

WHITE PAPER

FH[®] Healthcare Indicators and FH[®] Medical Price Index 2024

An Annual View of
Place of Service
Trends and Medical Pricing

A FAIR Health White Paper, March 26, 2024



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Summary

This is the seventh annual edition of FH[®] Healthcare Indicators and FH[®] Medical Price Index, two measures developed by FAIR Health to provide perspective in a rapidly changing healthcare environment. Drawing on the independent nonprofit's national database of billions of privately insured healthcare claims—the largest in the country—these two measures apply different approaches to illuminate different aspects of the national healthcare sector, including, among other factors, trends in the place of service and billed charge and allowed amounts for professional services.

FH Healthcare Indicators analyze trends involving the place of service, or setting (e.g., office, retail clinic, urgent care center, telehealth, ambulatory surgery center [ASC] and emergency room [ER]), for healthcare in recent years. Focusing on alternative places of service—retail clinics, urgent care centers, telehealth and ASCs—as well as ERs, FH Healthcare Indicators evaluate changes in utilization, geographic and demographic factors, diagnoses, procedures and costs. In the new edition, all time frames shift forward one year from the previous edition. For example, if a chart last year showed usage trends from 2016 to 2021, this year's chart shows 2017 to 2022. Here are some of the key findings from the period ending in 2022:

- Utilization increased the most in retail clinics (202 percent) from 2021 to 2022.¹ Utilization increased 138 percent in ERs, 88 percent in ASCs, 43 percent in urgent care centers and 8 percent in telehealth.
- ERs held the highest percentage of medical claim lines in 2022 among the places of service studied, with 4.2 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 3.9 percent for telehealth, 2.1 percent for urgent care centers, 1.1 percent for ASCs and 0.2 percent for retail clinics. The remainder of the services were rendered in traditional places of service, such as physician offices.
- In 2022 as in previous years, more claim lines were submitted for females than males in most age groups in these alternative places of service and ERs.
- In 2022, New York was one of the top five states for urgent care centers and telehealth, as measured by the percentage of medical claim lines accounted for by those places of service, but it was not among the top five states for retail clinics.
- In 2022, COVID-19 remained on the list of most common diagnostic categories in retail clinics, urgent care centers, telehealth and ERs (for individuals over the age of 22). However, COVID-19 diagnoses rose in the rankings of retail clinics and telehealth, fell in those of ERs and stayed the same in those of urgent care centers.
- Across offices, urgent care centers and retail clinics in 2022, the highest median allowed amount for CPT^{®2} 99204 (new patient office or other outpatient visit, 45-59 minutes) was in offices at \$183, while the median allowed amount for urgent care centers was \$174 and for retail clinics \$149.

FH Medical Price Index tracks the weighted average growth in median procedure billed charges and median allowed amounts in six procedure categories. This report does not consider facility fees. The categories are:

- Professional evaluation and management (E&M; excluding E&Ms performed in a hospital setting);
- Hospital E&M (excluding E&Ms performed in a professional setting, such as typical office visits);
- Medicine (excluding E&Ms);

¹ Utilization in this study is a relative, normalized measure, not an absolute one. See Methodology section.

² CPT © 2023 American Medical Association (AMA). All rights reserved.

- Surgery (procedures for which the physician would bill);
- Pathology and laboratory (including both technical and professional components, e.g., both equipment and professional services); and
- Radiology (including both technical and professional components).

May 2012 is the base month, to which values in later periods are compared; therefore, FH Medical Price Index establishes a consistent point of reference that makes it easy to identify and compare shifts.

In the first edition, FH Medical Price Index presented an overview from May 2012 to May 2017, which was extended in the second edition to November 2018; each edition since has added one additional year of data. In the new edition, the indices are extended to November 2023. Findings include the following, all for the period November 2022 to November 2023:

- Of the six procedure categories, professional E&Ms and medicine each had the greatest percent increase in charge amount index, five percent. The pathology and laboratory charge amount index increased four percent, while the surgery charge amount index increased three percent.
- Hospital E&Ms and radiology each had the smallest percent increase in charge amount index, one percent.
- Professional E&Ms and hospital E&Ms each had the greatest increase in allowed amount index, three percent. The pathology and laboratory allowed amount index grew two percent, while the medicine and surgery allowed amount indices each increased one percent.
- Radiology was the only category to have a decrease in allowed amount index, four percent.

Background

In a white paper published in March 2018, FAIR Health launched two new measures of healthcare information: FH[®] Healthcare Indicators and FH[®] Medical Price Index.³ Designed to provide perspective in a rapidly changing healthcare environment and a “macro” view into the nation’s healthcare system, the measures are updated annually to reflect ongoing changes; this is the seventh annual release.

Since the first edition, the healthcare sector has continued to evolve and grow more complex. Healthcare stakeholders continue to need information that will enable them to discern fundamental trends and patterns, and to make decisions on that basis. FH Healthcare Indicators and FH Medical Price Index are intended to serve all such constituents, including healthcare consumers and policy makers, insurers and companies that self-insure, third-party administrators, hospitals and health systems, physicians and other individual providers, pharmaceutical and device manufacturers, federal and state government officials, legislators, economists and academic researchers.

Both FH Healthcare Indicators and FH Medical Price Index use the same data source: FAIR Health’s database of over 45 billion claim records, which is growing at a rate of over 3 billion claim records a year. The data are contributed by payors and administrators who insure or process claims for private insurance plans. A national, independent nonprofit organization, FAIR Health uses this repository—the nation’s largest collection of private healthcare claims data—in furtherance of its mission of bringing transparency and integrity to healthcare costs and health insurance information.

³ FAIR Health, *FH[®] Healthcare Indicators and FH[®] Medical Price Index: A New View of Place of Service Trends and Medical Pricing*, A FAIR Health White Paper, March 2018, <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Medical%20Price%20Index%20and%20FH%20Healthcare%20Indicators--whitepaper.pdf>.

Like previous releases, this year's edition of FH Healthcare Indicators and FH Medical Price Index is intended to assist healthcare stakeholders in a variety of ways. For example, health systems can use the information in budgeting and considering affiliations or market expansion; insurers in designing plan benefits and provider networks, informing reimbursement policies and setting premiums; government agencies and policy makers in framing public health campaigns and responses, framing legislation and/or evaluating the impact of existing legislative and regulatory initiatives; investors in researching the healthcare sector; and economists, researchers and the general public in seeking to track and evaluate important trends.

In this edition, as in previous editions, FH Healthcare Indicators and FH Medical Price Index each advance one year in the data they report: FH Healthcare Indicators to 2022 and FH Medical Price Index to 2023.

Methodology

FH Healthcare Indicators Methodology

To segregate FAIR Health claims data into venues of care, FAIR Health used standard Centers for Medicare & Medicaid Services (CMS) place of service codes to identify retail clinics, urgent care centers and offices. ERs were identified based on the CMS place of service, the bill type and/or an emergency department visit CPT code; telehealth using CMS place of service, telehealth-specific CPT codes or telehealth modifiers; and ASCs using CMS place of service or the bill type.

The data were then aggregated by a variety of key fields, including state, urban/rural, diagnostic categories (e.g., urinary tract infection, ear infection, acute respiratory infection), year of service and patient demographics (age and gender), to identify trends and patterns in utilization and variation in cost. Diagnostic categories were consolidated from the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) into clinically relevant groups to make them consumer-friendly. The data were evaluated with single and multiple variables to look for distinct trends and associations, which were then used to create graphical representations of the information.

In the graphical representations, the term “claim lines” refers to the individual procedures listed on insurance claims. A single claim for one patient may have multiple claim lines, with each line reflecting a separate procedure. To normalize the data and avoid fluctuations due to natural changes within plan data (e.g., the addition of a new plan contributor, or an existing contributor's addition or loss of a major employer and its members), FAIR Health calculates each data point as a percentage of the total number of medical claim lines for each year. When rural or urban data for a place of service are evaluated, the denominator is all medical claim lines within that year and region. When total national data for a place of service are evaluated, the entirety of medical claim lines for that year is the denominator.

Once this claim line percentage is established, FAIR Health creates charts that present “percent of all medical claim lines.” In this case, the number of claim lines for the place of service being evaluated in a particular location (state, rural, urban or national) in a particular year is presented as a percentage of all claim lines within the FAIR Health database that are designated as medical claim lines (not including dental or pharmacy claim lines) in that location in that year. The rural/urban designation is based on where the patient was receiving care. For example, in figure 1, rural retail clinic claim lines in 2017 are shown as a percentage of all rural medical claim lines in that year.

FH Medical Price Index Methodology

FAIR Health used two of its benchmark products, FH[®] Medical and FH[®] Allowed Medical, to calculate, respectively, charge amounts and allowed amounts for FH Medical Price Index. For each procedure code, the benchmark products (modules containing cost data based on recent claims) include a median value, which is the dollar value used for all codes included in the indices. For the 2023 indices, the last 11 releases of the FH Medical and FH Allowed Medical benchmark products were used to establish the price component of the indices. The total frequency across the entire time period for each procedure code within the selected categories (professional E&M, hospital E&M, medicine, surgery, pathology and laboratory, and radiology) was used to select codes for inclusion or exclusion. Each procedure code that had a total combined frequency of one million or more occurrences in the last 11 module releases on or before the date of the index was included in the indices. This allowed for natural inclusion of new codes and eventual exclusion of deleted codes in a gradual and controlled manner so as not to create potentially misleading fluctuations.

Once the list of codes to be included in the 2023 indices was established, the median charge or allowed amount for each code from the most recent benchmark product release was used as the price and multiplied by the corresponding frequency for that code for the last 11 releases, producing the release code median total. Then, all release code median totals in a category were summed to get a total dollar value for each release in that category (the release median total). That release median total was divided by the total frequency to generate a release average median. Each index was then created by using the following index formula: dividing each release average median for each month and year by the first release average median established (May 2012, the base):

$$\frac{\text{Release Weighted Average of Median}_{\text{MONTH YEAR}}}{\text{Release Weighted Average of Median}_{\text{BASE}}} = \text{Index Value}_{\text{MONTH YEAR}}$$

Table 1 below provides a sample calculation of how an FH Medical Price Index value is derived.

Table 1. Calculation of FH Medical Price Index for professional E&M charge amounts over a sample of the period May 2012-November 2023

Release	Release Median Total	Total Frequency	Release Median Total/Total Frequency = Release Average Median	Index Formula	FH Medical Price Index Value
May 2012	\$280,020,108,863	2,013,522,941	\$139.07 (base)	$\left(\frac{\$139.07}{\$139.07}\right)$	1.00
Nov 2023	\$689,833,682,716	3,162,431,666	\$218.13	$\left(\frac{\$218.13}{\$139.07}\right)$	1.57

Limitations

The data used in this report comprise claims data for privately insured patients who are covered by insurers and third-party administrators who voluntarily participate in FAIR Health's data contribution program. Medicare Advantage (Medicare Part C) enrollees from contributing insurers are included, but not participants in Medicare Parts A, B and D.⁴ In addition, data from Medicaid, CHIP and other state and local government insurance programs are not included, nor are data collected regarding uninsured patients.

This is an observational report based on the data FAIR Health receives from private payors regarding care rendered to covered patients.

The report was not subject to peer review.

⁴ FAIR Health also receives the entire collection of claims for traditional Medicare Parts A, B and D under the Centers for Medicare & Medicaid Services Qualified Entity Program, but those data are not a source for this report.

FH Healthcare Indicators

As in previous years, FAIR Health studied four alternative places of service—retail clinics, urgent care centers, telehealth and ASCs—and compared them to more traditional venues of care, i.e., offices and ERs.

Retail Clinic

The normalized share of medical claim lines for retail clinics grew nationally 588 percent from 2017 to 2022 (figure 1), a faster pace of growth than that documented in last year's report (128 percent from 2016 to 2021).

From 2017 to 2022, more growth occurred in urban areas (530 percent) than in rural areas (313 percent). But from 2021 to 2022, the increase in the percentage share of retail clinic utilization was greater in rural areas (252 percent) than in urban areas (198 percent); nationally, the increase was 202 percent.

In rural, urban and national settings from 2016 to 2021, the percentage of all medical claim lines attributed to retail clinics was less than 0.1 percent. In 2022, however, that percentage was 0.2 percent. To put this growth in context, the percentage of medical claim lines associated with retail clinics increased from a low base in 2021 and still represented a low percentage overall in 2022.

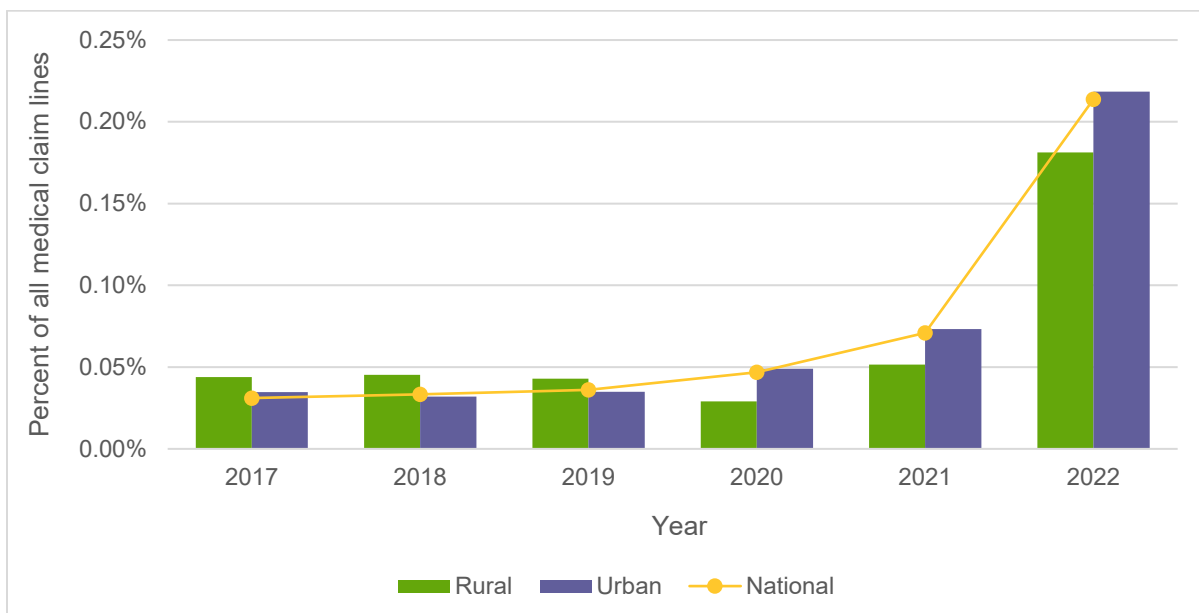


Figure 1. Claim lines with retail clinic usage as a percentage of all medical claim lines by rural, urban and national settings, 2017-2022

In the heat map below, states in which claim lines with retail clinic usage were a greater percentage of all medical claim lines than other states in 2022 are darker, while states with a lower percentage are lighter (figure 2). The five states in which retail clinic claim lines constituted the greatest percentage of medical claim lines were (from greatest to least) Rhode Island, Maine, Minnesota, Connecticut and Tennessee. Rhode Island, Maine and Connecticut remained in first, second and fourth place from 2021. Minnesota rejoined the list after falling off in 2021 and Tennessee replaced Georgia in fifth place.

The five states with the lowest retail clinic usage in 2022, in order from least to most, were Wyoming, South Dakota, Mississippi, Oklahoma and Alabama. Wyoming remained in last place, as it had in 2021, while South Dakota and Mississippi switched places, with South Dakota moving from third to last place in 2021 to second to last in 2022, and Mississippi moving from second to last place to third to last.

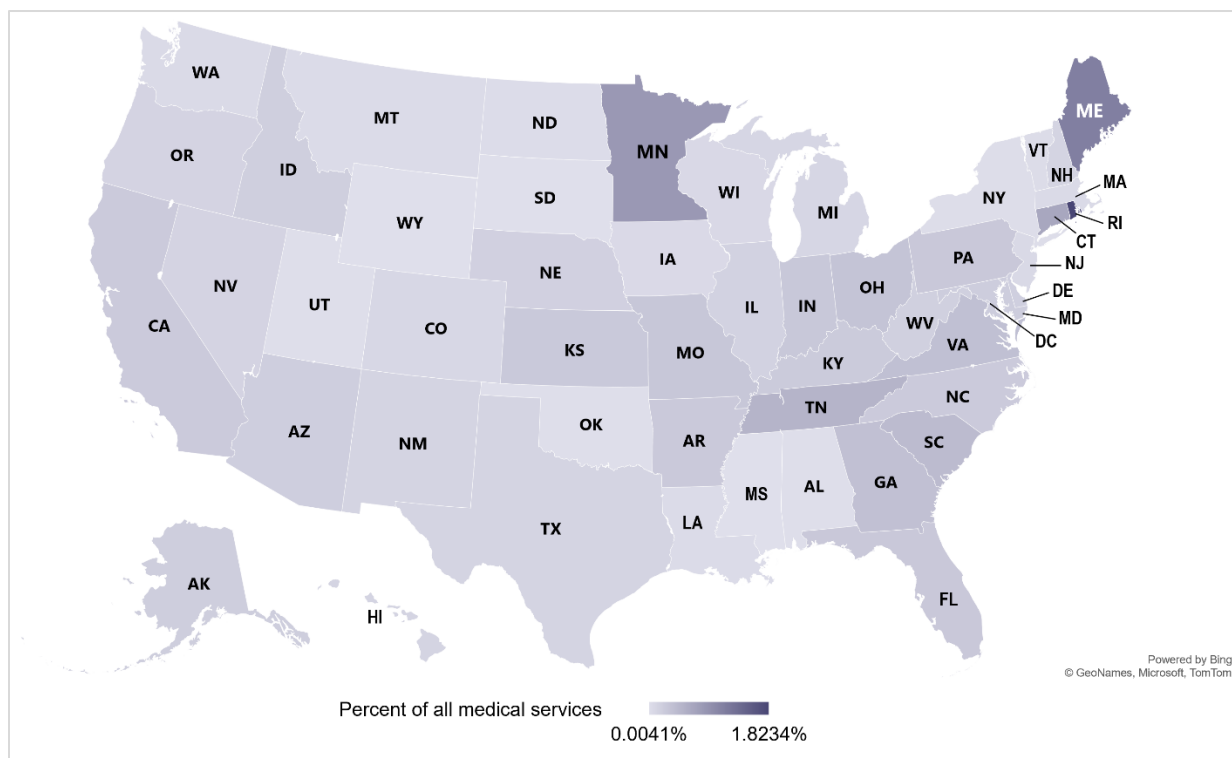


Figure 2. Percent of claim lines with retail clinic usage compared to all medical claim lines by state, 2022

The age distribution of retail clinic claim lines in 2022 (figure 3) was similar to that in 2021, but there were some changes. After increasing in 2021, the age groups 11-18 and 19-22 fell from 11 and 8 percent to 8 and 7 percent, respectively. In contrast, the age group 61-70 saw growth from 8 percent of claim lines in 2021 to 10 percent in 2022. Similarly, the age group 0-10 rose from 6 percent of claim lines in 2021 to 8 percent in 2022. In 2022, as in 2021, individuals aged 31-40 had the greatest share of claim lines for retail clinics, and their share remained at 18 percent.

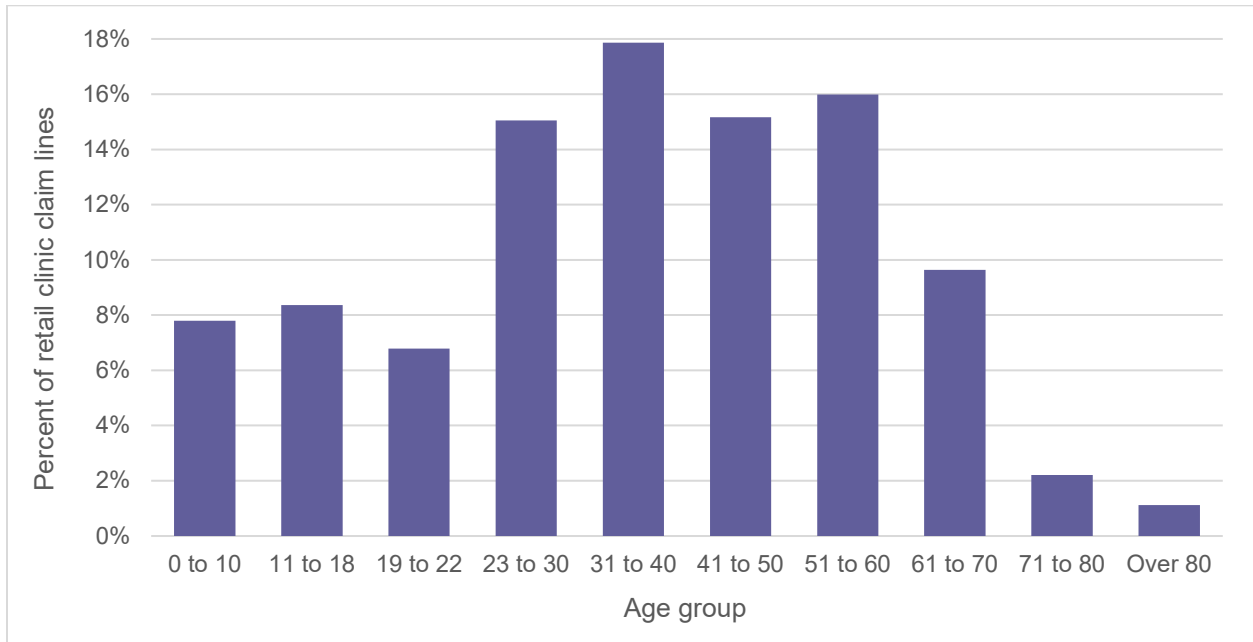


Figure 3. Percent of claim lines with retail clinic usage by age group, 2022

In 2022 as in previous years, more claim lines were submitted for females than for males in most age groups in retail clinics.⁵ In 2022, the gap between males and females at retail clinics stayed the same or became larger in all age groups except the over 80 age group, in which the share of claim lines from females dropped from 57 to 56 percent (figure 4). The female share in the age ranges from 19 to 30, which had been 60 to 63 percent in 2021, was 62 to 65 percent in 2022. In the age ranges from 31 to 60, the female share was from 57 to 58 percent in 2021 and from 59 to 60 percent in 2022. As in previous years, the only age group in which retail clinic claim lines for males outnumbered those for females was that of children aged 0-10; in 2022 as in 2021, males accounted for 51 percent of the claim lines in that age group and females 49 percent.

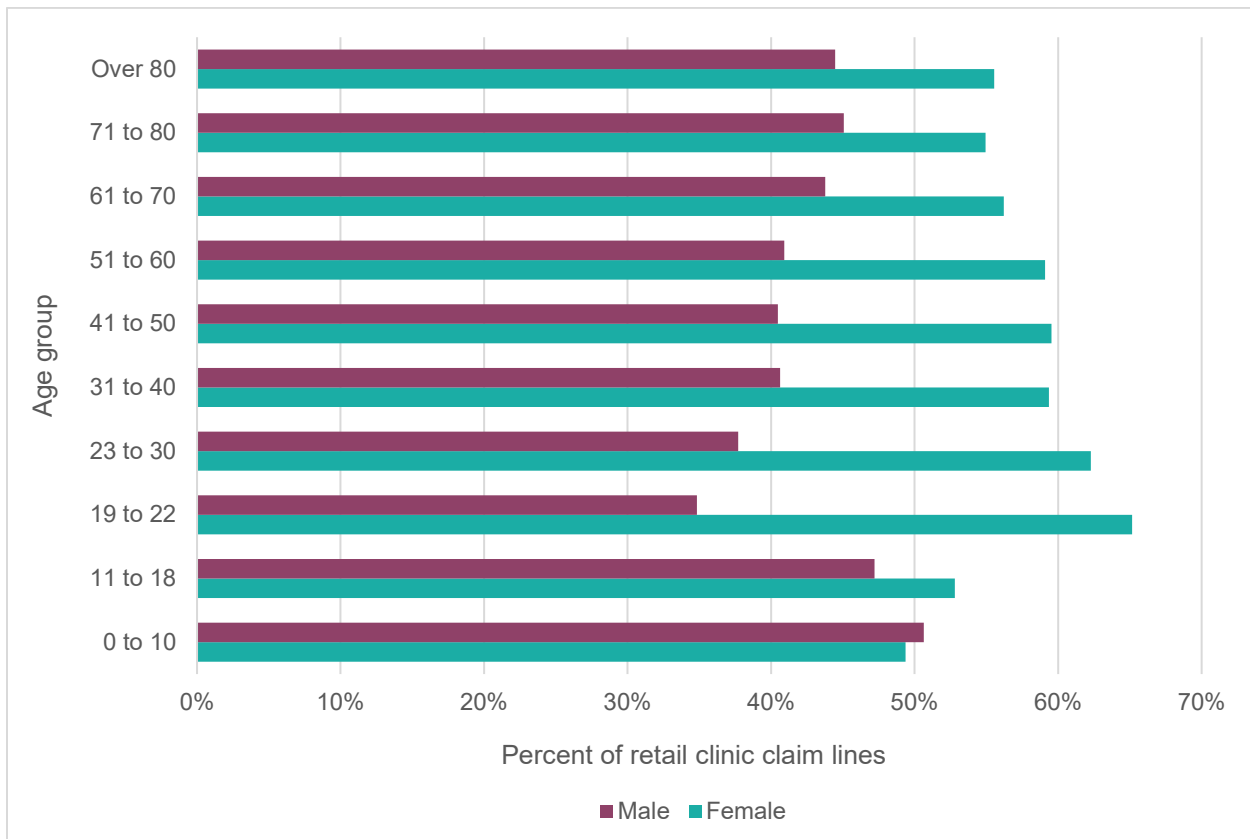


Figure 4. Percent of claim lines with retail clinic usage by age and gender, 2022

⁵ In 2022 as in past years, more claim lines were submitted for women than for men in most age groups in alternative places of service and ERs. As noted in past editions, this is consistent with the findings of other researchers that women are more likely than men to visit physicians and make use of healthcare services. See, for example, Jill J. Ashman, Esther Hing and Anjali Talwalkar, *Variation in Physician Office Visit Rates by Patient Characteristics and State, 2012*, NCHS Data Brief, no. 212 (Hyattsville, MD: National Center for Health Statistics, 2015), <https://www.cdc.gov/nchs/data/databriefs/db212.pdf>; and Klea D. Bertakis et al., “Gender Differences in the Utilization of Health Care Services,” *Journal of Family Practice* 49, no. 2 (2000):147-52, <https://www.ncbi.nlm.nih.gov/pubmed/10718692>.

The most common diagnostic category in retail clinics in 2022, at 24 percent of the distribution, was encounter for immunization, which had been in second place at 17 percent in 2021 (figure 5). Exposure to communicable diseases, which had been in first place among diagnostic categories in retail clinics in 2021 (22 percent), fell to eighth place in 2022 (3 percent). In 2022, encounter for examination was the second largest diagnostic category, rising from 14 percent in 2021 to 17 percent in 2022. Acute respiratory diseases and infections, which had been in fourth place among diagnostic categories in retail clinics at 10 percent in 2021, rose to third place in 2022 with 15 percent of the distribution. COVID-19, which had appeared for the first time in the top 10 retail clinic diagnostic categories in 2021 in seventh place with three percent of the distribution, rose to fourth place in 2022 with seven percent.

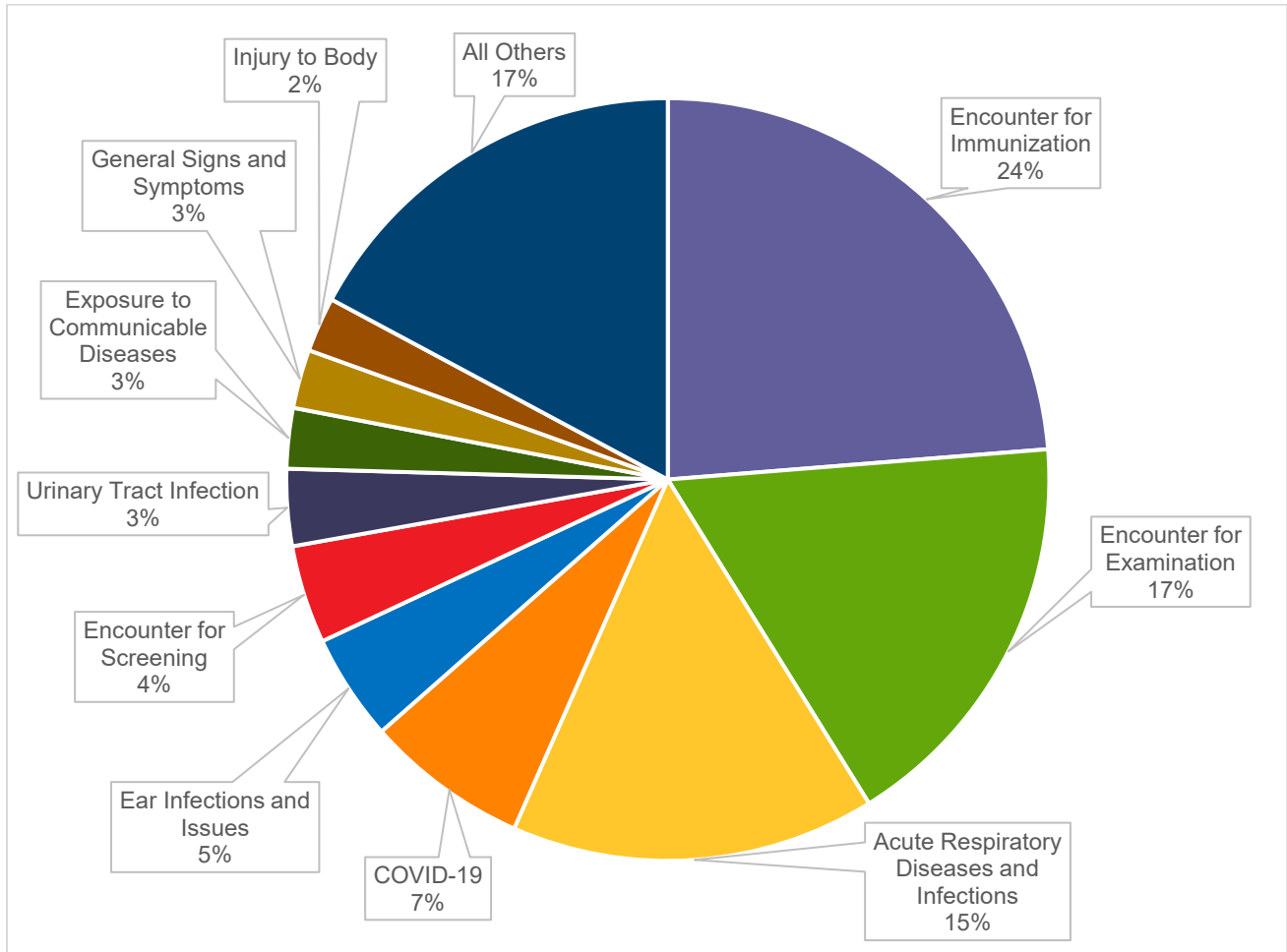


Figure 5. Distribution of claim lines with retail clinic usage by diagnostic category, 2022

As in previous years, the type of procedure most commonly performed in retail clinics in 2022 was established patient office or other outpatient services (figure 6), with 26 percent of the distribution in both 2021 and 2022. Infectious agent antigen detection moved from third place in 2021 (13 percent) to second place in 2022 (16 percent).

Whereas in 2021 urinalysis procedures had fallen from the top procedure categories, in 2022, this category rejoined in 10th place (one percent). Immunization administration for vaccines/toxoids fell from second place in 2021 (19 percent) to fifth place in 2022 (8 percent). Patient history (select aspects of patient history or review of systems, such as asthma symptoms evaluated or current tobacco smoker) rose from the eighth most common at 4 percent in 2021 to the fourth most common at 11 percent.

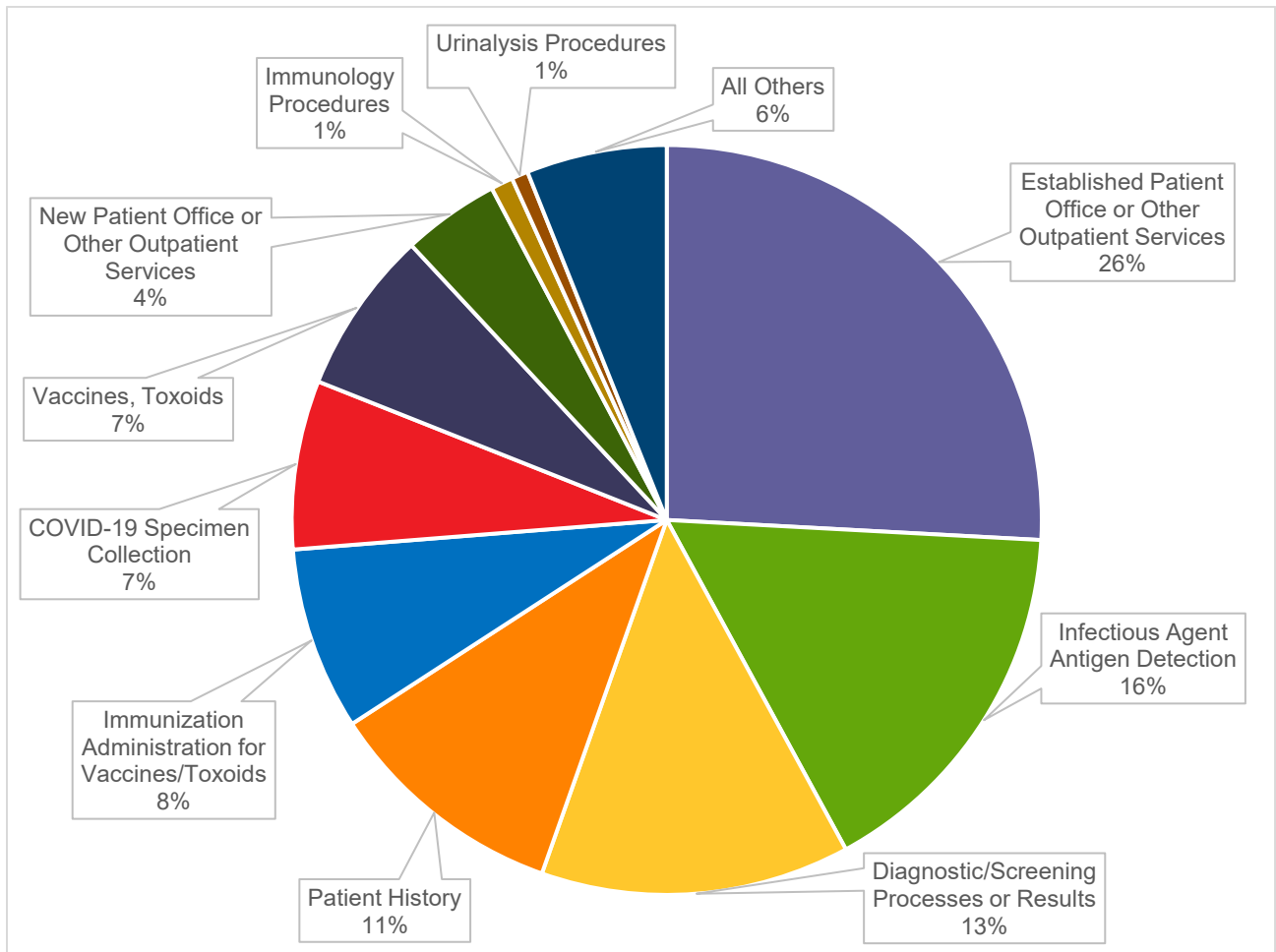
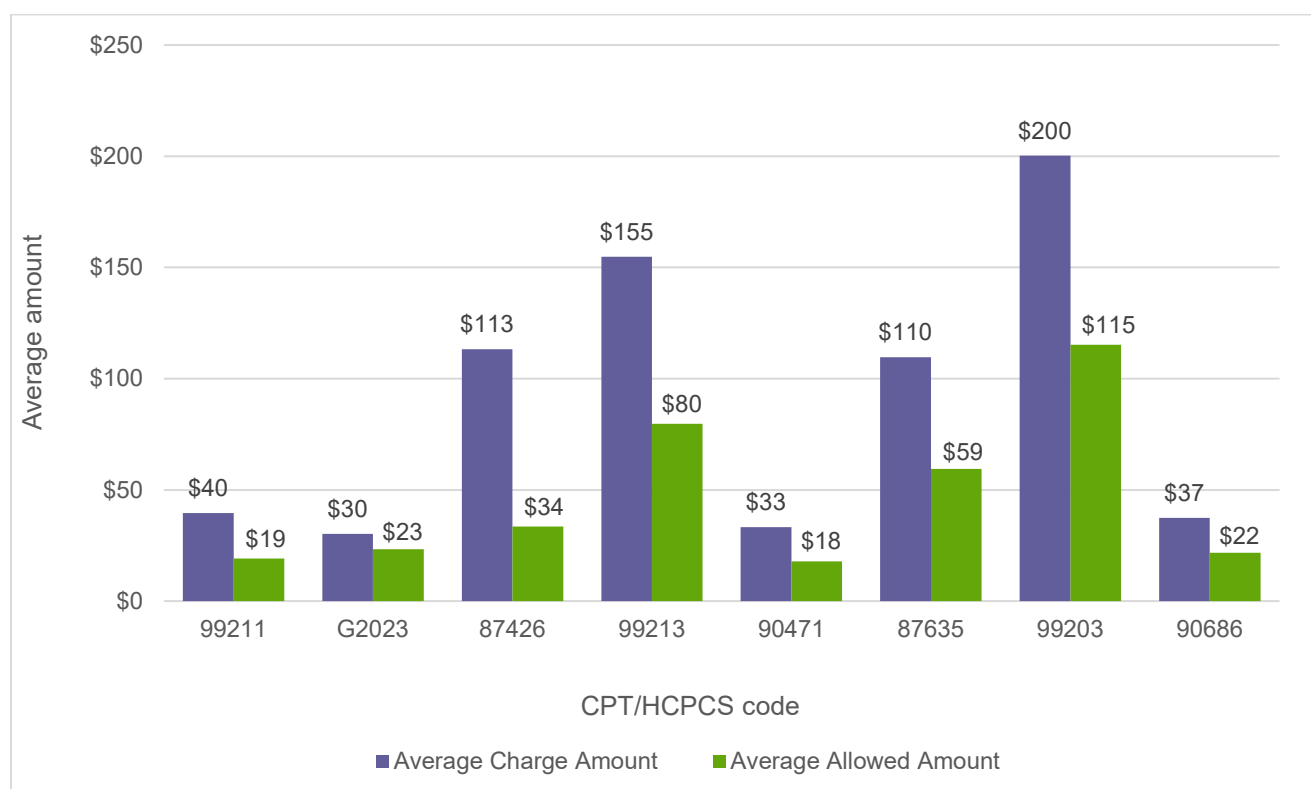


Figure 6. Distribution of claim lines with retail clinic usage by procedures, 2022

The average charges and allowed amounts for the most common procedures performed in retail clinics in 2022, as identified by CPT or HCPCS code, are shown in figure 7.

Six of the top eight codes by volume were the same in 2022 as they were in 2021. Two new codes: a laboratory test for COVID-19 (CPT 87635) and an office visit (CPT 99203) joined the top eight, while two COVID-19 vaccine codes fell off the list. In 2022, CPT 99203 (new patient office or other outpatient visit, 30-44 minutes) had the highest average charge (\$200) and allowed amount (\$115) of the top eight. The lowest average charge was \$30 for G2023 (specimen collection for COVID-19, any specimen source). The lowest average allowed amount was \$18, for CPT 90471 (administration of vaccine).



CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
99211	Office or other outpatient visit for the evaluation and management of established patient that may not require presence of healthcare professional	90471	Administration of vaccine
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [COVID-19]), any specimen source	87635	Amplified DNA or RNA probe detection of severe acute respiratory syndrome coronavirus 2 (COVID-19) antigen
87426	Detection test by immunoassay technique for severe acute respiratory syndrome coronavirus	99203	New patient office or other outpatient visit, 30-44 minutes
99213	Established patient office or other outpatient visit, 20-29 minutes	90686	Influenza vaccine, quadrivalent, preservative free, 0.5 mL dosage

Figure 7. Average charges and average allowed amounts for the most common procedures performed in retail clinics, 2022

Although certain charts in this paper report average charges and allowed amounts, actual charges and allowed amounts may vary greatly from the average. For example, the average charge amount for CPT 99203 varied from \$146 in the Northeast to \$201 in the South (table 2). The average allowed amount for that code varied from \$87 in the Northeast to \$119 in the West.

Table 2. Average charge amounts and average allowed amounts for CPT 99203 in retail clinics, by region, 2022

Region	Average charge amount	Average allowed amount
Midwest	\$158	\$94
Northeast	\$146	\$87
South	\$201	\$115
West	\$182	\$119

Urgent Care

The normalized share of claim lines for urgent care centers grew overall 207 percent from 2013 to 2022 (figure 8). This was a higher increase than that from 2012 to 2021 (125 percent). The increase from 2013 to 2022 was 211 percent for urban areas and 177 percent for rural areas.

In rural, urban and national settings, the percentage of all medical claim lines attributed to urgent care centers exceeded one percent from 2016 to 2022. From 2021 to 2022, nationally and in urban areas, urgent care usage as a percentage of medical claim lines rose 43 percent, from 1.5 percent to 2.1 percent, and in rural areas it increased 46 percent, from 1.3 percent to 1.9 percent.

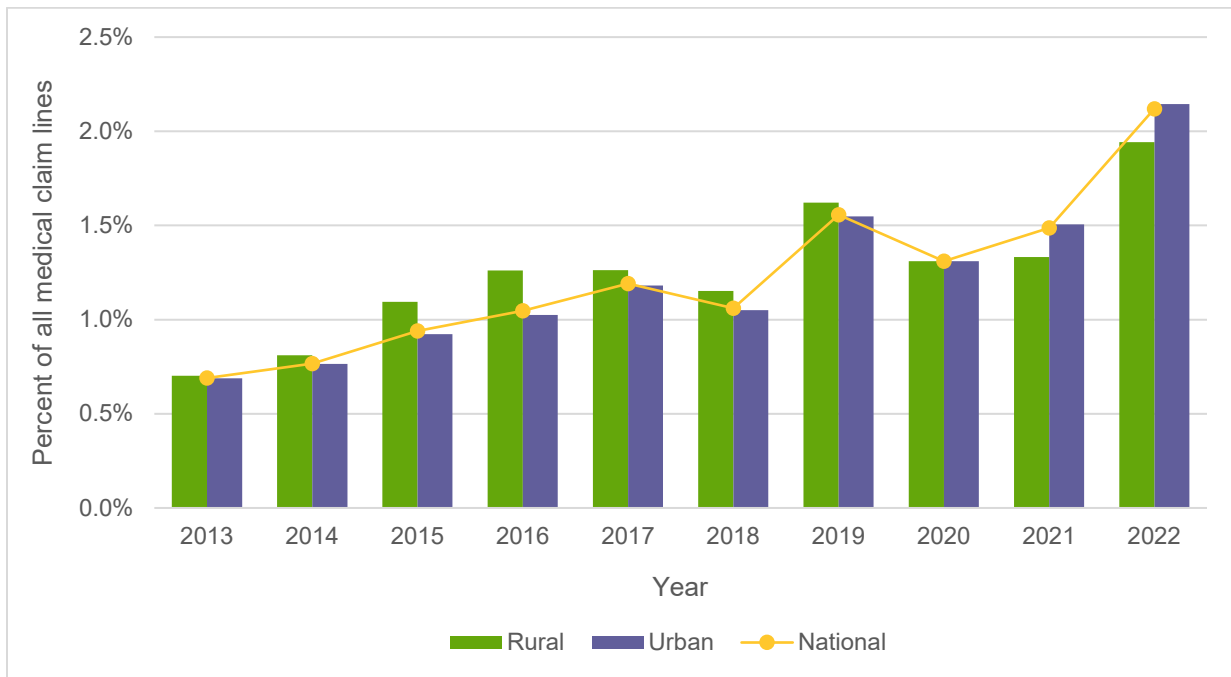


Figure 8. Claim lines with urgent care center usage as a percentage of all medical claim lines by rural, urban and national settings, 2013-2022

In 2022, the top five states for claim lines with urgent care center usage as a percentage of all medical claim lines by state were New Mexico, Hawaii, Maryland, New York and New Jersey (figure 9). Four of the top five states were on the list in both 2021 and 2022: New Mexico and Hawaii remained in first and second place, New York fell from third to fourth place and Maryland rose from fifth to third place. New Jersey was new to the top five in 2022 and Georgia, which had been fourth, fell off the list.

The five states with the lowest urgent care center usage in 2022 were North Dakota, Iowa, Nebraska, Arkansas and Massachusetts. The first three of these were on the list in 2021 in the same positions. Washington, DC, and Wisconsin fell off the list in 2022, while Arkansas and Massachusetts took their places.

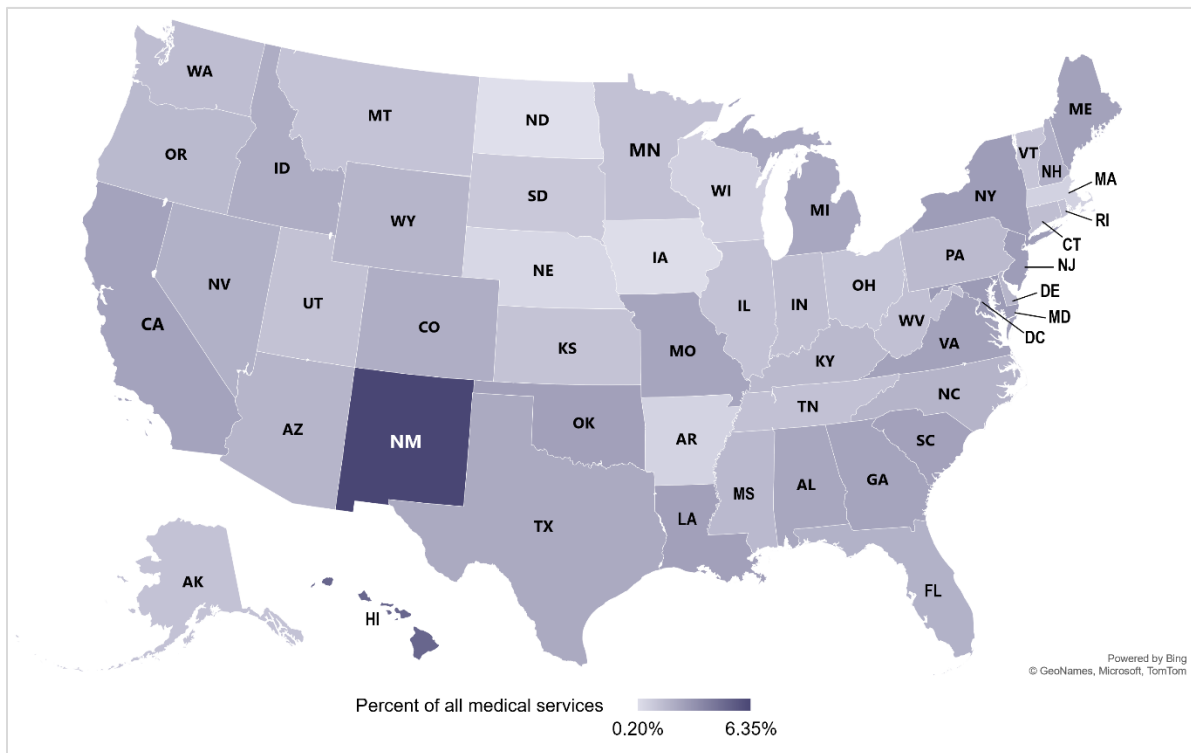


Figure 9. Percent of claim lines with urgent care center usage compared to all medical claim lines by state, 2022

As in previous years, the age group with the greatest share of claim lines for urgent care center usage in 2022 was that of individuals aged 31-40, but the percentage fell from 19 percent to 17 percent (figure 10). It was part of an age range, 23-50, that together accounted for 47 percent of the distribution in 2022 and had accounted for 51 percent in 2021. Other changes in the age distribution included a shift in the age group 0-10, which increased its share from 10 percent in 2021 to 12 percent in 2022 and a similar shift in the age group 61-70, which increased from 6 percent to 8 percent.

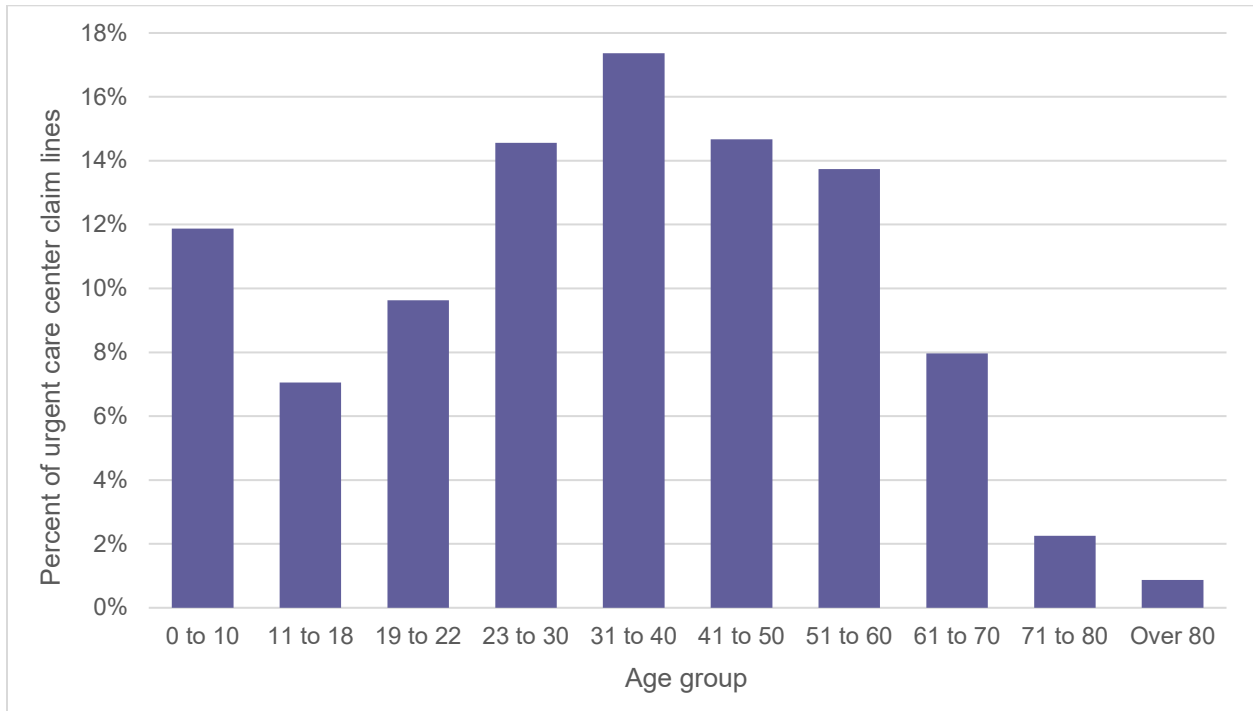


Figure 10. Percent of claim lines with urgent care center usage by age group, 2022

In 2022, as in previous years, urgent care center claim lines for females exceeded those for males in every age group except 0-10 (figure 11). After declining in 2020 and 2021, the gender disparity of females over males increased from 2021 to 2022 in most age groups. In the age ranges from 19 to 80, for example, the female percentage had varied from 56 to 60 percent in 2021, but in 2022 it varied from 59 to 62 percent. In the group of individuals aged over 80, however, the female share remained 61 percent in 2022 as it had been in 2021.

The most prominent gender disparity was in the age group 19-22, in which the share of females was 62 percent. The age group 19-22 was also the youngest in which the female share was considerably greater than the male. Under age 19, the share of females was closer to that of males. For example, in the age group 0-10, the female share of the distribution was 48 percent and, in the age group 11-18, it was 51 percent.

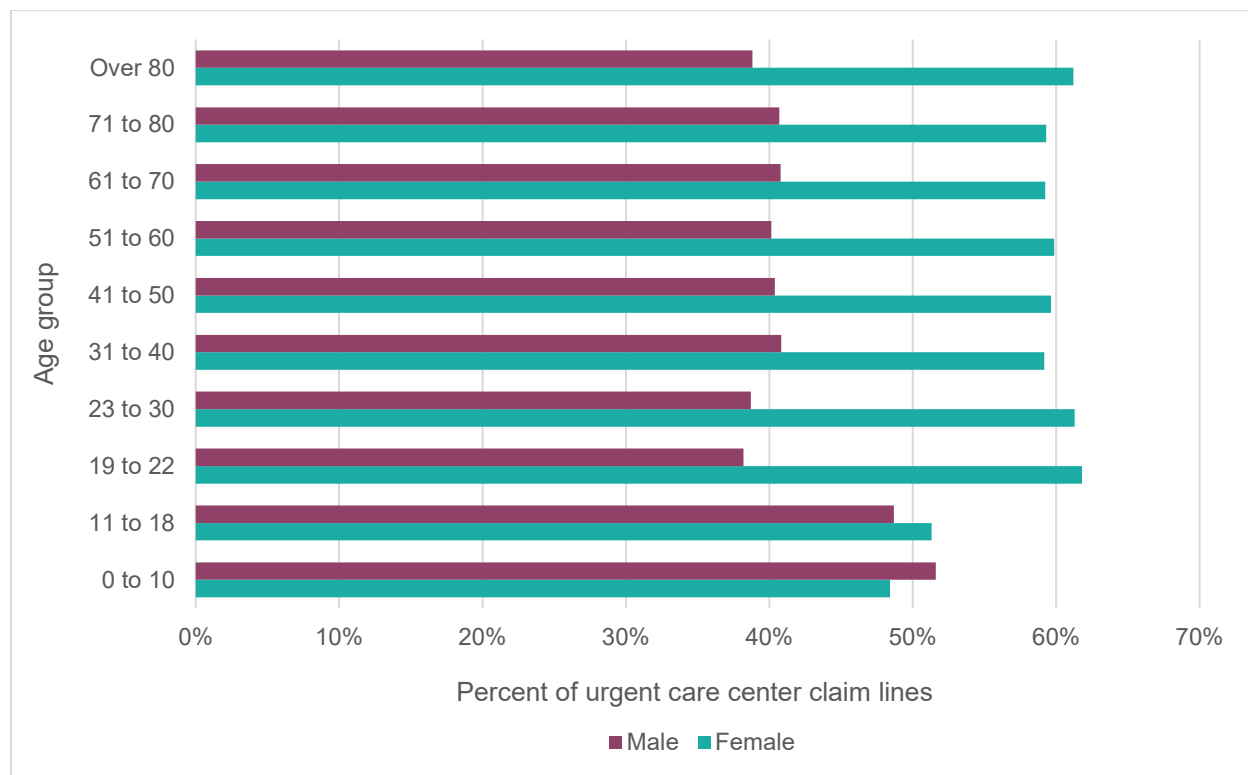


Figure 11. Percent of claim lines with urgent care center usage by age and gender, 2022

As in previous years, acute respiratory diseases and infections constituted the most common diagnostic category in urgent care centers in 2022 (figure 12), rising from 15 percent of claim lines in 2021 to 21 percent in 2022. In contrast, exposure to communicable diseases, which ranked in second place in 2021, fell to eighth place in 2022 and its share decreased from 13 percent to 4 percent. COVID-19 remained in third place, but dropped from eight percent of the distribution in 2021 to seven percent in 2022. Several other diagnostic categories increased in their percentage of claim lines in 2022. For example, urinary tract infections rose from seventh (five percent) to fourth position (six percent), and ear infections and issues rose to fifth position (five percent) after being in ninth position (three percent). In addition, influenza and pneumonia, which had ranked in 26th place with 0.6 percent of the distribution in 2021, rose to 11th place, with 3 percent of total urgent care claim lines. Encounter for examination, however, which had been in 5th place in 2021, fell off the list to 14th place in the distribution.

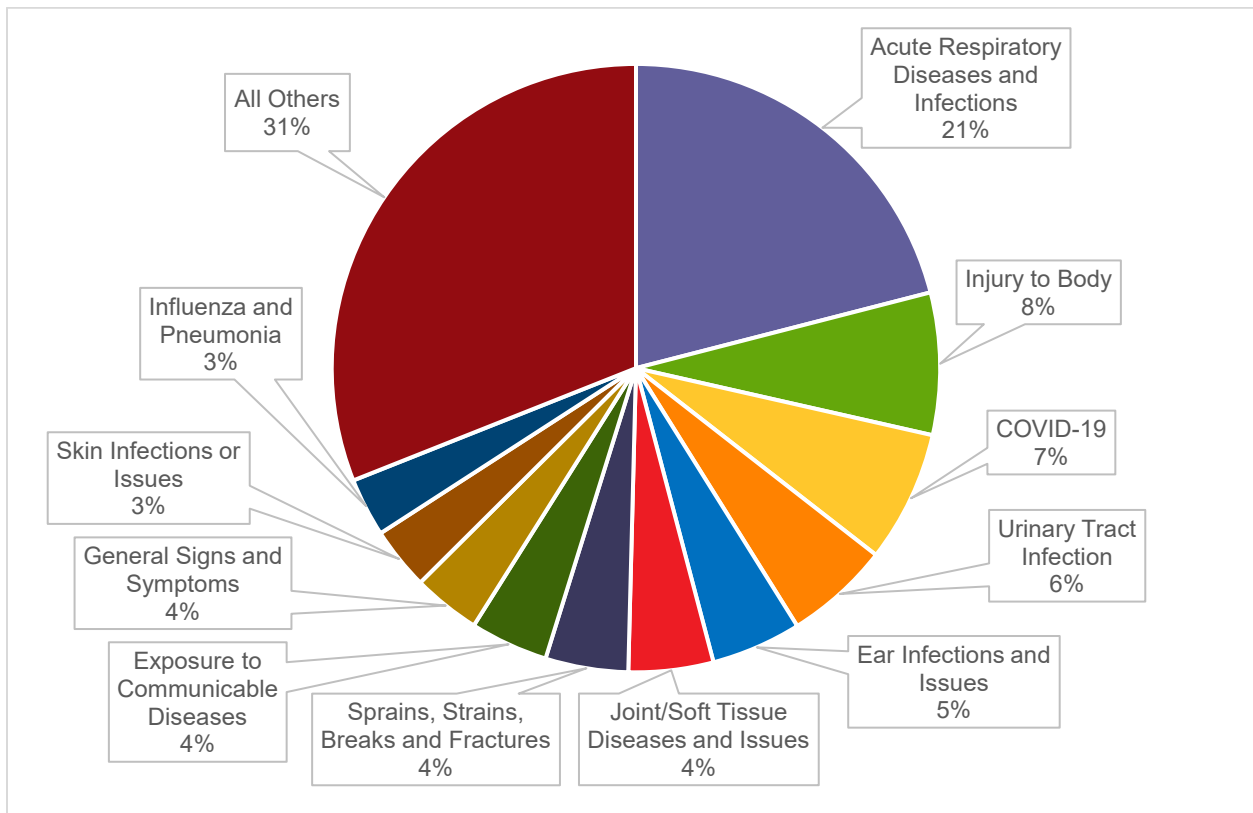


Figure 12. Distribution of claim lines with urgent care center usage by diagnostic category, 2022

As in retail clinics (figure 6), and as in previous years in urgent care centers, established patient office or other outpatient services constituted the most common procedure in urgent care centers in 2022 (figure 13), accounting for 27 percent of urgent care center claim lines in 2022, up from 24 percent in 2021. Urgent care visit services (codes specific to urgent care centers, including a global code for reimbursement with a flat fee and an “add-on” code to be used with codes for other services) continued to decrease, falling from 16 percent in 2021 to 11 percent in 2022 and dropping from third to fourth place. Infectious agent antigen detection, which largely consisted of influenza and COVID-19 testing, continued to rise, from 18 percent in 2021 to 21 percent in 2022. New patient office or other outpatient services rose from fourth place in 2021 to third place in 2022, though the percentage of claim lines fell from 14 percent to 13 percent.

After entering the list of top procedures in 2021, COVID-19 specimen collection fell off the list in 2022, while diagnostic radiology procedures of the lower extremities rejoined the list with one percent of the distribution.

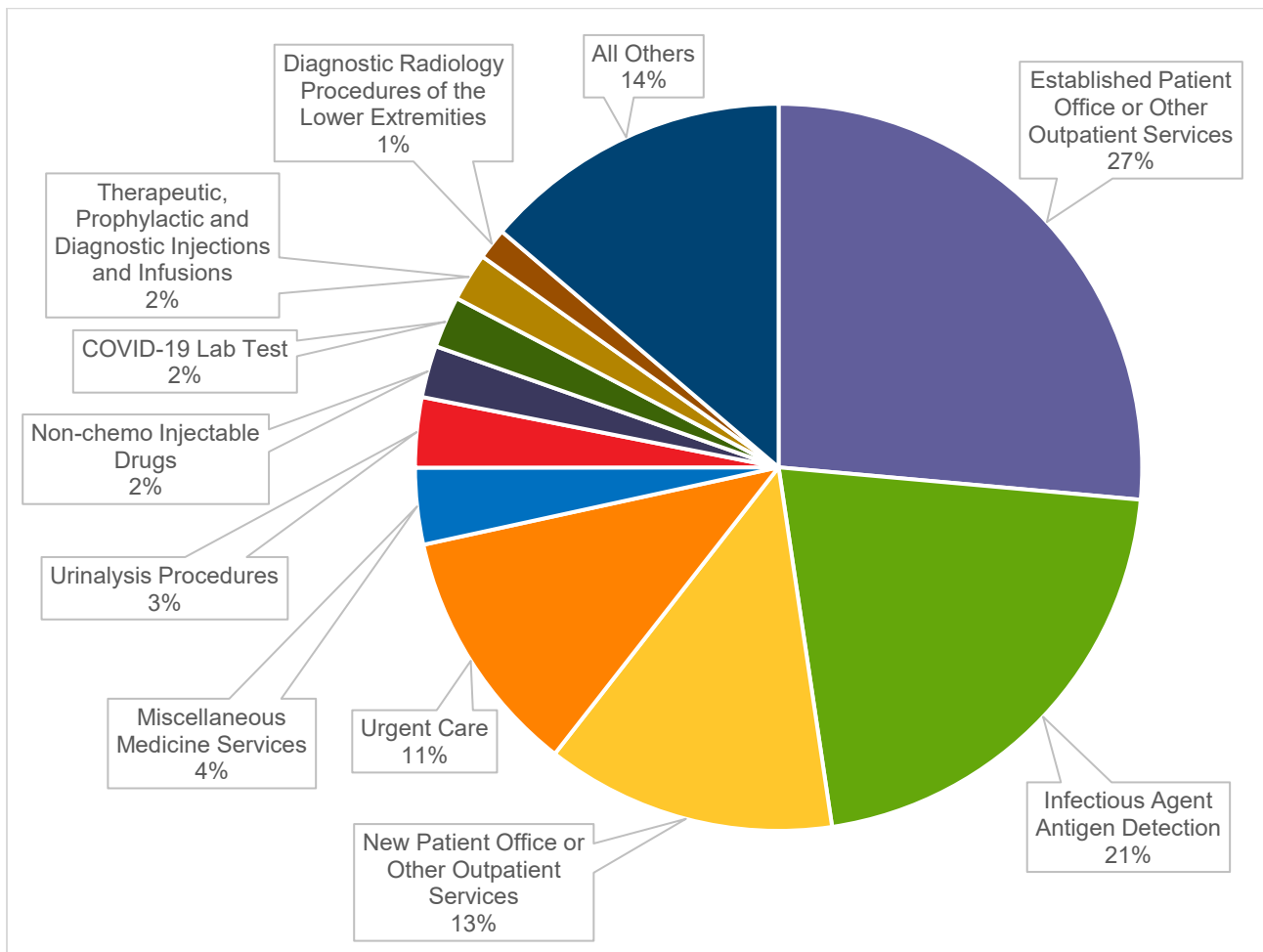
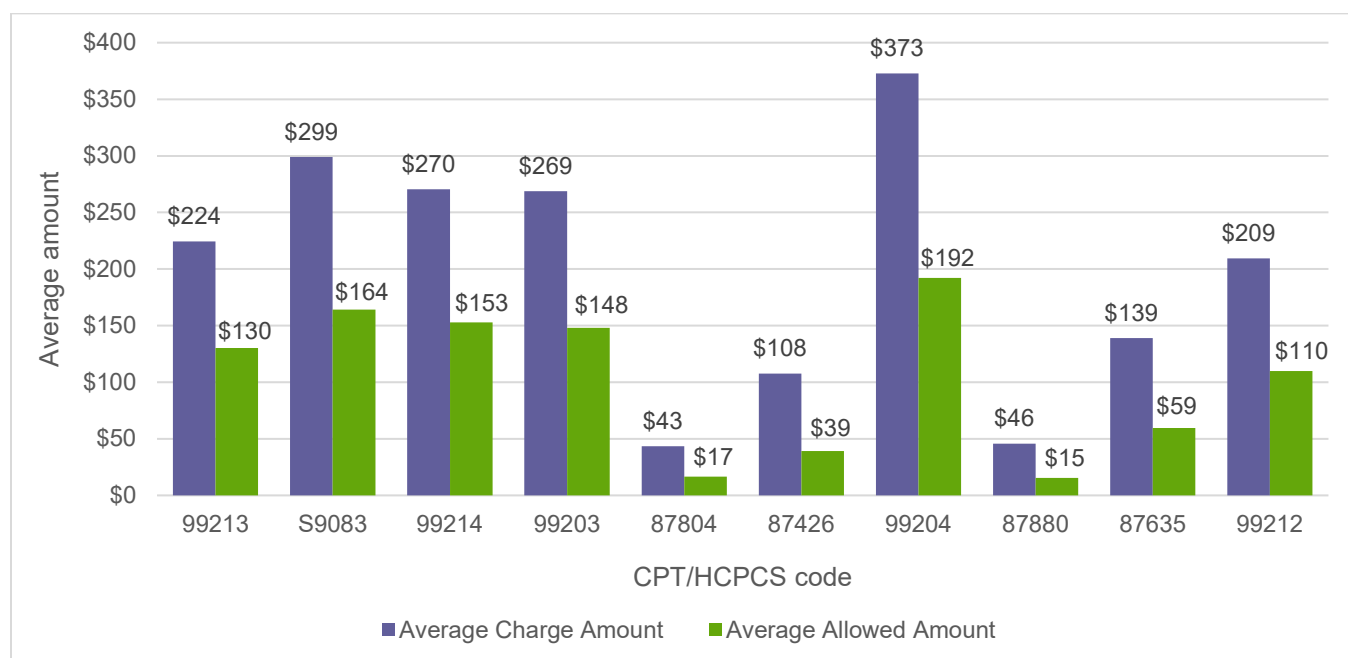


Figure 13. Distribution of claim lines with urgent care center usage by procedures, 2022

Nine of the 10 most common codes billed in an urgent care center were the same in 2022 as they were in 2021 (figure 14). The new code was a lab test for influenza (CPT 87804).

S9083 (global fee urgent care centers) fell from first place in 2021 to second place in 2022. CPT 99214 (established patient office or other outpatient visit, 30-39 minutes) rose from fifth place in 2021 to third place in 2022.

The highest average charge amount in 2022 was \$373 for CPT 99204 (new patient office or other outpatient visit, 45-59 minutes); that code also had the highest average allowed amount, \$192. The lowest average charge amount was \$43, for CPT 87804 (detection test by immunoassay with direct visual observation for influenza virus). The lowest average allowed amount was \$15 for CPT 87880 (detection test by immunoassay with direct visual observation for Streptococcus, group A [strep]).



CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
99213	Established patient office or other outpatient visit, 20-29 minutes	87426	Detection test by immunoassay technique for severe acute respiratory syndrome coronavirus
S9083	Global fee urgent care centers	99204	New patient office or other outpatient visit, 45-59 minutes
99214	Established patient office or other outpatient visit, 30-39 minutes	87880	Detection test by immunoassay with direct visual observation for Streptococcus, group A (strep)
99203	New patient office or other outpatient visit, 30-44 minutes	87635	Amplified DNA or RNA probe detection of severe acute respiratory syndrome coronavirus 2 (COVID-19) antigen
87804	Detection test by immunoassay with direct visual observation for influenza virus	99212	Established patient office or other outpatient visit, 10-19 minutes

Figure 14. Average charges and average allowed amounts for the most common procedures performed in urgent care centers, 2022

As previously noted, actual charges and allowed amounts may vary greatly from the average. For example, the average charge amount for S9083 varied from \$197 in the Midwest to \$418 in the West (table 3). The average allowed amount for that code varied from \$110 in the Midwest to \$167 in the Northeast.

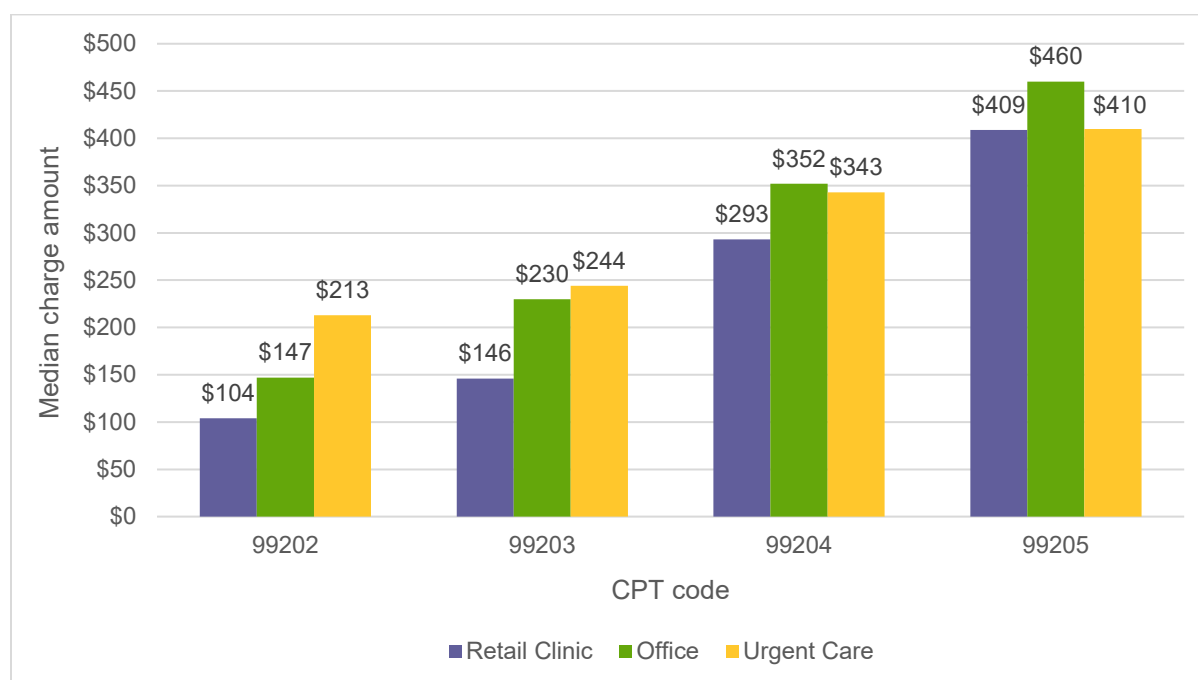
Table 3. Average charge amounts and average allowed amounts for S9083 in urgent care centers by region, 2022

Region	Average charge amount	Average allowed amount
Midwest	\$197	\$110
Northeast	\$294	\$167
South	\$286	\$152
West	\$418	\$159

Retail Clinic, Office and Urgent Care Center: A Price Comparison

As in previous years, for a comparison of prices at retail clinics, traditional offices and urgent care centers, FAIR Health analyzed claims data for new patient E&M codes. A new patient E&M visit includes a detailed history for the patient, a detailed examination and medical decision making. Counseling and coordination of care with other providers also may occur. The visits are coded by length of time: CPT 99202 is 15-29 minutes, CPT 99203 is 30-44, CPT 99204 is 45-59 and CPT 99205 is 60-74.

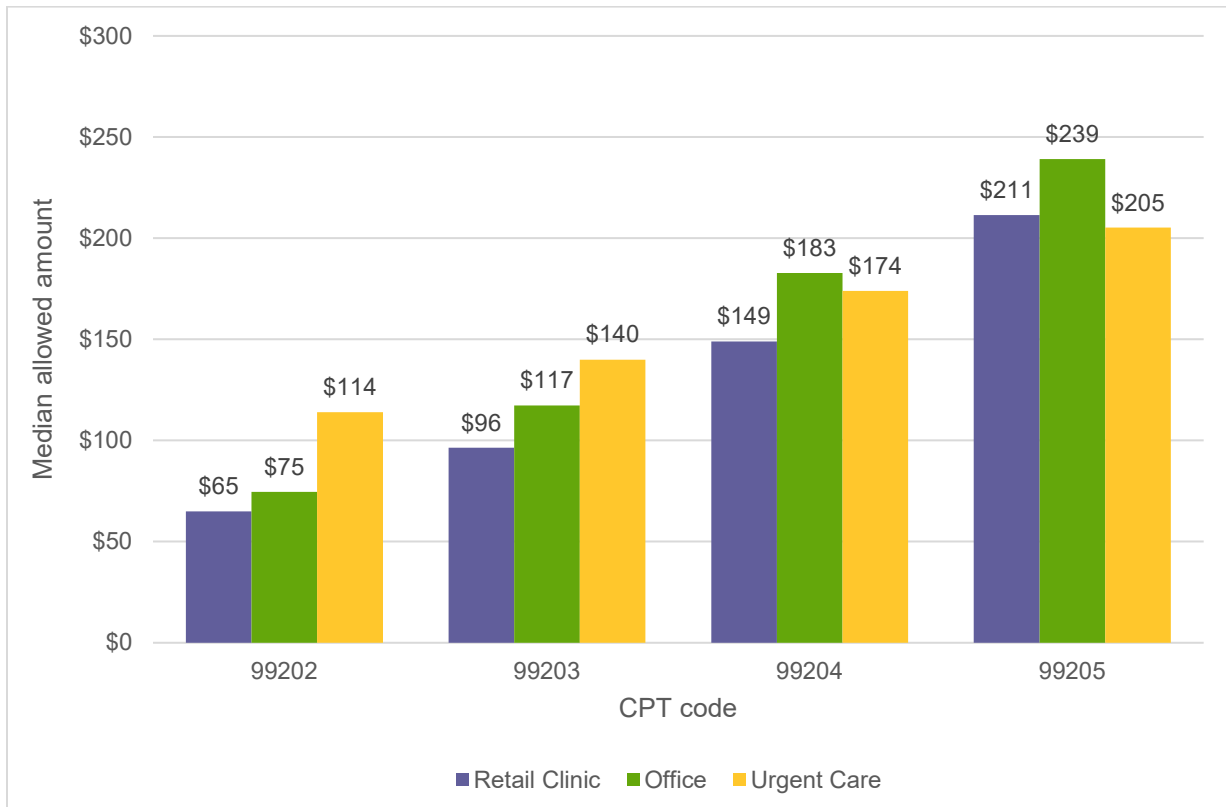
In 2022, the median charge amounts across retail clinics, offices and urgent care centers (figure 15) were similar to those seen in 2021 for two out of four codes. For CPT 99202, urgent care centers had the highest median charge, followed by offices and retail clinics in both years. The order was the same for CPT 99203. CPT 99204, however, differed between years: In 2021, offices had the highest median charge, followed by retail clinics and then urgent care centers, but in 2022, the order from highest to lowest was offices (\$352), urgent care centers (\$343) and retail clinics (\$293). Unlike in previous years, in 2022, retail clinics had enough volume to establish values for CPT 99205. For that code, offices had the highest median charge (\$460), followed by urgent care centers (\$410), while retail clinics had the lowest median charge (\$409).



CPT Code	Description
99202	New patient office or other outpatient visit, 15-29 minutes
99203	New patient office or other outpatient visit, 30-44 minutes
99204	New patient office or other outpatient visit, 45-59 minutes
99205	New patient office or other outpatient visit, 60-74 minutes

Figure 15. Median charge amounts for retail clinics, offices and urgent care centers for new patient E&M codes, 2022

When the same comparisons among retail clinics, offices and urgent care centers were made on the basis of median allowed amounts, the results for 2022 (figure 16) were similar to those for charge amounts in the same year (figure 15). As for charge amounts, urgent care centers had the highest allowed amount values for CPT 99202 and 99203, with offices in second place and retail clinics in third; offices had the highest for CPT 99204, with urgent care centers in second place and retail clinics in third. Unlike in previous years, in 2022, retail clinics had enough volume to establish allowed amount values for CPT 99205. For that code, the order from highest to lowest differed from charge amounts. Offices had the highest median allowed amount value (\$239); retail clinics were in second place (\$211) and urgent care centers in third (\$205).



CPT Code	Description
99202	New patient office or other outpatient visit, 15-29 minutes
99203	New patient office or other outpatient visit, 30-44 minutes
99204	New patient office or other outpatient visit, 45-59 minutes
99205	New patient office or other outpatient visit, 60-74 minutes

Figure 16. Median allowed amounts for retail clinics, offices and urgent care centers for new patient codes, 2022

Telehealth

Normalized telehealth usage grew 3,490 percent nationally from 2017 to 2022 (figure 17).⁶ During the same period, in urban areas, telehealth usage grew 3,483 percent and in rural areas 4,774 percent. The rural/urban designation is based on where the patient was receiving care.

Telehealth grew the most in 2020, when the COVID-19 pandemic began. In that year, national telehealth utilization increased 6,117 percent, from 0.21 percent of medical claim lines in 2019 to 13.35 percent in 2020. It then dropped to 3.58 percent in 2021, still above the pre-pandemic level.

In 2022, national telehealth utilization climbed eight percent from 2021, remaining well above pre-pandemic levels but far lower than its peak in the first pandemic year of 2020. Telehealth's national share of medical claim lines climbed from 3.58 percent in 2021 to 3.89 percent in 2022—still approximately 19 times higher than its 2019 level. In urban areas, telehealth increased from 3.79 percent in 2021 to 4.15 percent in 2022; in rural areas, the increase was from 1.88 percent in 2021 to 2.05 percent in 2022.

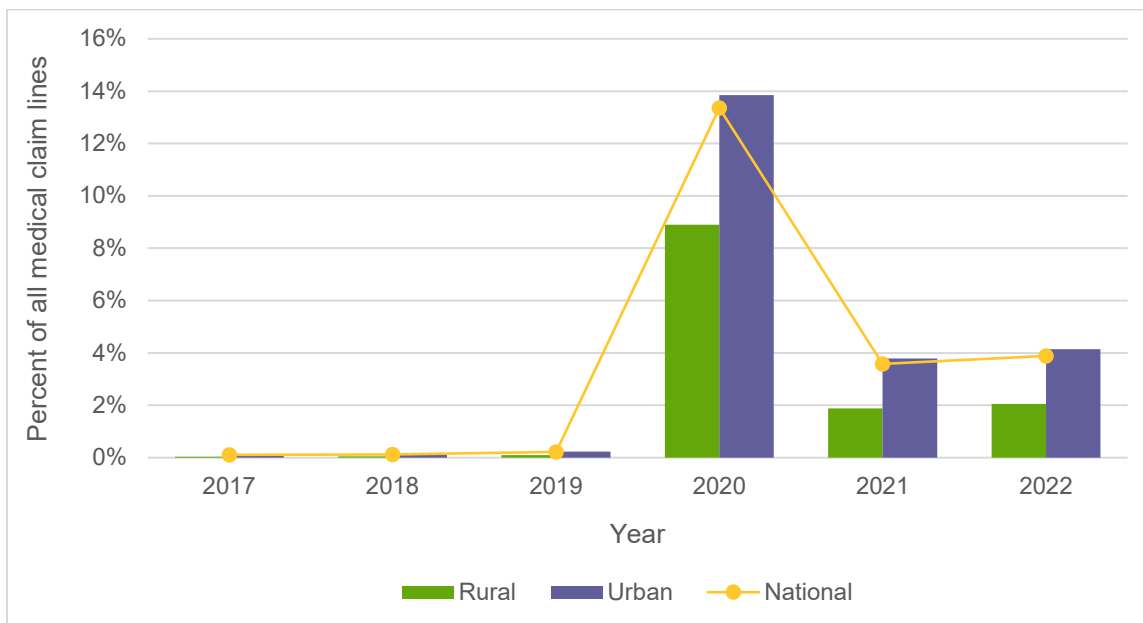


Figure 17. Claim lines with telehealth usage as a percentage of all medical claim lines by rural, urban and national settings, 2017-2022

⁶ For this edition, FAIR Health changed the method of calculation, so this chart is not directly comparable to the same chart in previous years' editions.

In 2022, the top five jurisdictions for telehealth claim lines as a percentage of all medical claim lines by state (or district) were Washington, DC; Massachusetts; Delaware; Oregon; and New York (figure 18). Washington, DC; Massachusetts; and Oregon remained in the top five from 2021, though Washington, DC, rose from second to first place and Massachusetts fell from first to second. Vermont, which had been 3rd in 2021, fell to 13th place; Connecticut, which had been 5th in 2021, fell to 6th place. Oregon remained in fourth place and New York entered in fifth. The state designation for telehealth is based on where the patient received care.

All five states with the lowest telehealth use rates in 2022 (Mississippi, South Dakota, Alabama, North Dakota and Iowa) had been on that list in 2021. Mississippi was in the lowest place both years; Alabama had been fourth from the bottom in 2021 and moved to third from the bottom in 2022; and South Dakota moved from the third from the bottom to the second from the bottom. North Dakota moved from second from the bottom to fourth from the bottom.

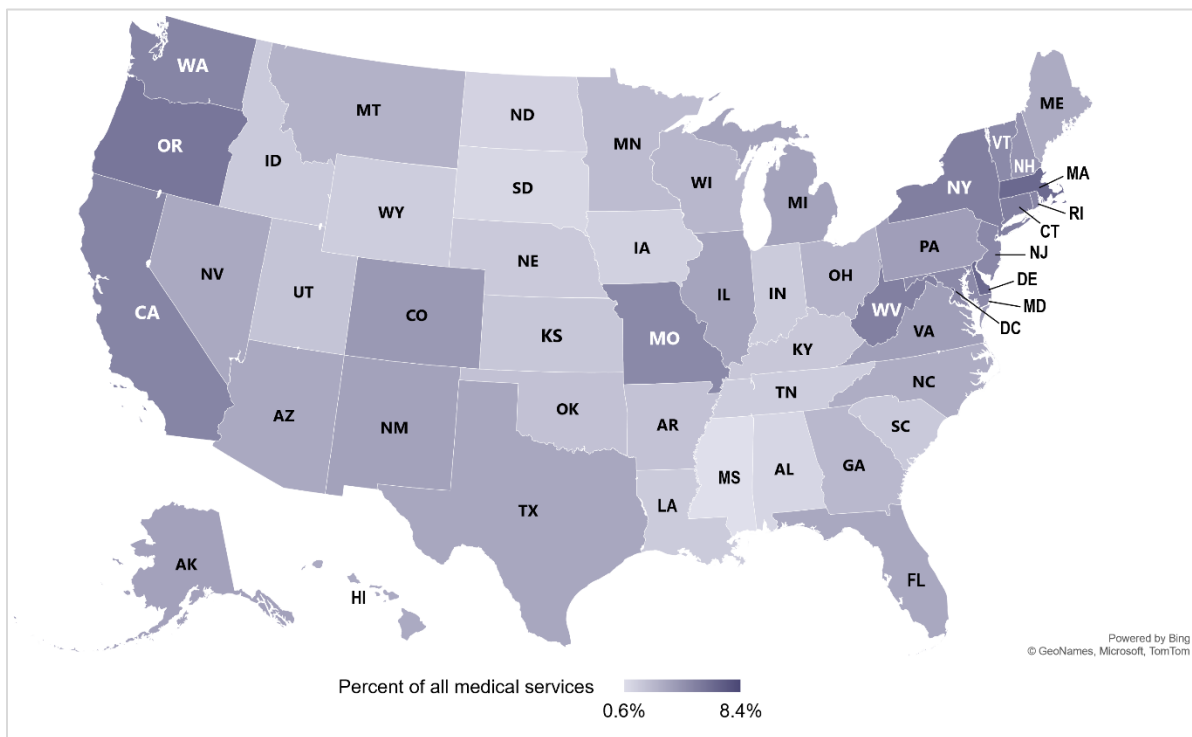


Figure 18. Percent of claim lines with telehealth usage compared to all medical claim lines by state, 2022

As in previous years, the age group with the largest share of telehealth claim lines in 2022 was that of individuals aged 31-40 (22 percent; figure 19). In 2022, the age group 23-30 accounted for 17 percent of telehealth claim lines, up from 16 percent in 2021, while the age group 41-50 remained at 16 percent of the distribution in 2022. The age groups 0-10 and 11-18 both fell in their share of the distribution from 2021 to 2022; the age group 0-10 fell from 6 to 4 percent and the age group 11-18 fell from 10 to 8 percent. In contrast, the age groups 61-70 and 71-80 grew in their share of the distribution. The age group 61-70 rose from eight to nine percent and the age group 71-80 rose from two to three percent.

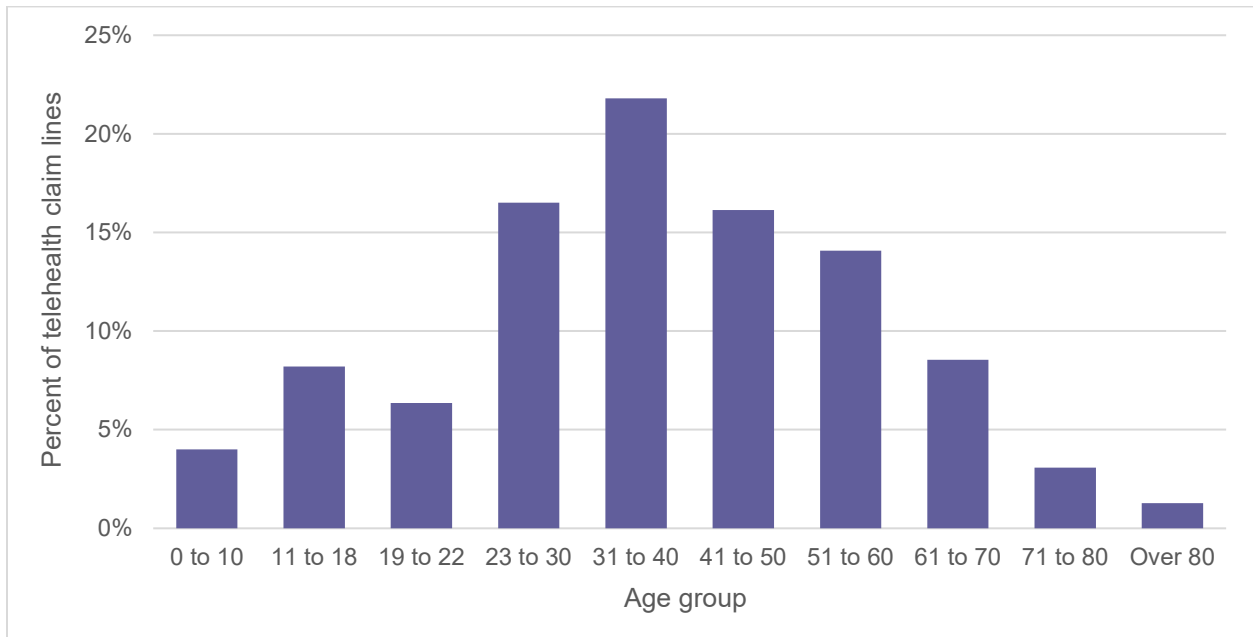


Figure 19. Percent of claim lines with telehealth usage by age group, 2022

In 2022, as in 2021, claim lines with telehealth usage were submitted more for females than males in every age group except children aged 0-10 (figure 20). In the 0-10 age group, the male share was 60 percent in 2022. Males accounted for less than 40 percent of the distribution in all other age groups except 71-80 (41 percent).

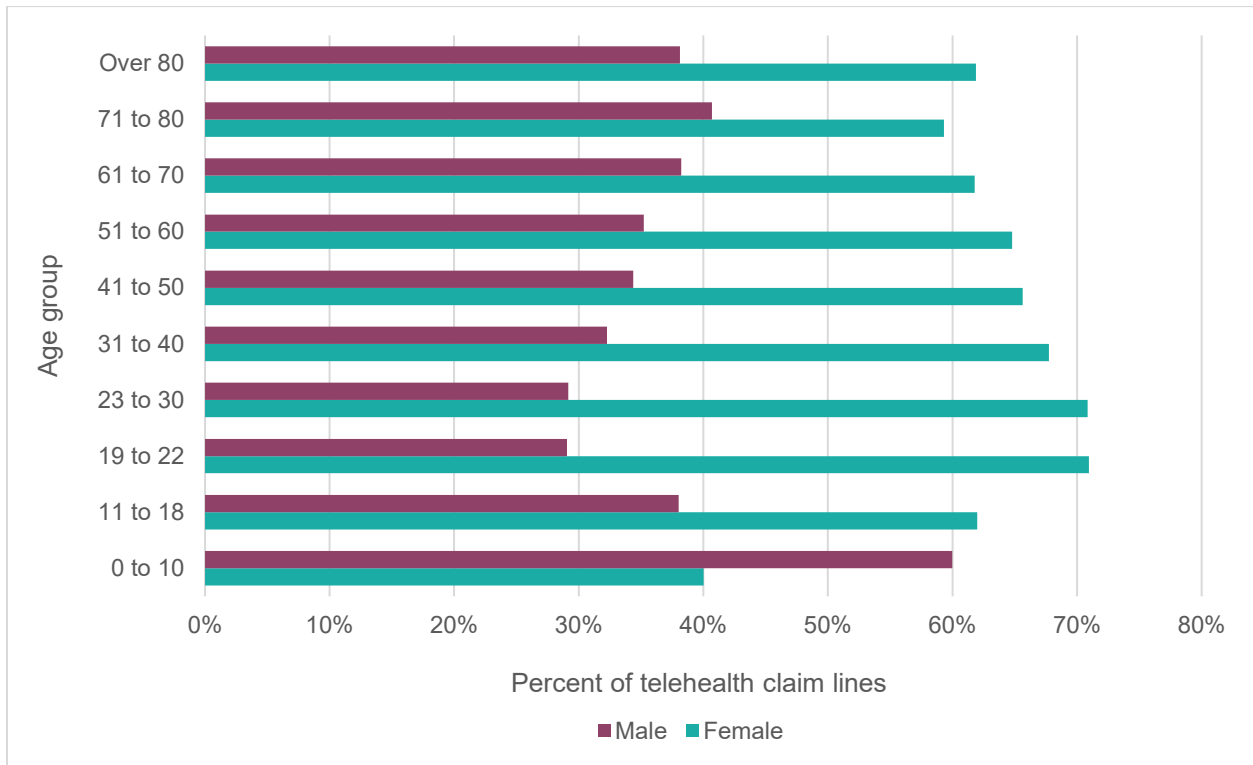


Figure 20. Percent of claim lines with telehealth usage by age and gender, 2022

As in previous years, the most common telehealth diagnostic category in 2022 was mental health conditions, which continued to grow from 57 percent of the distribution in 2021 to 61 percent in 2022 (figure 21). Acute respiratory diseases and infections remained the second most common reason for a telehealth visit in 2022 with three percent of the distribution. Developmental disorders moved from the third most common reason to the sixth most common, and COVID-19, which joined the list in 2021, moved from the fifth to third most common telehealth diagnostic category. In 2022, substance use disorders moved from 9th to 8th place, continuing an upward trend from 2020 when it was in 12th place. Month-to-month details of changes in top telehealth diagnostic categories and other telehealth trends can be found in FAIR Health’s Monthly Telehealth Regional Tracker.⁷

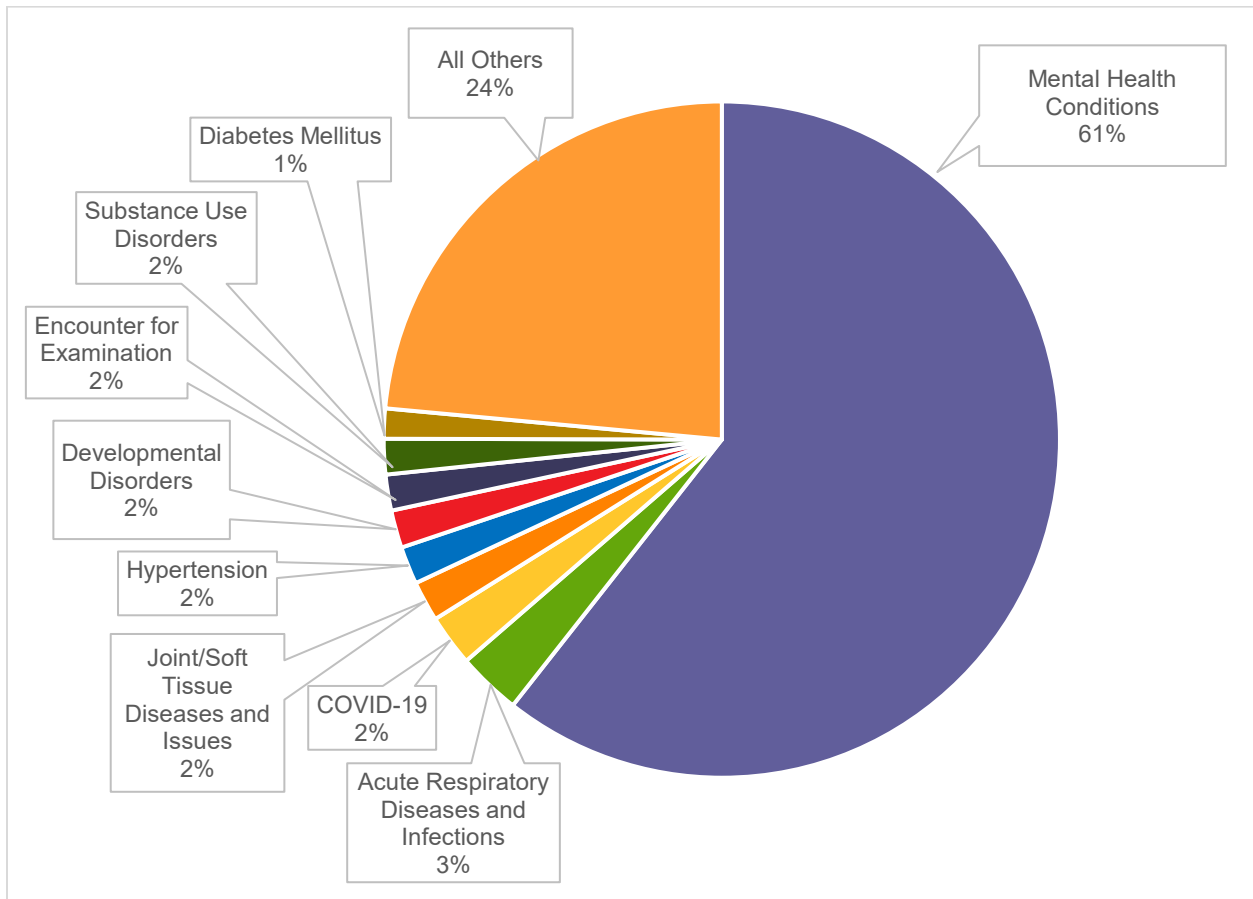


Figure 21. Distribution of claim lines with telehealth usage by diagnostic category, 2022

⁷ “Monthly Telehealth Regional Tracker,” FAIR Health, accessed February 15, 2024, <https://www.fairhealth.org/states-by-the-numbers/telehealth>.

Ambulatory Surgery Center

In 2022, normalized ASC usage reversed the decline that had begun in 2020 (figure 22). From 2021 to 2022, national ASC usage climbed 88 percent; in rural areas the increase was 78 percent and in urban areas 89 percent. The decrease in 2020 was likely due in large part to restrictions on elective surgery at the start of the COVID-19 pandemic,⁸ and the decrease in 2021 may have been due to shortages of supplies and staffing.⁹ The resumption of elective procedures and increases in higher-acuity procedures at ASCs,¹⁰ as well as reduced costs for services when compared with hospitals,¹¹ may have contributed to the increase in 2022.

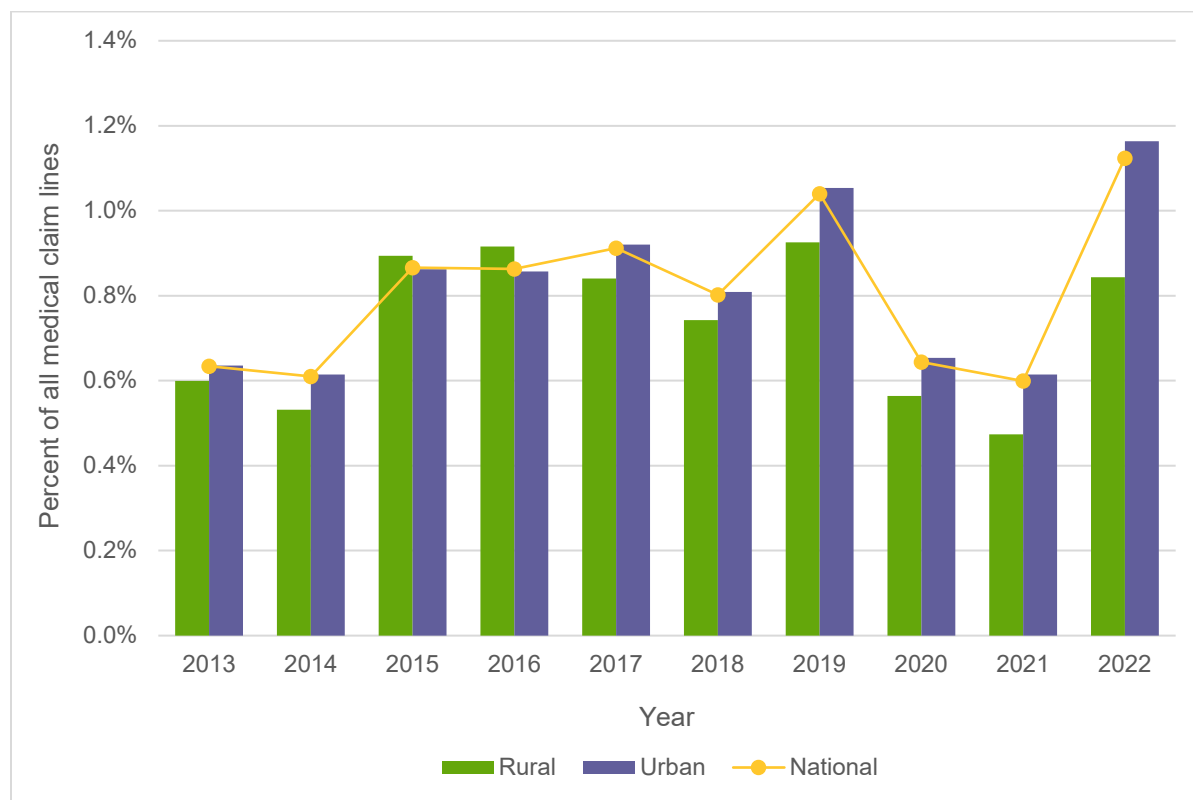


Figure 22. Claim lines with ASC usage as a percentage of all medical claim lines by rural, urban and national settings, 2013-2022

Over the longer term, the national share of claim lines for ASCs grew 77 percent from 2013 to 2022, compared to a decline of five percent from 2012 to 2021. The growth from 2013 to 2022 was greater in urban (83 percent) than rural areas (41 percent). In 2022, national ASC utilization rose to 1.12 percent, above where it had stood in 2013 (0.63 percent), erasing the declines in 2020 and 2021 and exceeding all

⁸ Angie Stewart, "5 Ways COVID-19 Affected ASCs in 2020," *Becker's ASC Review*, December 4, 2020, <https://www.beckersasc.com/asc-news/5-ways-covid-19-affected-asc-in-2020.html>.

⁹ Laura Dyrda, "COVID-19 Is Still Out There: 7 Ways ASCs Are Affected Heading into 2022," *Becker's ASC Review*, December 16, 2021, <https://www.beckersasc.com/or-clinical-quality/covid-19-is-still-out-there-7-ways-asc-are-affected-heading-into-2022.html>.

¹⁰ Jack Hawkins, Ryan Mendez and Colin Park, "ASCs in 2022: A Year in Review," *Becker's ASC Review*, February 13, 2023, <https://www.beckersasc.com/asc-transactions-and-valuation-issues/asc-in-2022-a-year-in-review.html>.

¹¹ Susan J. Morse, "Ambulatory Surgery Centers Compete with Hospitals for Outpatient Dollars," *Healthcare Finance*, August 17, 2022, <https://www.healthcarefinancenews.com/news/ambulatory-surgery-centers-compete-hospitals-outpatient-dollars>.

prior years of study as well. Urban ASC utilization climbed to 1.16 percent in 2022 from 0.64 percent in 2013, and rural ASC utilization climbed to 0.84 percent in 2022 from 0.60 percent in 2013.

As in previous years, more ASC claim lines in 2021 were submitted for females than males in almost every age group (figure 23). The cases where males outnumbered females, as in previous years, were the age groups 0-10 (males 60 percent) and 11-18 (males 54 percent). In 2022, males and females in the age groups over 50 continued to be close to equal in percentage share. Males accounted for 46 percent of the age group 51-60, 47 percent of the age group 61-70, 46 percent of the age group 71-80 and 47 percent of the age group over 80.

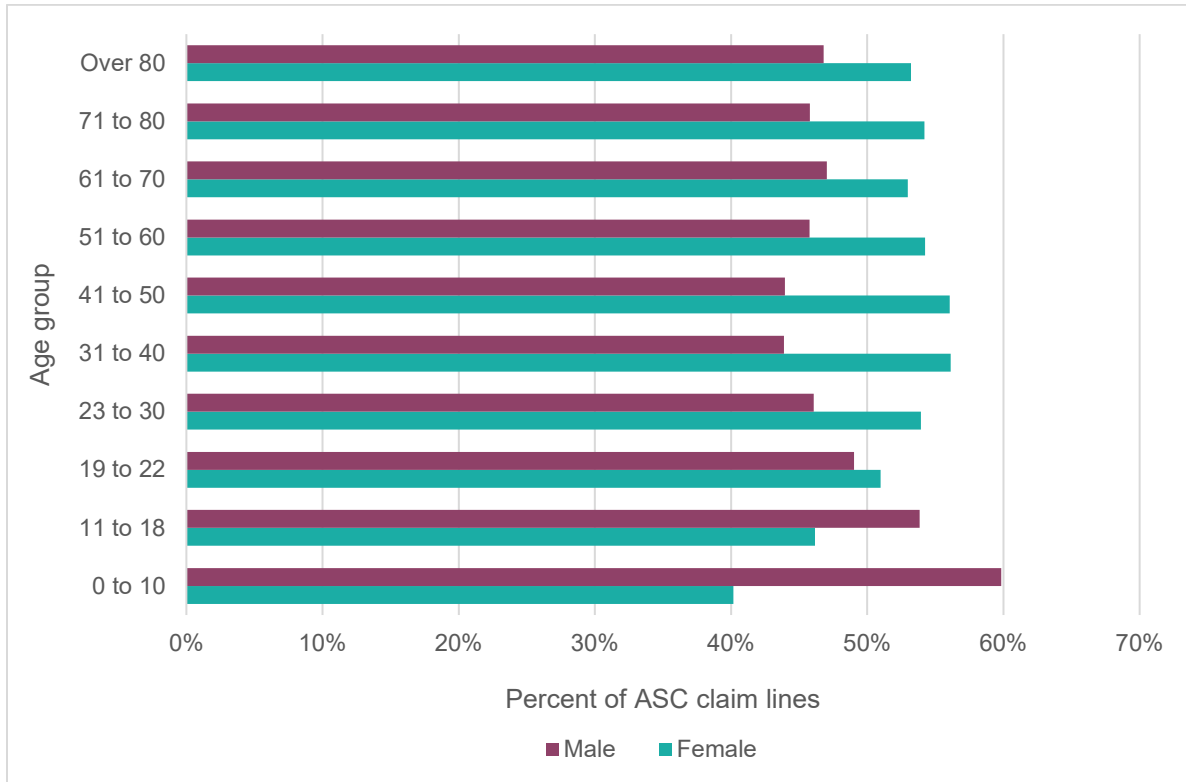


Figure 23. Percent of claim lines with ASC usage by age and gender, 2022

Emergency Room

Following steep declines driven by the COVID-19 pandemic in 2020 and 2021, the normalized share of claim lines for ERs increased 138 percent nationally from 2021 to 2022, rising from 1.8 percent to 4.2 percent of all medical claim lines (figure 24). To put this in context, the national increase from 2019 (the year before the pandemic) to 2022 was only 42 percent; the pandemic years of 2020 and 2021, with their sharp decreases, were anomalies. From 2021 to 2022, in urban areas, the increase in medical claim lines associated with ERs was 136 percent, and in rural areas 142 percent. Over the longer term, ER usage from 2013 to 2022 increased 146 percent nationally, 144 percent in urban areas and 114 percent in rural areas. This contrasts with the decline recorded from 2012 to 2021, when the decrease was 1 percent nationally and in urban areas and 15 percent in rural areas.

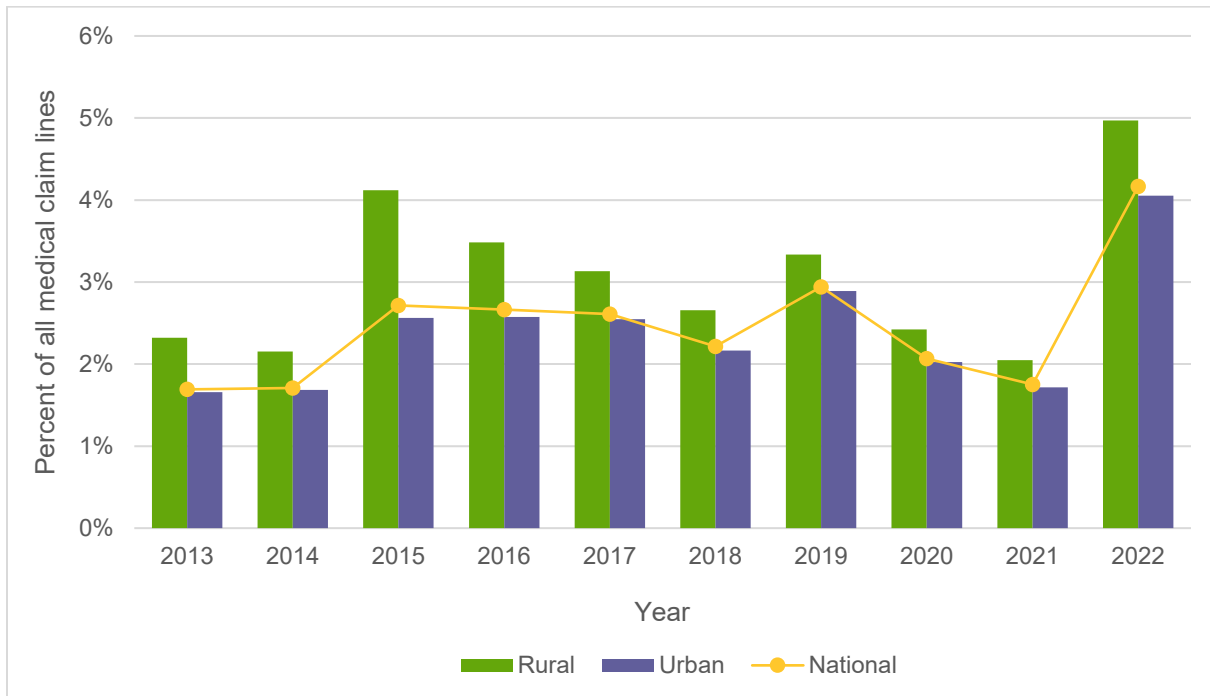


Figure 24. Claim lines with ER usage as a percentage of all medical claim lines by rural, urban and national settings, 2013-2022

The age distribution for ERs in 2022 (figure 25) showed some slight differences from that recorded for 2021. The major difference was that the age group 71-80 had six percent of the distribution in 2022 compared to four percent in 2021. In addition, in the age range from 11 to 50, the share of claim lines decreased by one percent in 2022, while in the age groups 0-10, 61-70 and over 80, the share increased by one percent. As in previous years, the age group with the greatest share of claim lines for ER usage in 2022 was 51-60 (17 percent). The next largest age groups were 31-40 and 41-50, each with 15 percent of the distribution.

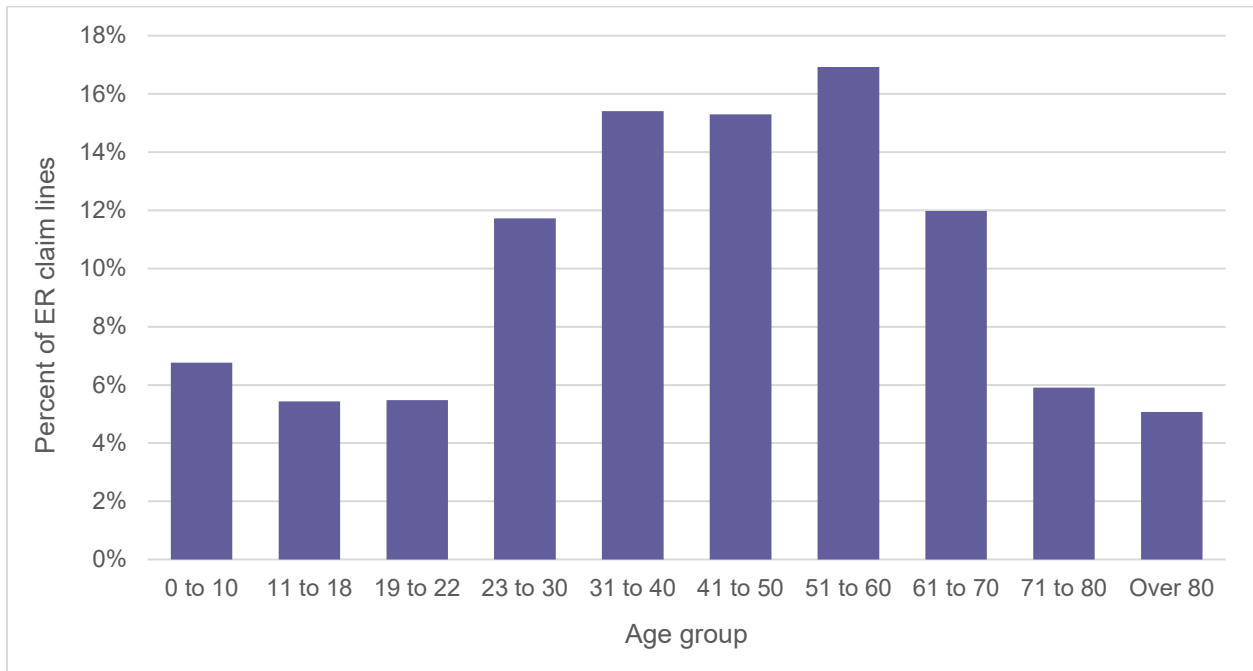


Figure 25. Percent of claim lines with ER usage by age group, 2022

As with all of the other places of service studied for gender, and as in 2021, more claim lines with ER usage in 2022 were submitted for females than males in most age groups (figure 26). The sole case in which the male share exceeded the female share was the age group 0-10, in which claim lines for boys (56 percent) outnumbered those for girls (44 percent). In 2021, males accounted for no less than 40 percent of the distribution in every age group, but in 2022, the male shares in two age groups were under 40 percent: 19-22 (males 39 percent) and 23-30 (males 38 percent). In most age groups, females grew or stayed the same in their share of the distribution; for example, in the age group 71-80, females grew from 52 percent in 2021 to 55 percent in 2022. Only the age group 11-18 showed growth in the male share in 2022, climbing from 47 percent to 48 percent. The age group 61-70, in which the male and female shares were approximately equal (50 percent) in 2021, had a higher share of females in 2022 (53 percent).



Figure 26. Percent of claim lines with ER usage by age and gender, 2022

Figure 27 shows the 2022 distribution of claim lines with ER usage by diagnostic category for individuals over the age of 22. As in 2021, chest pain was the number one ER diagnostic category in 2022. COVID-19 fell from 5th place on the list of top diagnostic categories to 10th place. The ordering of the top four remained the same as in 2021, and diagnoses in 6th to 10th place in 2021 (sprains, strains and fractures; general signs and symptoms involving circulatory and respiratory system; general signs and symptoms; head injury; and digestive system issues) each moved up one place in 2022. Urinary tract infections entered the list in 12th place, replacing complications of pregnancy, which fell to 13th. Overall, the diversity of conditions seen in the ER continued to expand, with the category of “All Others” growing from 38 percent of the distribution in 2021 to 41 percent in 2022.

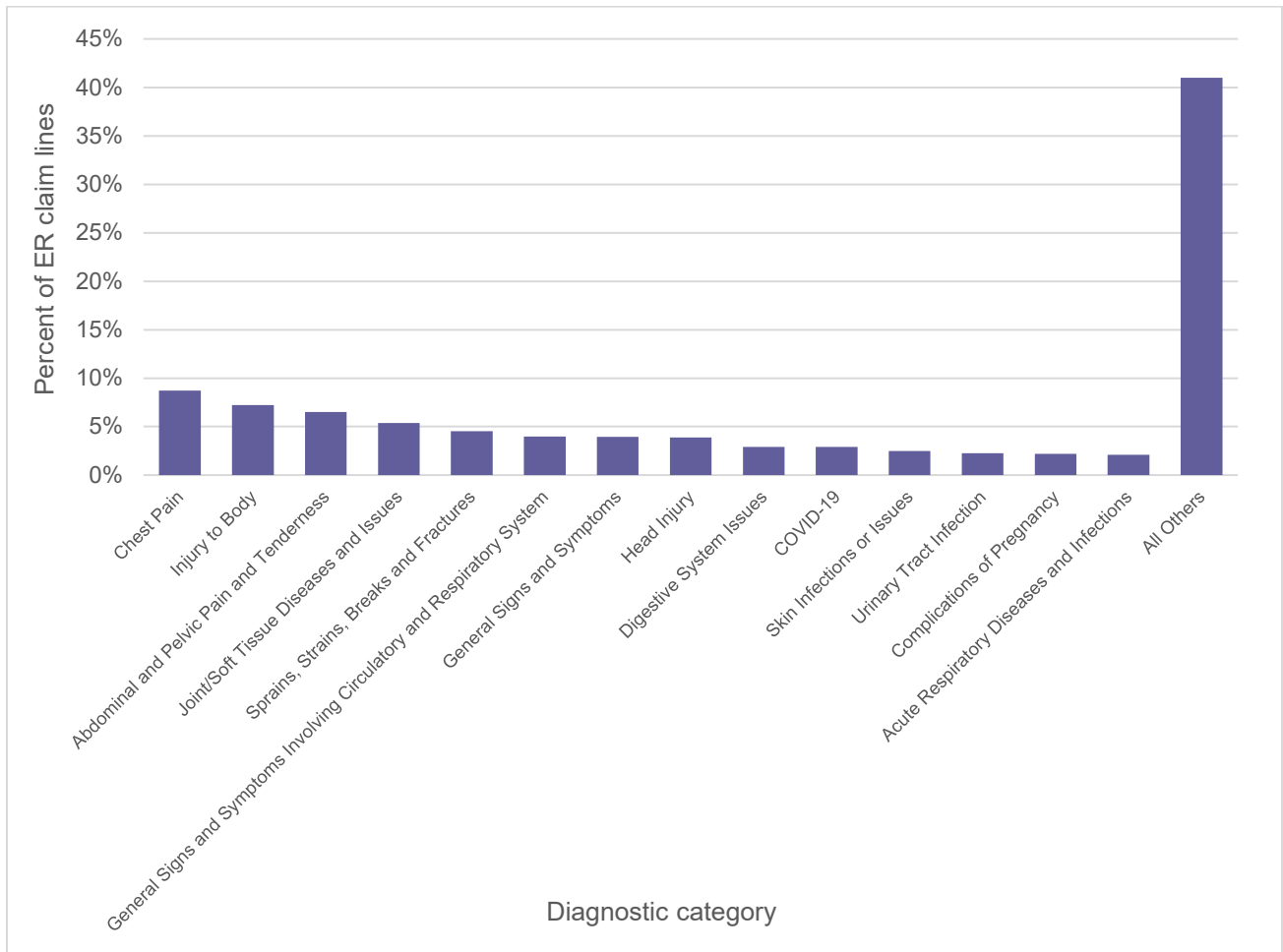


Figure 27. Distribution of claim lines with ER usage by diagnostic category for individuals over 22 years of age, 2022

The 2022 distribution of claim lines with ER usage by procedures for individuals in all age groups, not including E&Ms (figure 28), was somewhat different from that in 2021. Again, diagnostic radiology of the chest was the most common procedure, with 12 percent of the 2022 distribution as compared to 15 percent of the 2021 distribution, and the top four procedure categories were all in the same order. However, diagnostic radiology of the abdomen (in fifth place in 2021 and sixth place in 2022) traded places with diagnostic radiology of the head and neck, though both still accounted for approximately six percent of the distribution. Diagnostic radiology of the spine and pelvis, and urinalysis procedures, entered the top procedures list in 2022 in 10th and 11th place respectively, and diagnostic radiology of the lower extremities rose from 11th to 8th place. The category of “All Others” increased from 27 percent in 2021 to 31 percent in 2022.

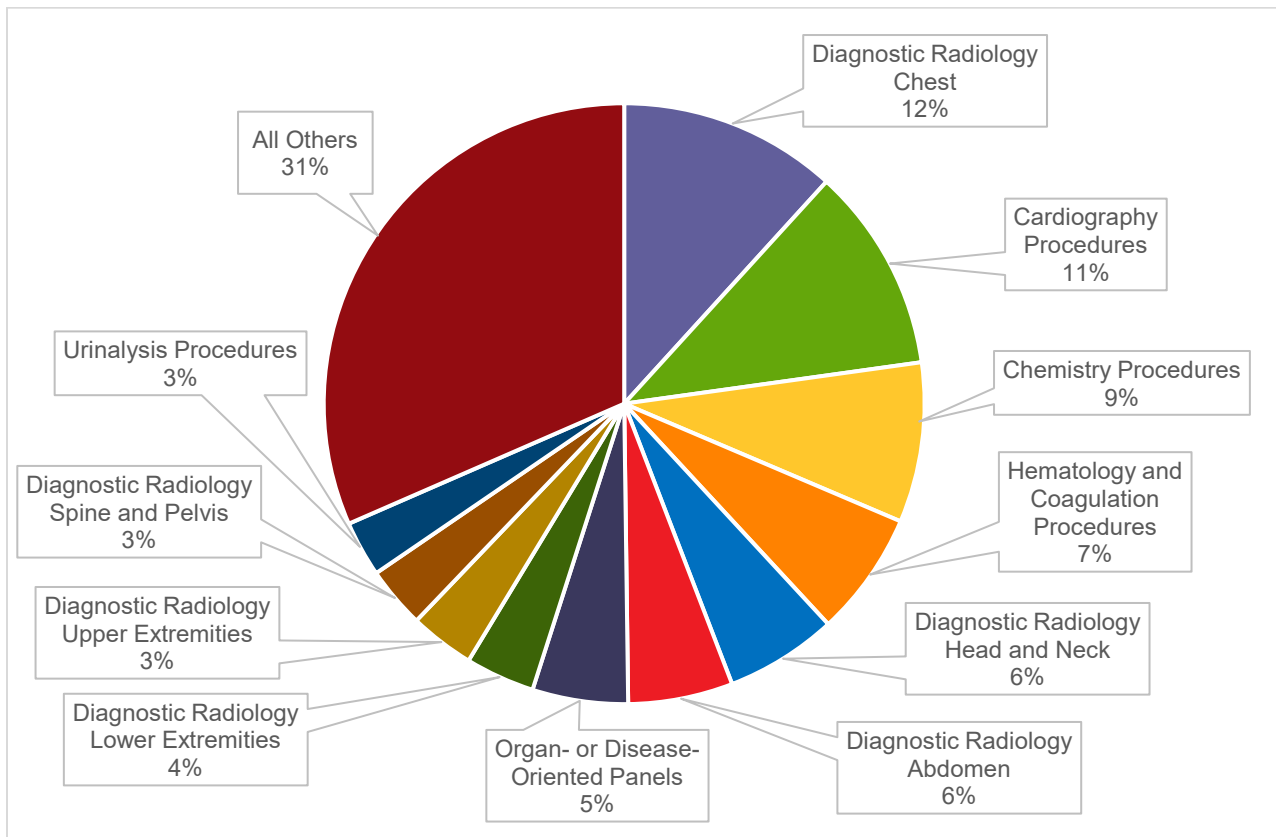
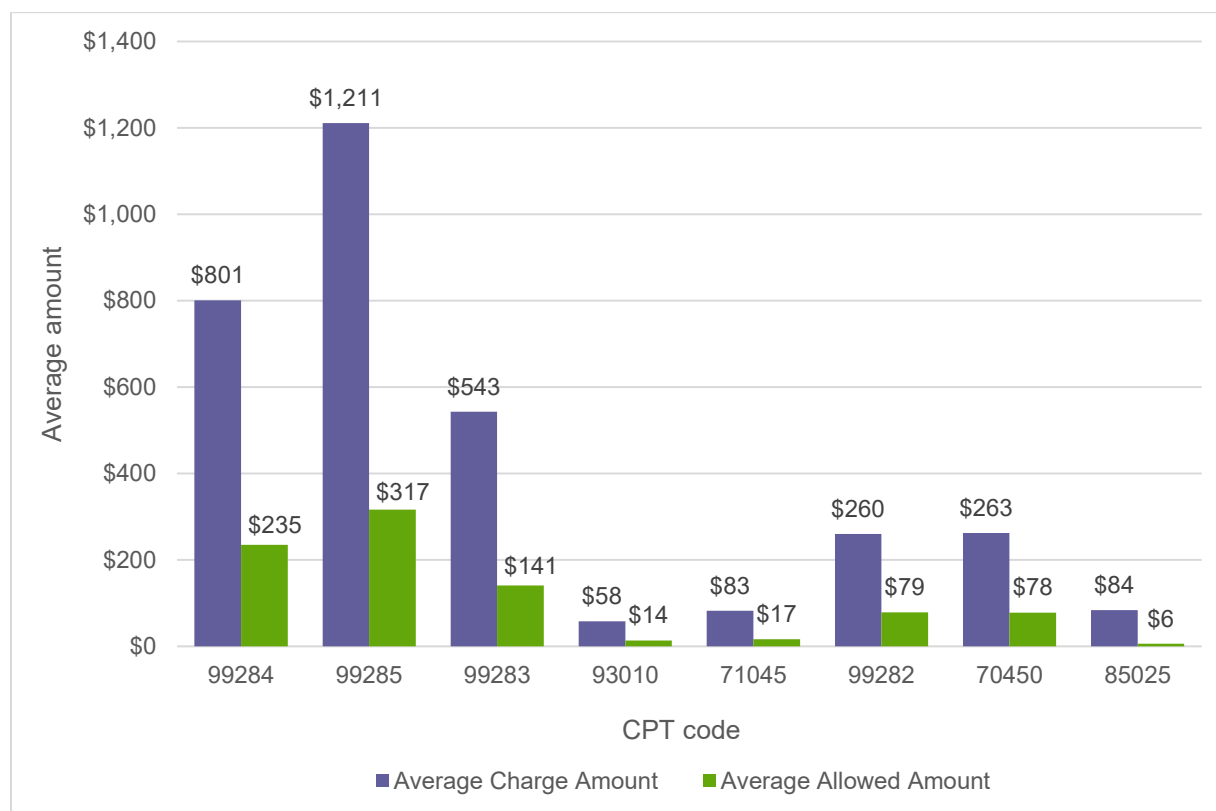


Figure 28. Distribution of claim lines with ER usage by procedures for individuals in all age groups, not including E&Ms, 2022

Figure 29 shows average charges and allowed amounts for the eight most common ER procedure codes in 2022.¹² There was only one change in the codes from 2021 to 2022. CPT 70450 (CT scan head or brain without contrast) climbed from eighth to seventh place, while CPT 85025 (complete blood cell count [red cells, white blood cell, platelets], automated test and automated differential white blood cell count) fell from seventh to eighth place. As in 2021, the highest average charge amount (\$1,211) and average allowed amount (\$317) in 2022 were for CPT 99285 (emergency department visit with high level of medical decision making). Also as in 2021, the lowest average charge amount (\$58) was for CPT 93010 (routine electrocardiogram [ECG] using at least 12 leads with interpretation and report only). The lowest average allowed amount in 2022 was \$6 for CPT 85025.



CPT Code	Description	CPT Code	Description
99284	Emergency department visit with moderate level of medical decision making	71045	X-ray of chest, 1 view
99285	Emergency department visit with high level of medical decision making	99282	Emergency department visit with straightforward medical decision making
99283	Emergency department visit with low level of medical decision making	70450	CT scan head or brain without contrast
93010	Routine electrocardiogram (ECG) using at least 12 leads with interpretation and report only	85025	Complete blood cell count (red cells, white blood cell, platelets), automated test and automated differential white blood cell count

Figure 29. Average charges and allowed amounts for the most common procedures performed in ERs, 2022

¹² For this edition, FAIR Health altered the methodology to include only professional fees, in contrast to past editions, which included professional and facility fees.

As noted earlier in this white paper, actual charges and allowed amounts may vary greatly from the average. For example, the average charge amount for CPT 99283 (emergency department visit with low level of medical decision making) varied from \$413 in the Midwest to \$692 in the South (table 4). The average allowed amount for that code varied from \$124 in the Northeast to \$151 in the West.

Table 4. Average charge amounts and average allowed amounts for CPT 99283 by region, 2022

Region	Average charge amount	Average allowed amount
Midwest	\$413	\$134
Northeast	\$422	\$124
South	\$692	\$148
West	\$437	\$151

FH Medical Price Index

As stated in the Methodology section, FH Medical Price Index uses median charge amounts and median allowed amounts and calculates the changes in those amounts across the years. FH Medical Price Index is based on FAIR Health’s benchmark products. Changes in the indices may not be entirely driven by prices, but also by CPT code mix and changes in relative utilization.

Professional E&M

The professional E&M indices include CPT codes in the AMA CPT code category Evaluation and Management Services for procedures typically performed in a professional setting as opposed to a hospital setting. This includes office visits such as CPT 99213.

E&M codes in the Office or Other Outpatient Services Category for both new and established patients were redefined in 2021. For example, CPT 99213 used to be defined as a 15-minute office visit for an established patient but is now defined as a 20-29-minute office visit for an established patient. Since these codes are dominant within this index based on frequency of use, more variation is likely in this category in the future.

The professional E&M charge amount index observed its highest increase from May to November 2023, after having a consistent steady upward trend since the base period of May 2012 (figure 30). CPT 99214 (established patient office or other outpatient visit, 30-39 minutes) and CPT 99213 account for more than half of the frequency in this category and are the primary drivers of the observed increase. This was due to increases in frequency and in median value for both codes. The index increased from 1.49 in November 2022 to 1.57 in November 2023, a five percent change.

Of the six categories, professional E&Ms and medicine had the largest increase in charge amount index from November 2022 to November 2023.

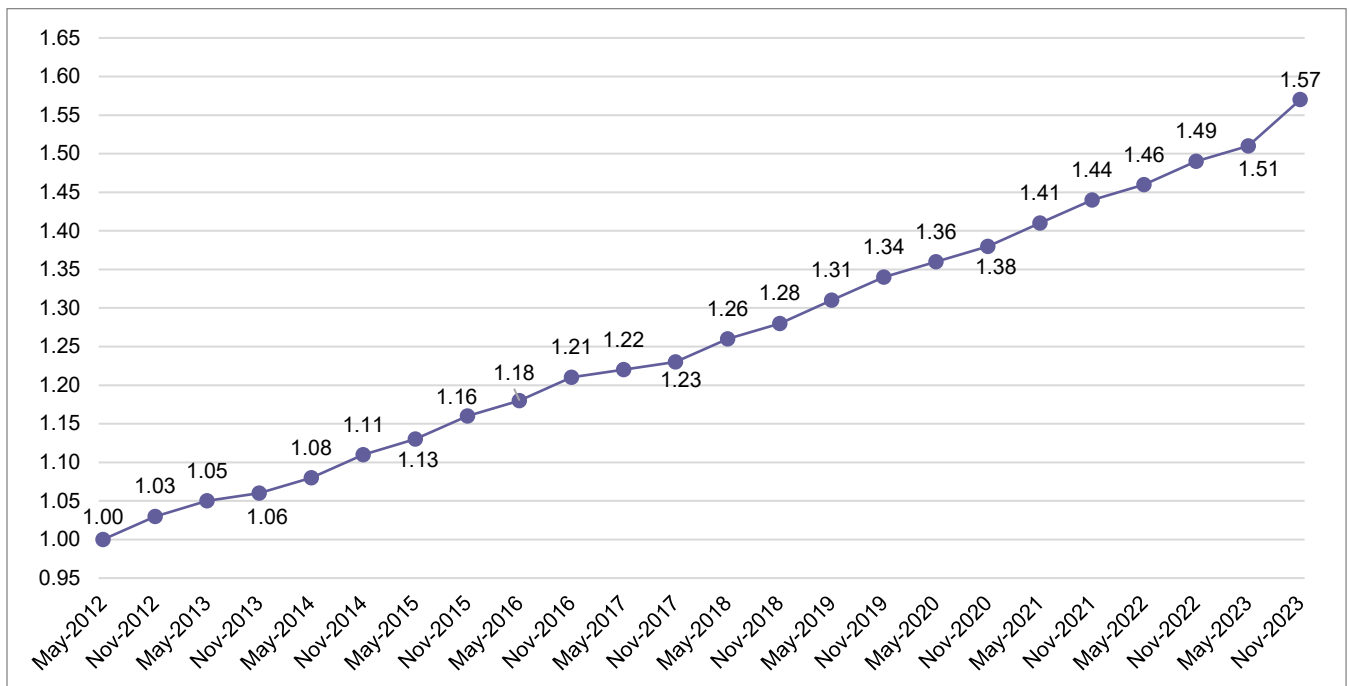


Figure 30. Professional E&M charge amount index

The professional E&M allowed amount index saw a reduction in November 2022 for the first time since the base period (figure 31). However, the index reverted to its upward trend in 2023, growing from 1.46 in November 2022 to 1.50 in November 2023, a three percent change.

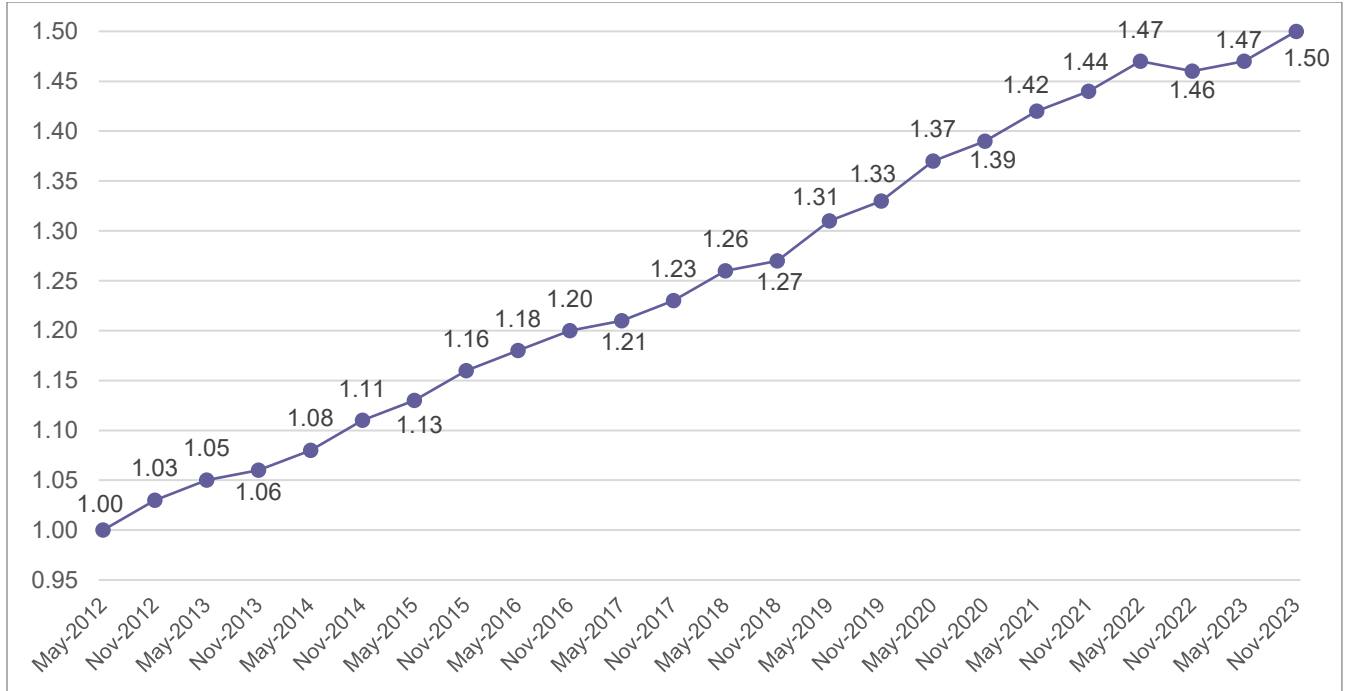


Figure 31. Professional E&M allowed amount index

Hospital E&M

The hospital E&M indices, which correspond to professional charges and allowed amounts, include CPT codes in the AMA CPT code category Evaluation and Management Services for procedures typically performed in a hospital setting, such as CPT 99223 (initial hospital care with moderate level of medical decision making; if using time, at least 75 minutes) or CPT 99283 (emergency department visit with low level of medical decision making). They exclude E&Ms typically performed in a professional setting, such as common office visits. Facility fees are not included.

The hospital E&M charge amount index observed a slight decrease in November 2023 compared to May 2023 after historically experiencing growth at a rapid pace (figure 32). The index increased from 1.83 in November 2022 to 1.85 in November 2023, a one percent change.

CPT 99284 (emergency department visit with moderate level of medical decision making) and CPT 99291 (critical care, first 30-74 minutes) were the main drivers of the observed increase. This was due to an increase in the frequency and median value for both codes. A decrease in the median value for CPT 99283 (emergency department visit with low level of medical decision making) mitigated the growth in the index.

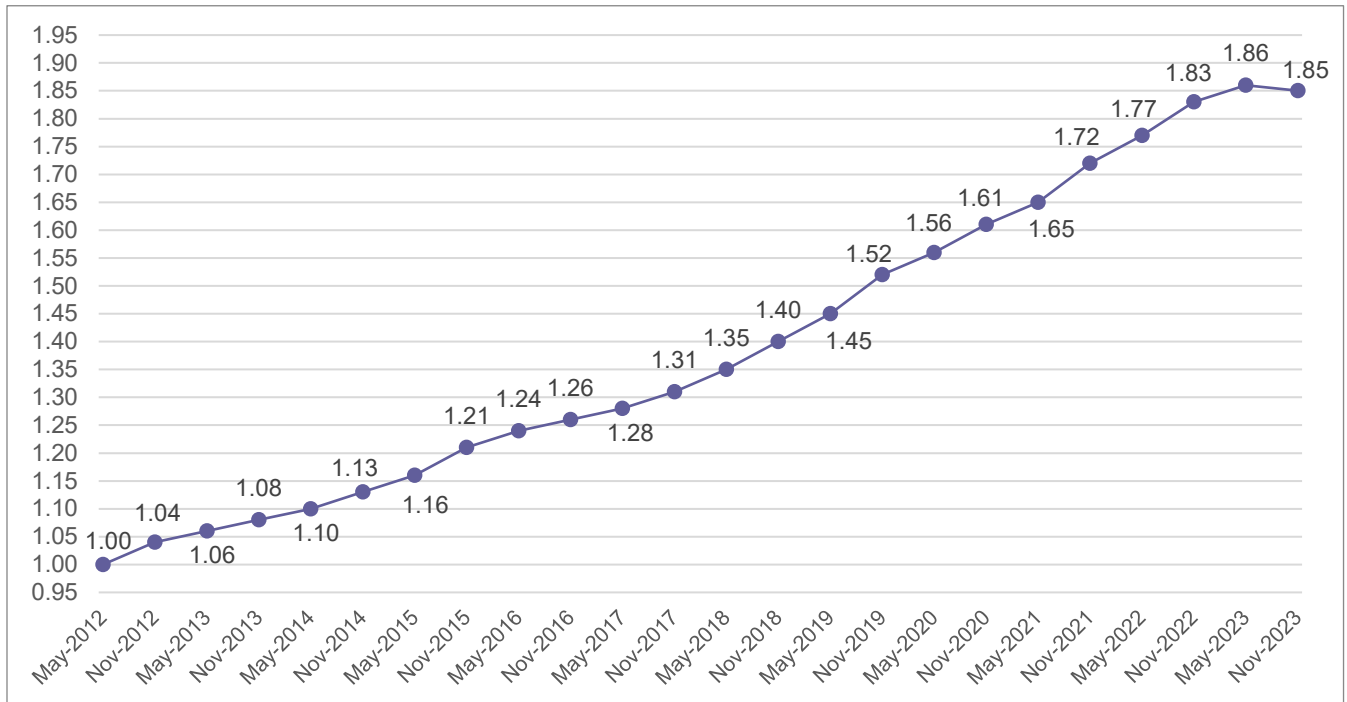


Figure 32. Hospital E&M charge amount index

The hospital E&M allowed amount index returned to an upward trend after a decrease in May 2023 (figure 33). The index increased from 1.73 in November 2022 to 1.79 in November 2023, a three percent change.

CPT 99232 (subsequent hospital care with moderate level of medical decision making; if using time, at least 35 minutes), CPT 99285 (emergency department visit with high level of medical decision making) and CPT 99284 (emergency department visit with moderate level of medical decision making) were the main drivers of the increase in this index. This was due to an increase in the median values of all three procedures.

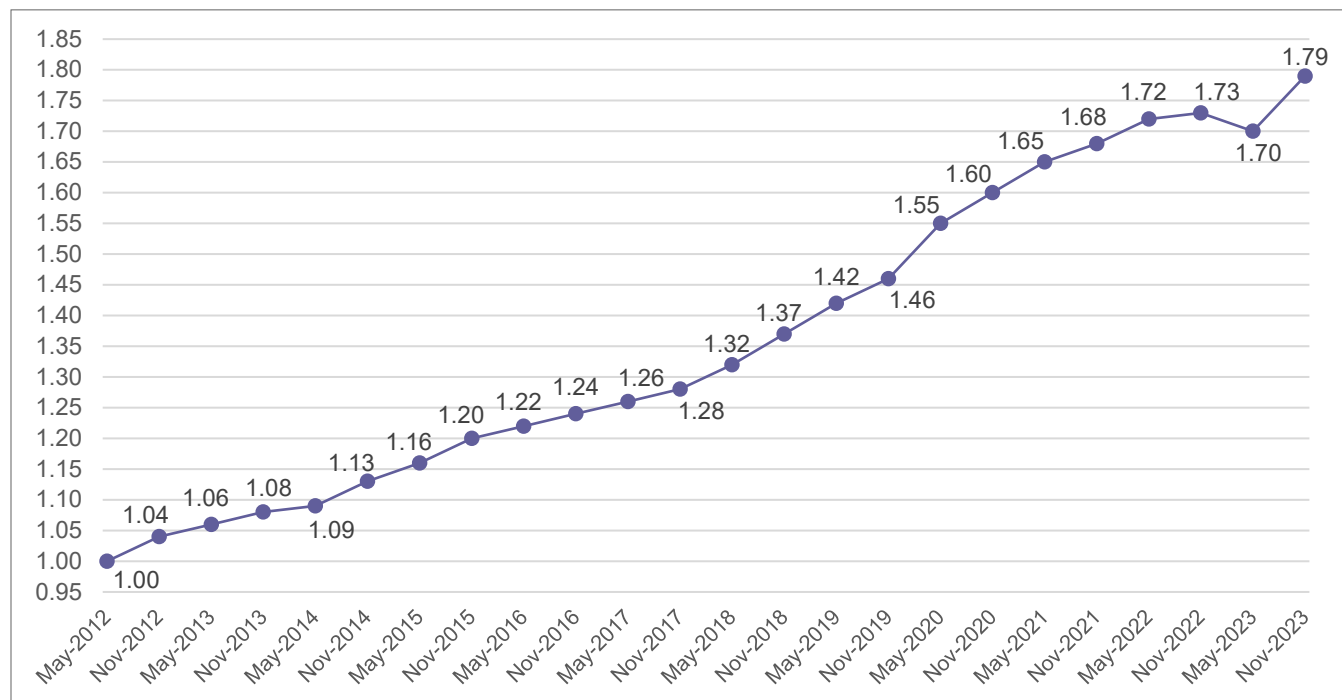


Figure 33. Hospital E&M allowed amount index

Medicine

The medicine indices include all procedures that are not E&Ms, meet the frequency criterion of one million or more and are found in the CPT code ranges from CPT 90281 to CPT 99199 and CPT 99500 to CPT 99607. They include services such as immunizations, psychiatry services, dialysis procedures and allergy and immunology procedures.

The medicine charge amount index observed a large increase from May to November 2023 after growing at a steady pace (figure 34). CPT 90837 (psychotherapy, one hour) was a large driver of this change. This was due to an increase in both its frequency and median value, with a more notable change observed in the frequency. The index grew from 1.31 in November 2022 to 1.37 in November 2023, a five percent change.

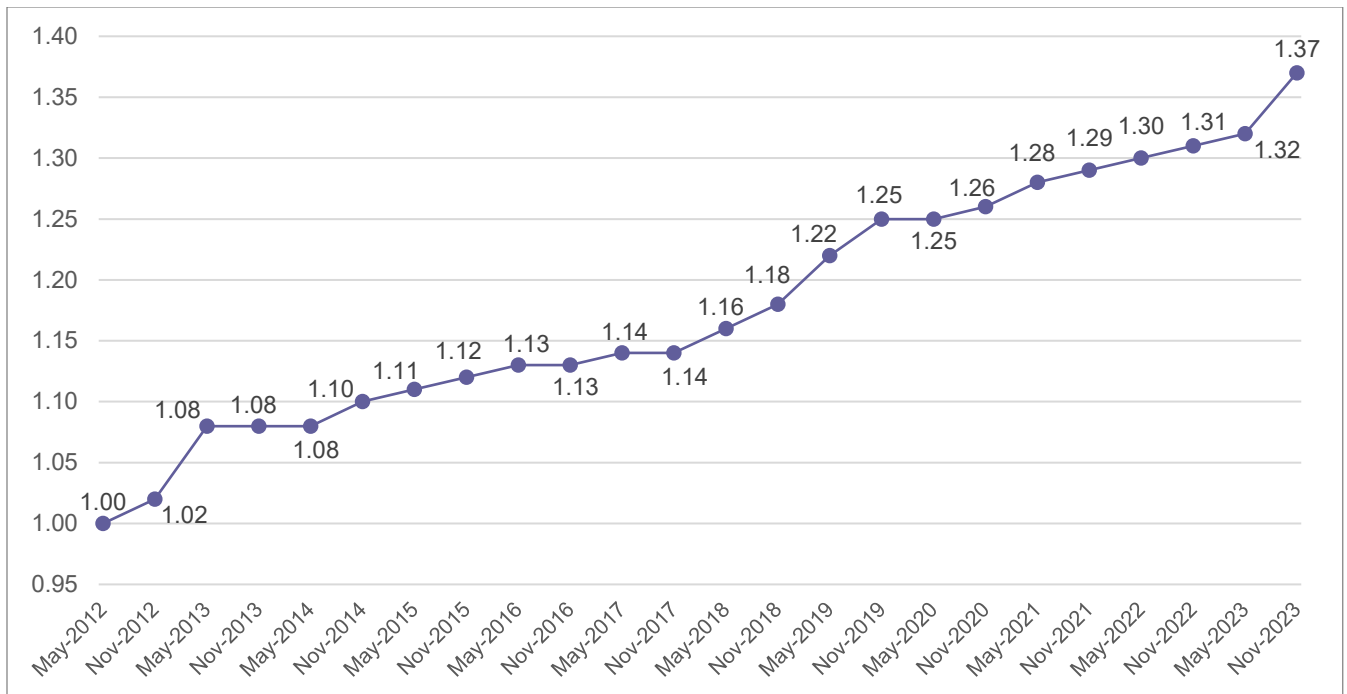


Figure 34. Medicine charge amount index

The medicine allowed amount index appears to have flattened after a large jump from November 2021 to May 2022 (figure 35). The index increased from 1.48 in November 2022 to 1.50 in November 2023, a one percent change.

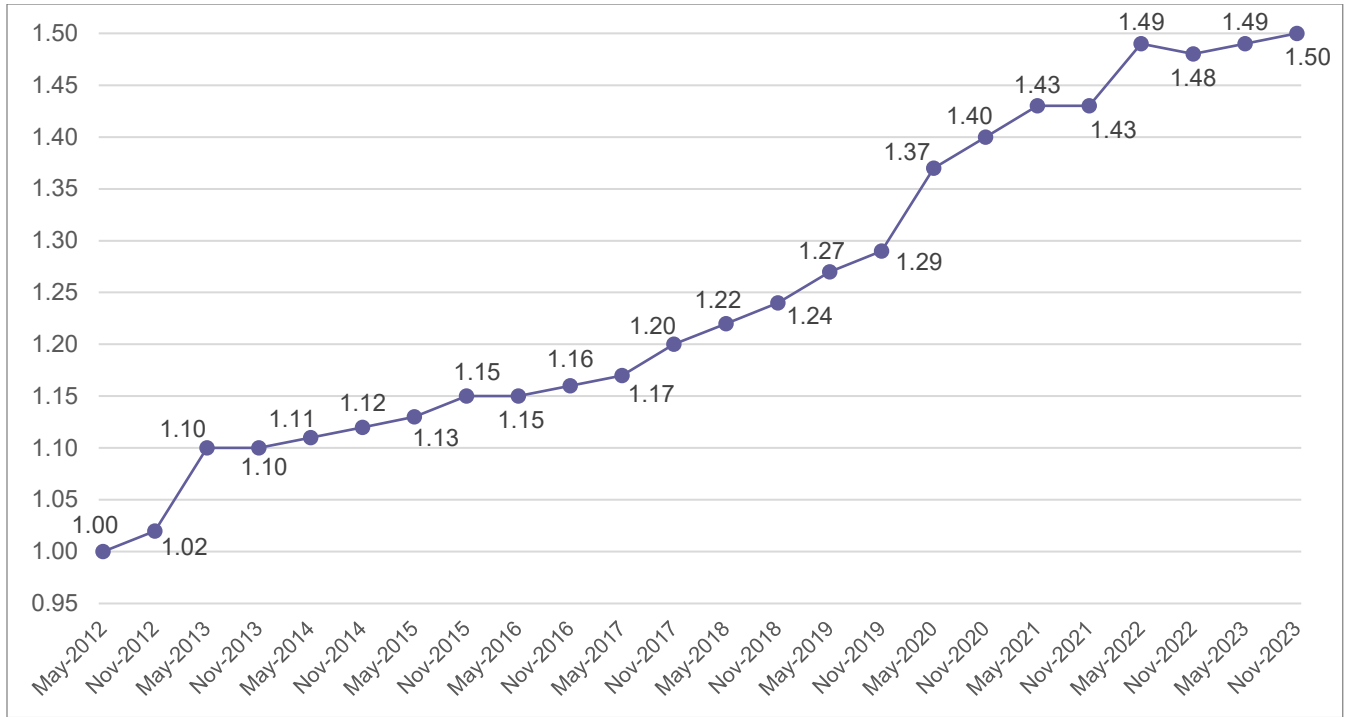


Figure 35. Medicine allowed amount index

Surgery

The surgery indices include codes typically found in the surgical portion of the CPT code book, such as CPT 17003, which is destruction of a precancer skin growth, 2-14 growths, and CPT 43239, which is a biopsy of the esophagus, stomach and/or upper small bowel using a flexible endoscope. These are procedures for which the physician would bill; facility fees, if any, are not reflected in the surgery indices.

The surgery charge amount index continued increasing at a high rate of growth characteristic of the years since 2017 (figure 36). CPT 59400 (vaginal delivery with care before and after delivery) was a large driver of the observed increase. This was due to an increase in both its frequency and median value. The index increased from 1.32 in November 2022 to 1.36 in November 2023, a three percent change.

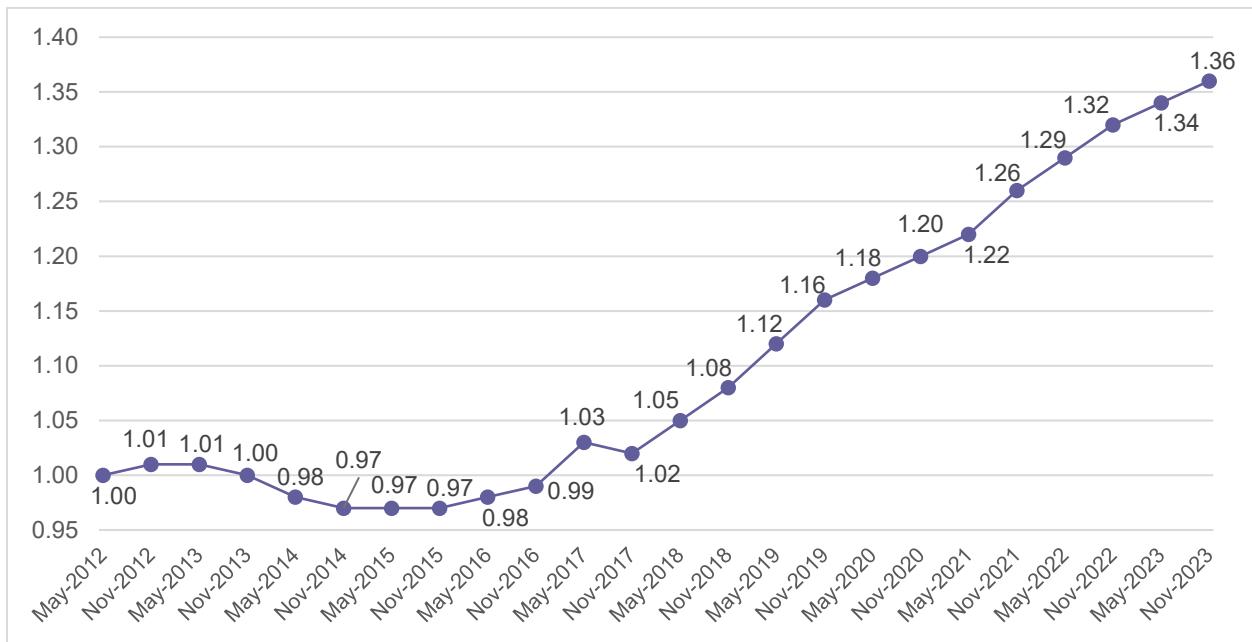


Figure 36. Surgery charge amount index

The surgery allowed amount index decreased from November 2022 to May 2023, then rebounded in November 2023 (figure 37). The index increased from 1.37 in November 2022 to 1.39 in November 2023, a one percent change.

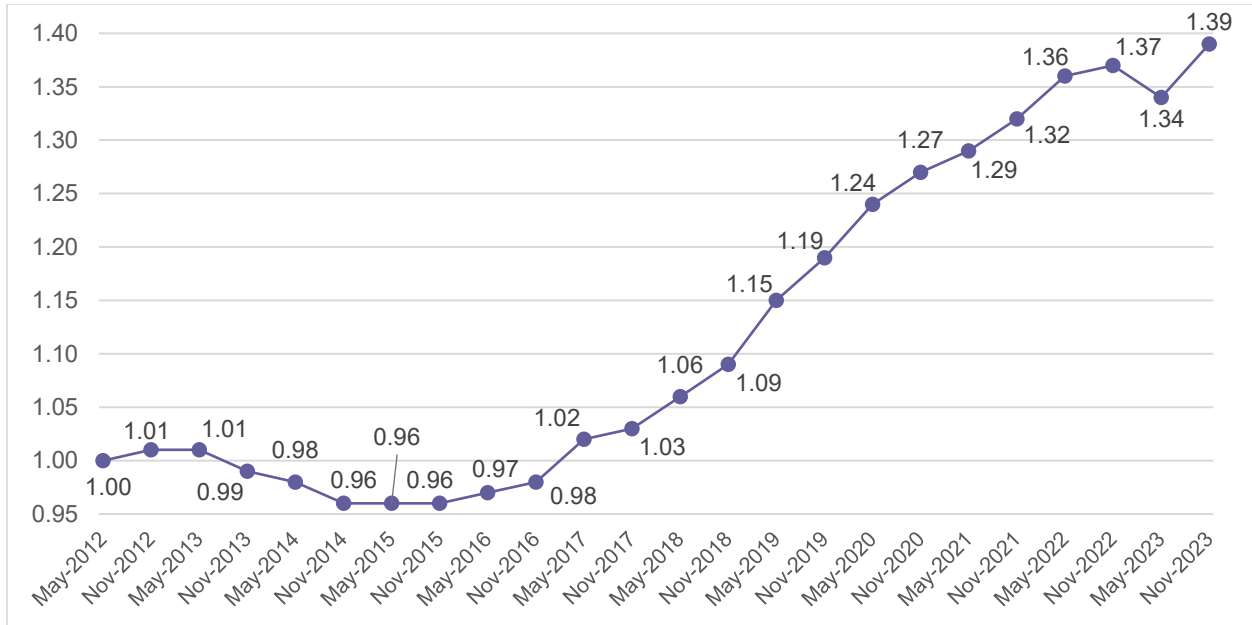


Figure 37. Surgery allowed amount index

Pathology and Laboratory

The pathology and laboratory indices include the CPT code range 80047 through 89398, which identifies such procedures as organ- or disease-oriented panels, drug testing, therapeutic transfusion medicine, microbiology, anatomic pathology (postmortem), cytopathology and in vivo laboratory procedures. Technical (e.g., equipment) and professional costs are included, but not facility fees.

The pathology and laboratory charge amount index continued the quick pace of growth that started in 2019 (figure 38). The index increased from 1.34 in November 2022 to 1.40 in November 2023, a four percent change.

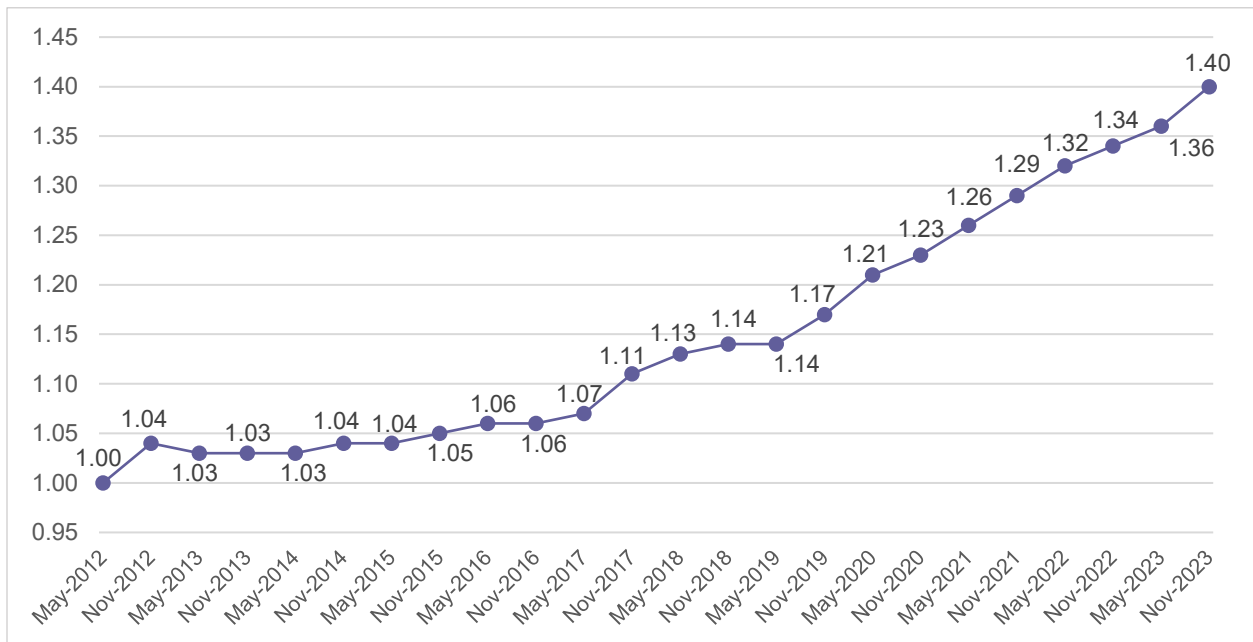


Figure 38. Pathology and laboratory charge amount index

The pathology and laboratory allowed amount index was flat from November 2022 to May 2023, then resumed growth in November 2023 (figure 39). The index increased from 1.25 in November 2022 to 1.27 in November 2023, a two percent change.

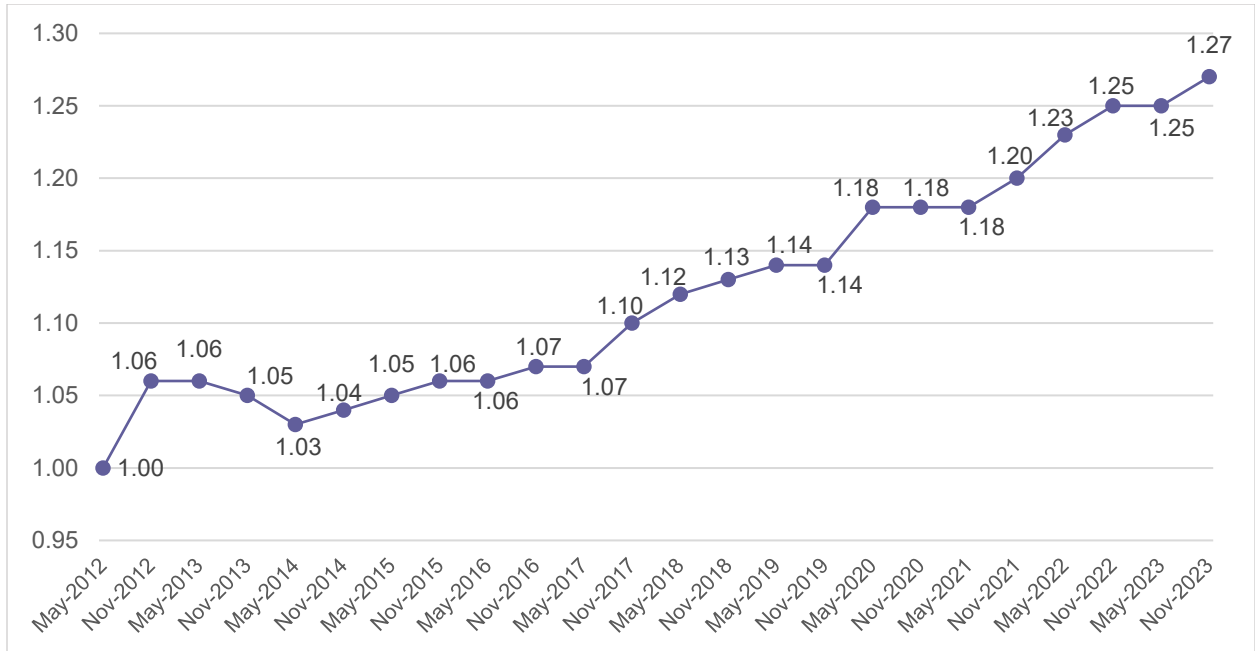


Figure 39. Pathology and laboratory allowed amount index

Radiology

The radiology indices include CPT codes from 70010 to 79999, representing a variety of imaging techniques to diagnose or treat diseases. X-rays, radiographs, ultrasounds, positron emission tomography (PET), CT and nuclear medicine are included in this category. Both technical and professional components are included, but not facility fees.

The radiology charge amount index observed a slight increase after remaining flat from November 2021 to May 2023 (figure 40). The index increased from 1.10 in November 2022 to 1.11 in November 2023, a one percent change.

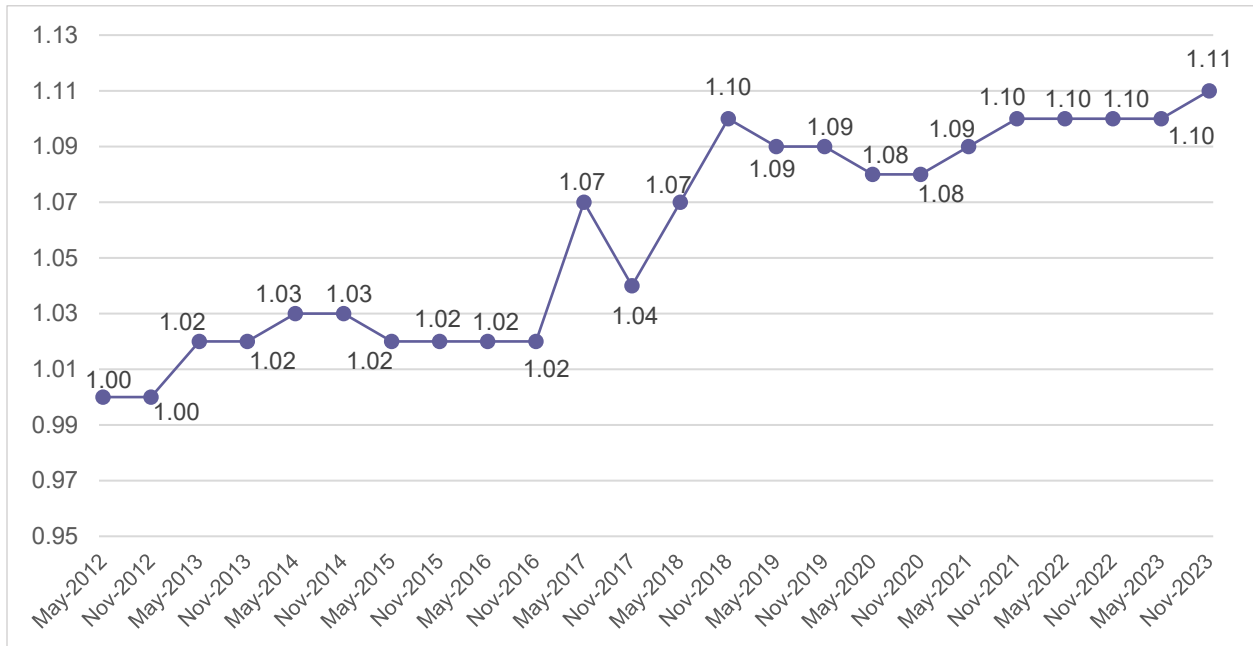


Figure 40. Radiology charge amount index

The radiology allowed amount index observed a large decrease after a multiyear period of growing at a slow rate (figure 41). The index decreased from 1.20 in November 2022 to 1.15 in November 2023, a four percent change.

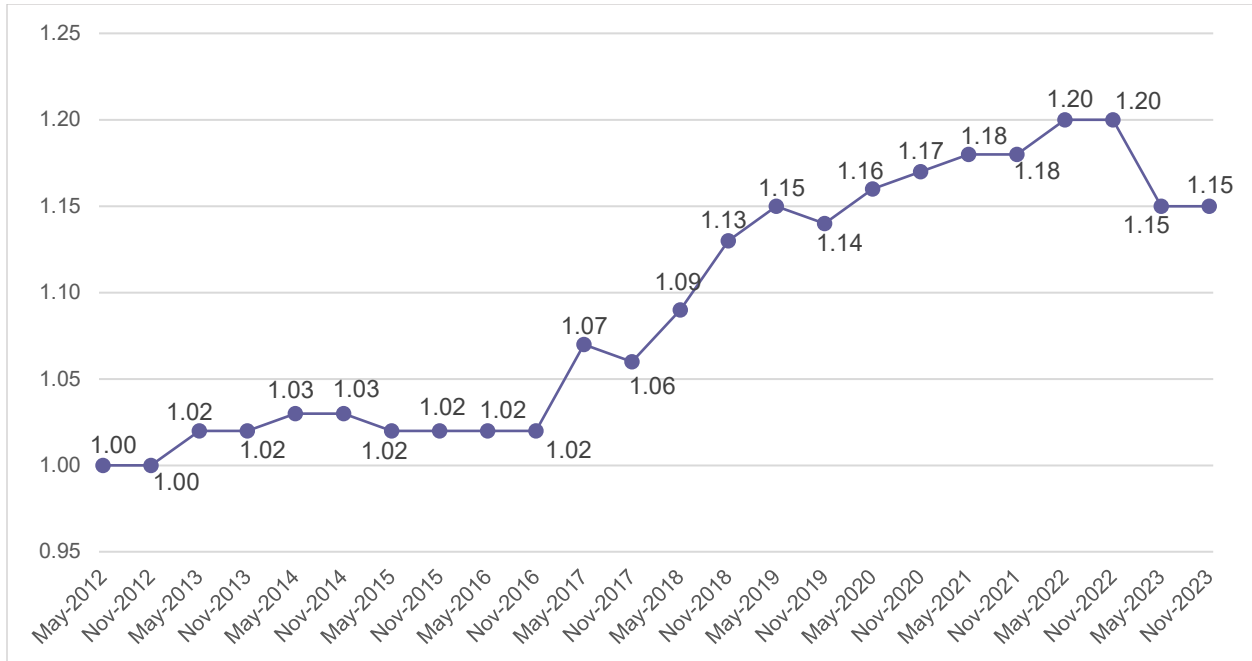


Figure 41. Radiology allowed amount index

Conclusion

This year's edition of FH Healthcare Indicators showed that, of all places of service studied for changes in utilization from 2021 to 2022, utilization increased the most in retail clinics (202 percent). In that period, utilization increased 138 percent in ERs, 88 percent in ASCs, 43 percent in urgent care centers and 8 percent in telehealth. Of these places of service, ERs held the highest percentage of medical claim lines in 2022, with 4.2 percent of all medical claim lines nationally. The comparable percentages for the other places of service were 3.9 percent for telehealth, 2.1 percent for urgent care centers, 1.1 percent for ASCs and 0.2 percent for retail clinics.

In 2022 as in previous years, more claim lines were submitted for females than males in most age groups in these places of service. In 2022, New York was one of the top five states for urgent care centers and telehealth, as measured by the percentage of medical claim lines accounted for by those places of service, but it was not among the top five states for retail clinics. In 2022, COVID-19 remained on the list of most common diagnostic categories in retail clinics, urgent care centers, telehealth and ERs (for individuals over the age of 22).

In the FH Medical Price Index for charges, professional E&Ms and medicine each increased five percent from November 2022 to November 2023, the greatest percent increase of the six procedure categories. Hospital E&Ms and radiology each had the smallest percent increase in charge amount index, one percent.

In the FH Medical Price Index for allowed amounts, professional E&Ms and hospital E&Ms each increased three percent, the greatest increase in the allowed amount index of the six categories. Radiology was the only category to have a decrease in allowed amount index, four percent.

Because of its importance to the US economy and the lives of Americans, understanding the trends and shifts in the healthcare sector is vital. By issuing this new edition of FH Healthcare Indicators and FH Medical Price Index, FAIR Health seeks to provide insights that can inform decision making by stakeholders throughout the healthcare sector, including consumers, payors, providers, government officials, policy makers and others. As part of its mission, FAIR Health will continue to issue these reports annually. In addition, FAIR Health makes available customized indicators and indices that offer specific data subsets (e.g., based on clinical category, geographic region, time period) of particular interest to stakeholders. Contact FAIR Health at info@fairhealth.org or 855-301-3247 to learn more about such customized studies.

About FAIR Health

FAIR Health is a national, independent nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information through data products, consumer resources and health systems research support. FAIR Health qualifies as a public charity under section 501(c)(3) of the federal tax code. FAIR Health possesses the nation's largest collection of private healthcare claims data, which includes over 45 billion claim records and is growing at a rate of over 3 billion claim records a year. FAIR Health licenses its privately billed data and data products—including benchmark modules, data visualizations, custom analytics and market indices—to commercial insurers and self-insurers, employers, providers, hospitals and healthcare systems, government agencies, researchers and others. Certified by the Centers for Medicare & Medicaid Services (CMS) as a national Qualified Entity, FAIR Health also receives data representing the experience of all individuals enrolled in traditional Medicare Parts A, B and D, which accounts for a separate collection of over 47 billion claim records; FAIR Health includes among the private claims data in its database, data on Medicare Advantage enrollees. FAIR Health can produce insightful analytic reports and data products based on combined Medicare and commercial claims data for government, providers, payors and other authorized users. FAIR Health's free, award-winning, national consumer websites are fairhealthconsumer.org and fairhealthconsumidor.org. For more information on FAIR Health, visit fairhealth.org.

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