opposed to via combinations of telemedicine and in-person modalities. Such telemedicine-only providers comprised a small percentage of all providers in WA-APCD data, and the proportion of audio-only telemedicine services rendered by these providers was consistently low over the evaluation period. While more work is needed, these findings may reflect beneficiaries' interest in being able to access both in-person and telemedicine care, rather than accessing the latter exclusively.

Geographic variation existed in audio-only telemedicine utilization. Several counties (Asotin, Columbia, Adams) clustered in the southeastern corner of the state exhibited low levels of use by all approaches (base, expanded, max cases). In contrast, the counties with the highest levels of audio-only telemedicine service utilization were more geographically dispersed. Future work should assess factors driving these geographic differences, as well as the potential impact of audio-only telemedicine on health outcomes in areas with high versus low levels of utilization.



Expanded and Max Cases

Secondary and tertiary approaches yielded several additional findings, which can be considered exploratory. First, under both approaches, telemedicine service counts gradually declined over the evaluation period. One interpretation could be that these declines reflected a shift back to in-person care. Conversely, the absence of reductions under the primary approach suggest that declines observed in secondary and tertiary approach could also reflect shifts in telemedicine modality (e.g., from audio-video to audio-only) or documentation methods (e.g., from pandemic code modifier CR to new, dedicated audio-only code modifiers).

A second finding was lower average per capita service utilization under the secondary approach compared to the primary approach (101 versus 177 services per 1,000 beneficiaries), with use occurring more often among female or Medicaid beneficiaries. These findings could reflect the HCA's emphasis, compared to other payers, on the use of the CR modifier for denoting audio-only telemedicine services.

Third, average per capita utilization of telemedicine was much greater under the max case, as compared to the base case (542 versus 177 services per 1,000 beneficiaries). Under the max case, service utilization was notably lower among beneficiaries that were older, residing in rural areas, or enrolled in Medicaid or Medicare compared to their representation in the overall evaluation population.

Services defined by the max case were frequently received by commercially insured beneficiaries. However, based on beneficiaries' health care needs and perceived need for health care, it should be notated that beneficiaries in subgroups may not utilize health care services in a

way that is proportional to their representation in an overall population due to factors including health care need and barriers to care. For example, older beneficiaries might be expected to experience a higher burden of illness, and thus require more frequent health care services. In turn, lower utilization of telemedicine in this group may represent difficulties related to access to telemedicine or comfort with audio-video visit technology.

Since the max case relied on code modifiers denoting audio-video telemedicine (95, GT), these findings are furthermore consistent with prior literature showing that older and lower income individuals are less likely to use audio-visual telemedicine visits (Benjenk et al., 2021; Medicaid.gov). Because this evaluation was designed to highlight – but not definitively comment on – potential disparities in the use of audio-only telemedicine services, further analysis is needed to more rigorously study the impact of audio-only telemedicine on health care access and outcomes for historically underserved communities in Washington State.

Strengths and Limitations

Limitations of this analysis included data constraints of the WA-APCD, including high levels of missingness of race and ethnicity, as well as the lack of other variables that may influence a beneficiary's choice to use audio-only telemedicine, such as internet connectivity, preferred language, and education level. Another limitation was the lack of outcomes data, which precluded conclusions about the appropriateness of audio-only telemedicine services. Strengths of the analysis include the multi-payer nature of the WA-APCD, which captures a significant portion of the health care provided in Washington and allows for comparisons across payer and beneficiary characteristics.

References

1. Agency for Toxic Substances and Disease Registry. CDC/ATSDR Social Vulnerability Index (SVI). https://svi.cdc.gov/map.html. Updated December 01, 2022.
2. Benjenk I, Franzini L, Roby D, Chen J. Disparities in Audio-only Telemedicine Use Among Medicare Beneficiaries During the Coronavirus Disease 2019 Pandemic. *Medical Care*. 2021;59(11):1014-1022. doi:10.1097/MLR.0000000000001631
3. Lo J, Rae M, Amin K, Cox C, Panchal N, Miller BF. Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic. https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/. Published March 15, 2022.
4. Medicaid.gov. Behavioral Health Services. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.
5. Rodriguez J, Betancourt J, Sequist TD, Ganguli I. Differences in the use of telephone and video telemedicine visits during the COVID-19 pandemic. *Am J Manag Care*. 2021;27(1):21-26. doi:10.37765/ajmc.2021.88573
6. State of Washington Office of Financial Management. Washington All-Payer Health Care Claims Database Program. https://ofm.wa.gov/washington-data-research/health-care/all-payer-health-care-claims. Published 2019.
7. Uscher-Pines L, McCullough CM, Sousa JL, et al. Changes in In-Person, Audio-Only, and Video Visits in California's Federally Qualified Health Centers, 2019-2022. *JAMA*. 2023;329(14):1219. doi:10.1001/jama.2023.1307
8. Washington Health Care Compare (a). Washington's APCD. https://www.wahealthcarecompare.com/washingtons-apcd.
9. Washington Health Care Compare (b). Data Products. https://www.wahealthcarecompare.com/data-products.
10. Washington State Health Care Authority. Washington State All-Payer Claims Database and Lead Organization Biennial Report. https://www.hca.wa.gov/assets/program/wa-apcd-performance-leg-report-20220331.pdf. Published March 31, 2022.

Appendix A

Table 2. Trend Stratification Variables

Variable Name	Description	Values
Beneficiary		
Age	Age of beneficiaries on January 1, 2022 or earliest available eligibility record	Categories defined by quartiles of age distribution
Gender	Beneficiary gender recorded in WA-APCD	Male, Female
Race	Beneficiary race recorded in WA-APCD	White, Black, Asian, Alaska Native/Pacific Islander, Other (WA-APCD categories)
Ethnicity	Beneficiary ethnicity recorded in WA-APCD	Hispanic, Non-Hispanic
Payer Type	Categorical variable denoting what type of insurance beneficiary is covered by	Commercial, Medicaid, Medicare, Other (WA-APCD categories)
County	County of beneficiary's residence location	County name
Beneficiary Rurality	Primary RUCA code of beneficiary's residence location	Urban, Rural
SVI	Composite measure of socioeconomic disadvantage measured at the county level. Values range from 0 (least disadvantage) to 100 (most disadvantage)	Categories defined by quartiles
Provider		
Provider Type	Denotes whether provider is a physician, APP, or other	Physicians, APP (NP or PA), Other
Primary Care Designation	Recorded clinical specialty of provider in terms of primary care	Yes/No
Provider Rurality	RUCA code of providers' practice location	Urban, Rural
Telemedicine Only	Binary indicator denoting whether provider delivers telemedicine exclusively	Telemedicine only clinician, All others

WA-APCD=Washington State All-Payer Claims Database; RUCA=Rural urban commuting area, APP=Advanced Practice Providers, NP=Nurse Practitioner, PA=Physician Assistant

Table 3. Baseline Characteristics of Beneficiaries in the WA-APCD and Insured for At Least Six Months in 2021

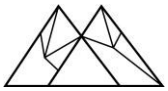
Variable	N	Mean (Standard Deviation) or %
Age (years)	4,295,382	37.2 (23.1)
Age Category		
… Under or equal to 35 years	2,149,294	50%
… 36-50 years	777,567	18.1%
… 51-65 years	773,359	18%
… Over 65 years	595,162	13.9%
Gender	4,295,382	
... Female	2,245,801	52.3%
... Male	2,049,456	47.7%
... Unknown	125	0%
Race	4,295,382	
… American Indian / Alaska Native	81,255	1.9%
… Asian	116,602	2.7%
… Black / African American	175,256	4.1%
… Native Hawaiian or Other Pacific Islander	39,579	0.9%
… White	1,298,137	30.2%
… Other	287,953	6.7%
... Missing	2,296,600	53.5%
Ethnicity	4,295,382	
... Non-Hispanic	1,850,824	43.1%
... Hispanic	306,850	7.1%
... Missing	2,137,708	49.8%
Payer Type	4,330,647	
... Commercial	1,948,277	45.4%
... Medicaid	1,867,967	43.5%
... Medicare	479,138	11.2%
Rurality by Zip Code	4,087,030	
... Rural	522,325	12.9%
... Urban	3,526,371	87.1%
County SVI	4,048,713	0.5 (0.2)
SVI (By Quartile)	4,048,713	
... Low (0-0.25)	226,674	5.6%
... Low-medium (0.26-0.50)	2,186,757	54%
... Medium-high (0.51-0.75)	1,166,735	28.8%
... High (0.76-1.0)	468,547	11.6%
Cumulative Days Covered By Insurance	4,295,382	350.2 (43.6)

Table 4. Most Common CPT Codes Used in Each Audio-Only Telemedicine Case Definition

Base Case			Expanded Case			Max Case		
CPT Code	Meaning	N (%)[1]	CPT Code	Meaning	N (%)[1]	CPT Code	Meaning	N (%)[1]
99442	Telephone E/M	277,717 (30.3)	99214	E/M of an established patient	67,003 (15.9)	90837	Psychotherapy 60 minutes	1,086,570 (33.8)
99441	Telephone E/M	142,981 (15.6)	Q3014	Telehealth originating site facility fee	63,904 (15.2)	99214	E/M of an established patient	562,274 (17.5)
99443	Telephone E/M	140,511 (15.3)	99213	E/M of an established patient	50,798 (12.1)	99213	E/M of an established patient	360,257 (11.2)
H0004	Behavioral health counseling and therapy, per 15 minutes	40,868 (4.5)	90837	Psychotherapy 60 minutes	19,587 (4.7)	90834	Psychotherapy 45 minutes	212,995 (6.6)
90837	Psychotherapy 60 minutes	36,668 (4.0)	H0004	Behavioral health counseling and therapy, per 15 minutes	15,913 (3.8)	99215	E/M of an established patient	101,803 (3.2)

CPT=current procedural terminology, E/M=Evaluation and Management

[1] Percentages represent the proportion of claims meeting in each case definition that included specified CPT codes.



Appendix B

CPT Code	Short Descriptor	Source
92507	Speech/hearing therapy	Medicare
92521	Evaluation of speech fluency	Medicare
92522	Evaluate speech production	Medicare
92523	Speech sound lang comprehen	Medicare
92524	Behavral qualit analys voice	Medicare
96130	Psycl tst eval phys/qhp 1st	Medicare
96131	Psycl tst eval phys/qhp ea	Medicare
96132	Nrpsyc tst eval phys/qhp 1st	Medicare
96133	Nrpsyc tst eval phys/qhp ea	Medicare
96136	Psycl/nrpsyc tst phy/qhp 1st	Medicare
96137	Psycl/nrpsyc tst phy/qhp ea	Medicare
96138	Psycl/nrpsyc tech 1st	Medicare
96139	Psycl/nrpsyc tst tech ea	Medicare
97535	Self care mngment training	Medicare
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service	HCA
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	HCA
99451	Interprofessional Telephone/Internet/Electronic Health Record Consultations	HCA
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes	HCA
99422	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes	HCA
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	HCA
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician	HCA
99429	Preventive medicine service that does not have a specific code	HCA
T1030	Nursing Care, in-home, by Registered Nurse (RN), Per Diem (8 Hours)	HCA
T1031	Nursing Care, in-home, by Licensed Practical Nurse (LPN) Per Diem (8 Hours)	HCA
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes	HCA
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes	HCA

99600	Home visit service or procedure that does not have a specific code	HCA
99492	1st psyc collab care mgmt	HCA
99493	Sbsq psyc collab care mgmt	HCA
99494	1st/sbsq psyc collab care	HCA
H0019	Alcohol/drug long-term res. (nonmedical, non-acute care in a res. tx. program; stay is typically longer than 30 days), per diem BH srvcs; long-term residential (nonmedical, non-acute care in a residential tx program where stay is typically longer than 30 days), w/o R&B, per diem	HCA
H0020	Alcohol/drug services; MAT admin. /dispense srvcs by a lic. progrm.	HCA
H0023	Behav. Hlth Outreach Srvc (planned approach to reach a targeted population)	HCA
H0025	Behav. hlth prev. educ. srvcs (delivery of services with target population to affect knowledge, attitude and/or behavior)	HCA
H0026	Alcohol/drug prevention	HCA
H0030	BH hotline service (ASO Only)	HCA
S9445	Pt education noc individ	HCA
S9470	Nutritional counseling, diet	HCA
H0003	Presumptive Drug Class Screening	HCA
H0010	Alcohol/drug services; subacute detox in hospital setting, per diem (inpatient residential addition program)	HCA
H0011	Alcohol/drug services; acute detox in Free Standing E&T facility, per diem (inpatient residential addition program Alcohol/drug services; acute detox in hospital setting, per diem (inpatient residential addition program)	HCA
H0016	Alcohol/drug services, per hour	HCA
H0017	Withdrawal management facility service in a Free Standing E&T, per diem. Withdrawal management facility service in a hospital setting, per diem.	HCA
H0018	BH srvcs; short-term residential (nonhospital residential tx program where stay is typically less than 30 days), w/o R&B, per diem Added clarity..... Majority of MH RTFs stays are longer than 30 days, thus the majority of codes used for this should be H0019 code. UHC Bea Dixon asking for clarification, see outstanding issues log #106	HCA
H0033	Oral med admin. direct obsrvtn.	HCA
H0034	Medication Training and Supp, per 15 mins	HCA
H0040	Assert. comm. tx. prgrm, per diem	HCA
H0043	Supp. Housing, per diem	HCA
H0045	Respite not-in-home, per diem	HCA
H0047	Alcohol/drug abuse svc, NOS	HCA
H0050	Alcohol/drug srvcs, per 15 mins	HCA
H2012	Behav hlth day trtmt, per hr	HCA

H2017	Psychosoc. rehab srvcs, per 15 mins	HCA
H2022	Comm. wrap-around svc, per diem	HCA
H2023	Supported employ, per 15 min	HCA
H2025	Supp maint employ, 15 min	HCA
H2027	Psycho-ed srvc, per 15 mins	HCA
H2028	Sex offend tx srvcs, per 15 mins	HCA
H2031	MH clubhouse srvcs, per diem	HCA
H2033	Multisys. ther. for juv., per 15 mins	HCA
H2036	Alcohol/drug tx program, per diem	HCA
H0010	Alcohol/drug services; subacute detox in Free Standing E&T facility, per diem (inpatient residential addition program)	HCA
S9125	Respite care, in the home, per diem	HCA
S9446	PT educ., not otherwise classified, by non- physician provider, in group setting, per session	HCA
S9480	Intnsv. O/P psychiatric srvcs, per diem	HCA
S9484	Crisis intervention, per hour	HCA
S9485	Crisis intrvntn mh, per diem	HCA
T1001	Nursing Assess./Eval.	HCA
T1005	Respite care services, 15 minutes	HCA
T1013	Sign Lang/Oral Interpreter Srvcs, oer 15 minutes	HCA
T1023	Progrm intake assmt screening to determine appropriateness of an individual for participation in a spec. progrm, project or tx protocol, per encounter	HCA
T2022	Case mangement per month	HCA
T2023	targeted case management per month	HCA
T2038	Community transition waiver/srvcs, per srvc	HCA
80305	Presumptive Drug Class Screening/Direct Optical Observation e.g. Dipstick method	HCA
80306	Presumptive Drug Class Screening via instrument assisted direct optical observation (e.g., immunoassay – dipsticks, cups, etc.),	HCA
80307	Presumptive Drug Class Screening / via Instrumented Chemistry Analyzer	HCA
90849	Multi fam. grp psychother. (does not require patient to be present)	HCA
96110	Developmental scrning; (e.g., Developmental Screening Test II, Early Language Milestone Screen), w/ intrprtn and rprt, per hour	HCA
96170	Behav.Hlth. Intrvtn. w/ fam; no pt, face to face, first 30 minutes	HCA
96171	Behav.Hlth. Intrvtn. w/ fam; no pt, face to face, each additional 15 minutes (List separately in addition to code for primary service)	HCA
96372	Injection for ther/proph/diag purposes SQ or IM	HCA
99075	Medical testimony	HCA
99304	Initial visit at nursing facility E/M, per day, (problem(s) are of low severity; approx. 25 minutes w/ the PT and/or fam. or caregiver)	HCA

99305	Initial visit at nursing facility E/M, per day, (problem(s) are of moderate severity; approx. 35 mins w/ the PT and/or fam. or caregiver)	HCA
99306	Initial visit at nursing facility E/M, per day, (problem(s) are of high severity; approx. 45 mins w/ the PT and/or fam. or caregiver)	HCA
99307	Subseqt. nursing facility visit, per day, E/M (patient stable, recovering, or improving; approx. 10 mins w/ the PT and/or fam. or caregiver)	HCA
99324	Domiciliary or rest home visit for new PT E/M (problem(s) are of low severity; approx. 20 mins w/ the PT and/or fam. or caregiver)	HCA
99325	Domiciliary or rest home visit for new patient E/M (problem(s) are of moderate severity; approx. 30 mins w/ the PT and/or fam. or caregiver)	HCA
99326	Domiciliary or rest home visit for new PT E/M (problem(s) are of moderate to high severity; approx. 45 mins w/ the PT and/or family or caregiver)	HCA
99327	Domiciliary or rest home visit for new PT E/M (problem(s) are of high severity; approx. 60 mins w/ the PT and/or fam or caregiver)	HCA
99328	Domiciliary or rest home visit for new PT E/M (Usually, the patient is unstable or has developed a significant new problem requiring immediate MD attention; approx. 75 mins w/ the PT and/or fam. or caregiver)	HCA
99334	Domiciliary or rest home visit for establ. PT E/M (problem(s) are self-limited or minor: approx. 15 mins w/ the PT and/or fam. or caregiver)	HCA
99335	Domiciliary or rest home visit for establ. PT E/M (problem(s) of low to moderate severity: approx. 25 mins w/ the PT and/or fam. or caregiver)	HCA
99337	Domiciliary or rest home visit for establ. PT E/M (PT may be unstable or may have developed a significant new prob. requiring immediate MD attention; approx. 60 mins w/ the PT and/or fam. or caregiver)	HCA
99341	Home visit for new PT E/M (problem(s) of low severity; approx. 20 mins are spent face - face w/ the PT and/or fam.)	HCA
99342	Home visit for new PT E/M (problem(s) of moderate severity; approx. 30 mins spent face - face w/ the PT and/or fam.)	HCA
99343	Home visit for new PT E/M (problem(s) of moderate to high severity; 45 mins spent face - face w/ the PT and/or fam.)	HCA
99344	Home visit for new PT E/M (problem(s) of high severity; approx. 60 mins spent face - face w/ other Pt and/or fam.)	HCA
99345	Home visit for new PT E/M (patient is unstable or has developed a significant new prob. requiring immediate physician attention: approx. 75 mins spent face - face w/ other PT and/or fam.)	HCA
99347	Home visit for establ. PT E/M (problem(s) are self- limited or minor; approx. 15 mins are spent face - face w/ the PT and/or fam)	HCA
99348	Home visit for estab. PT E/M (problems(s) of low to moderate severity; approx. 25 mins spent face - face w/ the PT and/or fam.)	HCA

99349	Home visit for estab. PT E/M (problem(s) of moderate to high severity; approx. 40 mins spent face - face w/ the PT and/or fam.)	HCA
99350	Home visit for estab. PT. E/M (problem(s) of moderate to high severity. The patient may be unstable or may have developed a significant new prob. Req. immediate MD attention; approx. 60 mins spent face - face w/ the PT and/or fam.)	HCA
90785	Psytx complex interactive	Medicare
90791	Psych diagnostic evaluation	Medicare
90792	Psych diag eval w/med srvcs	Medicare
90832	Psytx w pt 30 minutes	Medicare
90833	Psytx w pt w e/m 30 min	Medicare
90834	Psytx w pt 45 minutes	Medicare
90836	Psytx w pt w e/m 45 min	Medicare
90837	Psytx w pt 60 minutes	Medicare
90838	Psytx w pt w e/m 60 min	Medicare
90839	Psytx crisis initial 60 min	Medicare
90840	Psytx crisis ea addl 30 min	Medicare
90845	Psychoanalysis	Medicare
90846	Family psytx w/o pt 50 min	Medicare
90847	Family psytx w/pt 50 min	Medicare
90853	Group psychotherapy	Medicare
92526	Oral function therapy	Medicare
96116	Nubhvl xm phys/qhp 1st hr	Medicare
96121	Nubhvl xm phy/qhp ea addl hr	Medicare
96156	Hlth bhv assmt/reassessment	Medicare
96159	Hlth bhv ivntj indiv ea addl	Medicare
96160	Pt-focused hlth risk assmt	Medicare
96161	Caregiver health risk assmt	Medicare
96164	Hlth bhv ivntj grp 1st 30	Medicare
96165	Hlth bhv ivntj grp ea addl	Medicare
96167	Hlth bhv ivntj fam 1st 30	Medicare
96168	Hlth bhv ivntj fam ea addl	Medicare
97110	Therapeutic exercises	Medicare
97153	ADAPTIVE BEHAVIOR TX BY TECH	Medicare
97155	ADAPT BEHAVIOR TX PHYS/QHP	Medicare
97156	FAM ADAPT BHV TX GDN PHY/QHP	Medicare
97530	Therapeutic activities	Medicare
97802	Medical nutrition indiv in	Medicare
97803	Med nutrition indiv subseq	Medicare
97804	Medical nutrition group	Medicare
99202	OFFICE/OUTPATIENT VISIT NEW	Medicare
99203	OFFICE/OUTPATIENT VISIT NEW	Medicare
99204	OFFICE/OUTPATIENT VISIT NEW	Medicare

99205	OFFICE/OUTPATIENT VISIT NEW	Medicare
99211	Office/outpatient visit est	Medicare
99212	OFFICE/OUTPATIENT VISIT EST	Medicare
99213	OFFICE/OUTPATIENT VISIT EST	Medicare
99214	OFFICE/OUTPATIENT VISIT EST	Medicare
99215	OFFICE/OUTPATIENT VISIT EST	Medicare
99232	Subsequent hospital care	Medicare
99233	Subsequent hospital care	Medicare
99308	NURSING FAC CARE SUBSEQ	Medicare
99309	NURSING FAC CARE SUBSEQ	Medicare
99310	NURSING FAC CARE SUBSEQ	Medicare
99336	Domicil/r-home visit est pat	Medicare
99354	Prolong e&m/psyctx serv o/p	Medicare
99355	Prolong e&m/psyctx serv o/p	Medicare
99356	Prolonged service inpatient	Medicare
99357	Prolonged service inpatient	Medicare
99406	Behav chng smoking 3-10 min	Medicare
99407	Behav chng smoking > 10 min	Medicare
99497	Advncd care plan 30 min	Medicare
99498	Advncd care plan addl 30 min	Medicare
D9992	CASE MGMT, CARE COORDINATION	Medicare
G0108	Diab manage trn per indiv	Medicare
G0109	Diab manage trn ind/group	Medicare
G0270	Mnt subs tx for change dx	Medicare
G0296	Visit to determ ldct elig	Medicare
G0396	Alcohol/subs interv 15-30mn	Medicare
G0397	Alcohol/subs interv >30 min	Medicare
G0406	Inpt/tele follow up 15	Medicare
G0407	Inpt/tele follow up 25	Medicare
G0408	Inpt/tele follow up 35	Medicare
G0420	Ed svc ckd ind per session	Medicare
G0421	Ed svc ckd grp per session	Medicare
G0425	Inpt/ed teleconsult30	Medicare
G0426	Inpt/ed teleconsult50	Medicare
G0427	Inpt/ed teleconsult70	Medicare
G0438	Ppps, initial visit	Medicare
G0439	Ppps, subseq visit	Medicare
G0442	Annual alcohol screen 15 min	Medicare
G0443	Brief alcohol misuse counsel	Medicare
G0444	Depression screen annual	Medicare
G0445	High inten beh couns std 30m	Medicare
G0446	Intens behave ther cardio dx	Medicare
G0447	Behavior counsel obesity 15m	Medicare

G0459	Telehealth inpt pharm mgmt	Medicare
G0506	Comp asses care plan ccm svc	Medicare
G0513	Prolong prev svcs, first 30m	Medicare
G0514	Prolong prev svcs, addl 30m	Medicare
G2012	BRIEF CHECK IN BY MD/QHP	Medicare
G2025	Dis site tele svcs RHC/FQHC	Medicare
G2086	Off base opioid tx 70min	Medicare
G2087	Off base opioid tx, 60 m	Medicare
G2088	Off base opioid tx, add30	Medicare
G2211	Complex E/M visit add on	Medicare
G2212	Prolong outpt/office vis	Medicare
H0001	Alcohol and/or drug assess	Medicare
H0004	Alcohol and/or drug services	Medicare
H0031	MH health assess by non-md	Medicare
H0032	MH svc plan dev by non-md	Medicare
H0036	Comm psy face-face per 15min	Medicare
H0038	Self-help/peer svc per 15min	Medicare
H0046	Mental health service, nos	Medicare
H2011	Crisis interven svc, 15 min	Medicare
H2014	Skills train and dev, 15 min	Medicare
H2015	Comp comm supp svc, 15 min	Medicare
H2021	Com wrap-around sv, 15 min	Medicare
Q3014	Telehealth facility fee	Medicare
S9482	Family stabilization 15 min	Medicare
T1002	RN services up to 15 minutes	Medicare
T1015	Clinic service	Medicare
T1016	Case management	Medicare
T1017	Targeted case management	Medicare
T1027	Family training & counseling	Medicare
T2025	Waiver service, nos	Medicare
92508	Speech/hearing therapy	Medicare
96127	Brief emotional/behav assmt	Medicare
96158	Hlth bhv ivntj indiv 1st 30	Medicare
99441	Phone e/m phys/qhp 5-10 min	Medicare
99442	Phone e/m phys/qhp 11-20 min	Medicare
99443	Phone e/m phys/qhp 21-30 min	Medicare
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services, 15-30 min	Appendix T of AMA
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services, >30 min	Appendix T of AMA

96040	Medical Genetics and Genetic Counseling Services	Appendix T of AMA