IN-NETWORK REIMBURSEMENT RATES

For In-Network provider office visits only, for the CPT codes provided in Tables A, B (1) and B (2) provide, the weighted average allowed amounts for the following four (4) groups of providers:

• Primary Care Physicians, “PCPs”, defined as general practice, family practice, internal medicine, and pediatric medicine physicians.

• Non-psychiatrist Medical/Surgical Specialist Physicians, defined to include nonpsychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.

• Psychiatrists, including child psychiatrists.

• Non-psychiatrist Behavioral Health (“BH”) Professionals, defined as psychologists and clinical social workers.

Please complete Tables A, B (1) and B (2) for claims data for Calendar Year 2021, or for the period January 1, 2021, through the latest month in 2020 for which reasonably complete claims data is available.

Instructions for completing Table A follow:

• In Rows 1– 4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists.

Instructions for completing Tables B (1) and B (2) follow:

• In Rows 1– 3, Column A of Tables B (1) and B (2), insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• Rows 1 - 3, Column C of Tables B (1) and B (2), insert weighted average allowed amount as a percentage of the Medicare Fee schedule amount.