CBIZ OPTUMAS
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June 4, 2024

Subject: Colorado HB1215 – Commercial Facility Fee Identification Methodology Report

Commercial Facility Fee Identification Methodology - DRAFT

Overview

CBIZ Optumas (Optumas) was contracted by the Colorado Department of Health Care Policy and Financing (HCPF) to explore the policies, practices, and costs to Colorado health payers of facility fees as outlined in HB23-1215. Optumas was tasked with identifying outpatient facility fees within the Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) for 2017 through 2022. The APCD contains claims data from Medicare, Medicaid, and Commercial payers within the State of Colorado. The purpose of this memo is to detail the methodology used to identify hospital outpatient department (HOPD) facility fees within the Commercial claims portion of the APCD.

Steering Committee Review

This memo is being provided to the Steering Committee, as designated under HB23-1215, for review and consideration as an input to the final report as required by HB23-1215. As the Steering Committee reviews, we respectfully request consideration of the following questions related to the methodology and analysis:

- Have we sufficiently identified the appropriate methodology for identifying Commercial facility fees?
- What are your key observations from each of the required analytics?
- What additional caveats need to be captured as critical notes based upon this methodology?
- Is there any additional information or explanation that would assist in understanding the methodology and analytic results?

Data Validation

Optumas reviewed the data for all the requested fields to ensure they were complete and had the expected valid values. This review indicated that we received appropriate data aligned with our data request that would allow us to continue with the analysis. The exception to this is related to denied claims. The APCD does delineate if an individual service was denied during a visit but does not provide information on visits that were denied in their entirety. Optumas will note below for those analysis how this data limitation was handled.

We then reviewed the visit volume and financial field volume on a monthly longitudinal basis by service type and program. This review indicated that we did not have any major gaps or anomalies in the data. Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

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Optumas also received benchmarks from CIVHC that estimate they have about 75% of all covered lives within the APCD. Programs that are not included in the data are listed as follows:

- Uninsured patients and self-pay claims
- Self-insured employers
- Veterans Affairs (VA)
- Tricare
- Worker's compensation
- Medical coverage paid for by a property & casualty insurance company
    - Example – a person has a car accident, and medical bills are paid for by car insurance company

Billing Guidelines Research

The billing guidelines for facility fees charged to Commercial payers differ from the billing guidelines for facility fees charged to Medicare. Therefore, the Medicare facility fee identification methodology could not be applied to Commercial data, and additional research was required to review facility fees for Commercial data. The research included provider surveys for Colorado hospitals and hospital systems. The findings from that research were that the professional services and HOPD services are billed on two separate claims using their appropriate claim forms. UB-04 claim forms are used for HOPD, and HCFA-1500 claim forms are used for professional services. The facility fee portion of the visit is therefore identified as just the HOPD portion based on the UB-04 form, exclusive of any professional component. That methodology is consistent with the definition of facility fees as outlined in HB23-1215, as well as how providers reported their facility fees within the provider surveys. This methodology was applied consistently to all hospital types (PPS and Critical Access Hospitals).

Analytics

Optumas identified all non-ER Outpatient claims charged to Commercial payers, within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. This subset of data serves as the basis for the analytics to be performed that are outlined below. An initial overall summary of allowed amount and visits was performed to check for volume consistency or variation across the study period. The table below itemizes the initial summary of allowed amount, visits, and cost per visit.

Table 2.A – HOPD Summary

	Commercial HOPD Claims		
CY	**Allowed Amt.**	**Claim Count**	**Claim Cost**
2017	$1,232,105,279	877,127	$1,404.71
2018	$1,366,988,303	918,230	$1,488.72
2019	$1,422,974,929	825,716	$1,723.32
2020	$1,368,016,382	794,893	$1,721.01
2021	$1,613,557,184	1,086,441	$1,485.18
2022	$1,678,860,164	965,866	$1,738.19
Total	**$8,682,502,241**	**5,468,273**	**$1,587.80**

As required under 25.5-4-216(6)(a)(I) through (VII) C.R.S., the following analytics and summaries are to be derived from the APCD. Optumas has provided the methodology used to perform each analysis, and reference to the summary table in the appendices as applicable.

25.5-4-216(6)(a)(I)

Description

The number of patient visits for which facility fees were charged, including, to the extent possible, a breakdown of which visits were in-network and which were out-of-network.

Methodology

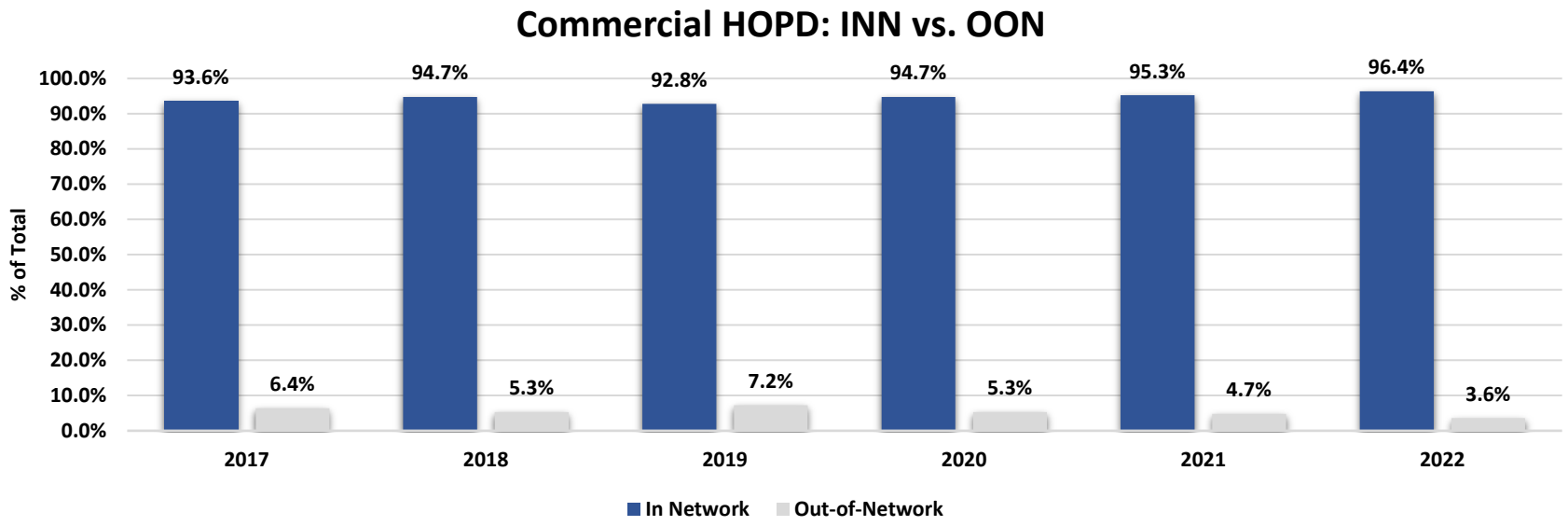
Optumas received a field in the APCD that indicates whether a claim was for an in-network or out-of-network provider. If this field was labeled as "unknown", Optumas assumed the claim was in-network. Optumas developed this assumption by benchmarking the volume of in-network (INN) and out-of-network (OON) claims by year. In aggregate, 7% of Commercial HOPD claims had an "unknown" network indicator. This field was then used to summarize the volume of visits and allowed amount for non-ER HOPD claims charged to Commercial payers, by in-network or out-of-network.

Results

There were between 794,000 and 1,087,000 HOPD visits each year for Commercial payers, totaling over 5.4M visits across the study period. Approximately 95% of Commercial related HOPD visits were for an in-network provider each year of the study period. See Exhibit I for the detailed results by year.

Exhibit I - Number of Patient Visits for which Facility Fees were charged in-network and out-of-network.

	HOPD Claim Count			Percentage of Total		
CY	In-Network	Out-of-Network	Total	In-Network	Out-of-Network	Total
2017	820,969	56,158	877,127	93.6%	6.4%	100.0%
2018	869,870	48,360	918,230	94.7%	5.3%	100.0%
2019	766,183	59,533	825,716	92.8%	7.2%	100.0%
2020	753,097	41,796	794,893	94.7%	5.3%	100.0%
2021	1,034,898	51,543	1,086,441	95.3%	4.7%	100.0%
2022	930,867	34,999	965,866	96.4%	3.6%	100.0%
Total	**5,175,884**	**292,389**	**5,468,273**	**94.7%**	**5.3%**	**100.0%**



25.5-4-216(6)(a)(II)

Description

To the extent possible, the number of patient visits for which the facility fees were charged out-of-network and the professional fees were charged in-network for the same outpatient service.

Methodology

Optumas utilized the analysis from above that identified OON HOPD visits. The member ID and date of service for that visit was used to find a corresponding professional E&M visit for the same date of service for that member. As noted above within the billing guidelines research, the professional fees are separate from the HOPD facility fee. The professional fees are also billed on a separate claim, resulting in the need to use the member ID and date of service methodology to identify the corresponding professional visit when a facility fee was billed. The following CPT codes were utilized to identify the E&M professional visit:

- CPT Codes 99202 – 99499: Professional Evaluation and Management

Table 3 below illustrates an example claim structure for a member that had a professional E&M visit and a HOPD visit on the same date of service. In this example, the member visited their physician and then had imaging done on their lower back at a HOPD. The claim example shows the date of service, the services provided, the place of service (POS) code, and the relevant financial fields. The financial fields reflect:

- *Allowed:* full amount that insurer (Commercial payer) has agreed to reimburse provider for each service.
- *Member Share:* the portion of the allowed amount that the member is responsible for paying. This amount will be dependent upon their deductible, copay, and coinsurance of their benefit package.
- *Paid:* Amount that the insurer (Commercial payer) paid.

Below is a description of the two claim examples:

- *Claim ID 999999001*: represents the E&M professional visit for member ABC123
  - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”
  - POS (place of service): 22 indicates the visit took place in the outpatient department
- *Claim ID 999999002*: represents hospital outpatient clinic visit for member ABC123
  - CPT 99214: “Established patient office or other outpatient visit, 30-39 minutes”
  - CPT 72100: “Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis”

- "The technician takes 2 or 3 views of the vertebrae in the lumbar region which is the lower part of the spine and the sacrum, the area that connects the spine to the pelvis. Lumbosacral spine X–rays help evaluate back injuries, persistent numbness, and low back pain."
- CPT 72070: "Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Hospital outpatient clinic visit for assessment and management of a patient's Spine and Pelvis"
- "A radiologic examination of the thoracic spine is an X–ray of the twelve chest thoracic vertebrae. An AP and lateral are basic projections. The X–rays are used in a controlled way to minimize the radiation exposure. The X–ray helps evaluate bone injuries and diseases, fractures, dislocations, osteoporosis and deformities in the curvature of the spine."

Table 3 – Claim Structure Example

Member ID	Claim ID	Service Date	CPT Code	POS	Allowed	Member Share	Plan Paid
ABC123	999999001	6/5/2017	99214	22	$86.24	$0.00	$86.24
ABC123	999999002	6/5/2017	72100	22	$35.54	$14.00	$21.54
ABC123	999999002	6/5/2017	72070	22	$34.47	$14.00	$20.47

Results

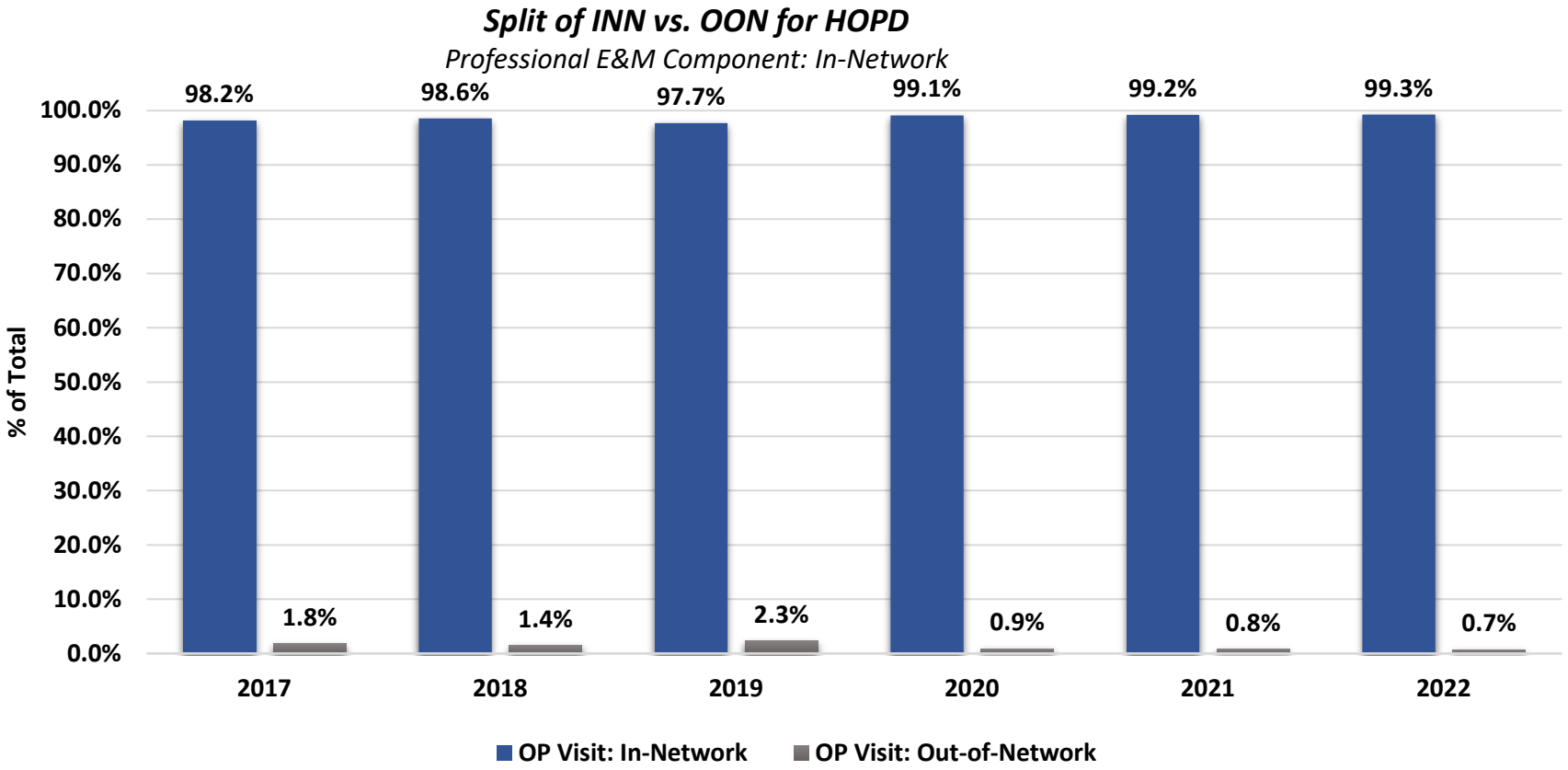
Of the roughly 1,500,000 HOPD visits with a Professional E&M visit on the same day that were charged to Commercial payers from 2017 -2022, 98.7% had a professional fee component that was also charged by an in-network provider. Only 1.3% of Outpatient visits with a Professional E&M visit that was charged by an in-network provider had an Outpatient HOPD visit charged by an out-of-network provider. See Exhibit II for a detailed table of results by year and in-network vs. out-of-network HOPD visits. Note, the total Outpatient visits displayed in this exhibit do not represent all Commercial Outpatient non-ER visits from 2017 – 2022. Only visits from a member that had an in-network Professional E&M visit on the same day as their HOPD visit are displayed.

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service.

	Professional E&M Visit In-Network: Claim Count		
CY	HOPD Visit: In-Network	HOPD Visit: Out-of-Network	Total
2017	202,621	3,745	206,366
2018	223,289	3,227	226,516
2019	257,281	6,084	263,365
2020	231,378	2,041	233,419
2021	286,855	2,316	289,171
2022	293,410	2,161	295,571
Total	**1,494,834**	**19,574**	**1,514,408**

	Percentage of Total		
CY	HOPD Visit: In-Network	HOPD Visit: Out-of-Network	Total
2017	98.2%	1.8%	100.0%
2018	98.6%	1.4%	100.0%
2019	97.7%	2.3%	100.0%
2020	99.1%	0.9%	100.0%
2021	99.2%	0.8%	100.0%
2022	99.3%	0.7%	100.0%
Total	**98.7%**	**1.3%**	**100.0%**

Exhibit II - Number of Patient Visits for which Facility Fees were charged out-of-network and the professional fees were charged in-network for the same service.



25.5-4-216(6)(a)(III)

Description

The total allowed facility fee amounts billed and denied.

Methodology

As noted in the Data Validation section, there is a data limitation on identifying all denied visits. The APCD includes information on when an individual service billed by the provider, such as the HOPD visit, was denied with the rest of the visit approved and paid. The data does not include information on when the entirety of the visit was denied. As such, Optumas is limited in reporting on the cases when the entire visit was denied but can report on the instances when the HOPD portion of the visit was denied while other services were approved and paid.

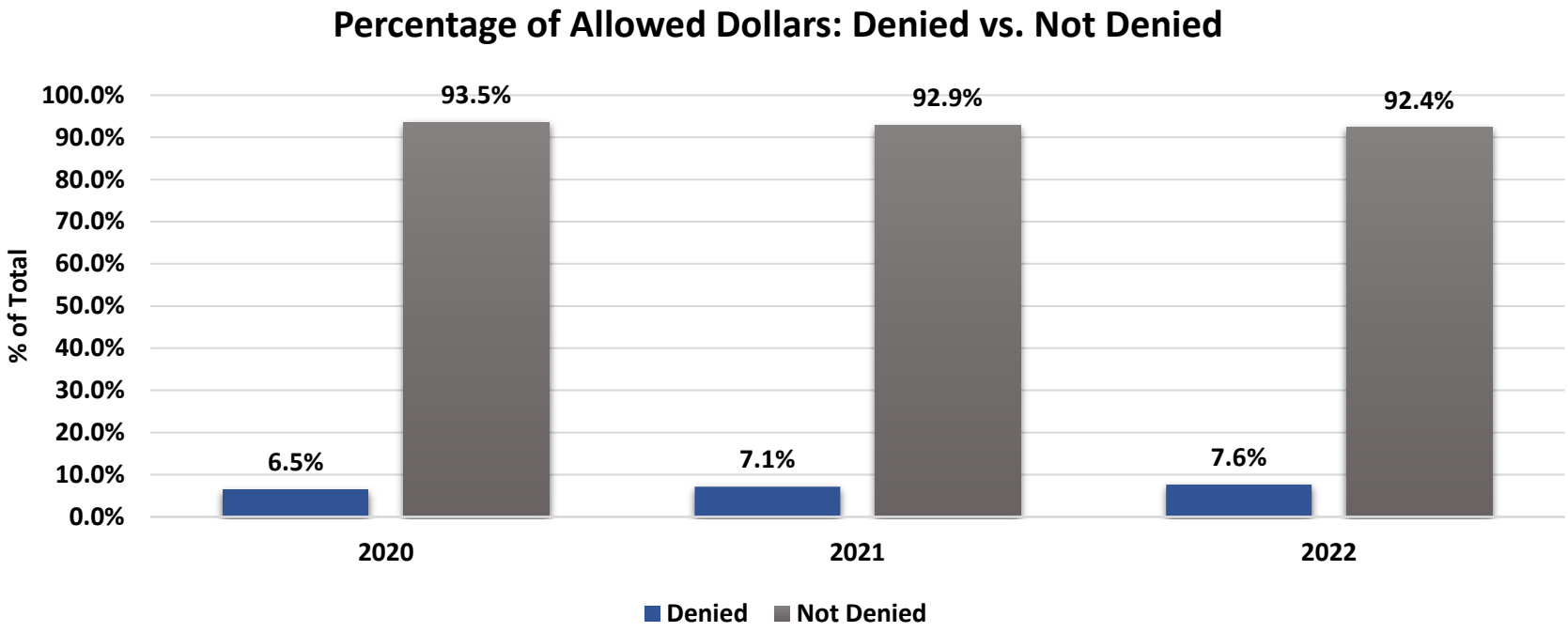
The APCD provides a field in the data on each individual claim line that indicates paid or denied status. Optumas summarized the allowed amount and visit count, delineated by paid or denied using the line level information in the data, for all HOPD visits by year in the Commercial data for the study period. Note, the denied indicator was not sufficiently populated for 2017 – 2019. For those three years, Optumas did not consider the data to be credible for the analysis. As such, the data has been removed from the summary tables below.

Results

About 93% of allowed dollars for HOPD visits were paid, and approximately 7% were denied across 2020 – 2022. As noted above, this does not include instances where the entire visit was denied. See Exhibit III for the detailed table of results by year, paid or denied status, for Commercial HOPD visits.

Exhibit III – The total allowed Facility Fee amounts billed and denied.[1]

	Allowed Dollars			Percentage of Total		
CY	Denied	Not Denied	Total	Denied	Not Denied	Total
2020	$88,256,555	$1,279,759,827	$1,368,016,382	6.5%	93.5%	100.0%
2021	$115,093,371	$1,498,463,813	$1,613,557,184	7.1%	92.9%	100.0%
2022	$127,876,219	$1,550,983,945	$1,678,860,164	7.6%	92.4%	100.0%
Total	**$331,226,145**	**$4,329,207,584**	**$4,660,433,730**	**7.1%**	**92.9%**	**100.0%**



[1] The denied indicator for the 2017 – 2019 data was not sufficiently populated. The data from these three years has been removed from this analysis.

25.5-4-216(6)(a)(IV)

Description

The top ten most frequent CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees were charged.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) most frequent codes would be expanded to the top twenty-five (25) codes. This is intended to align with the provider surveys and the level of detail requested from providers for other components of the final report.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the most frequently billed services.

Results

The 25 most frequent procedure codes for which facility fees were charged to Commercial payers are displayed in Exhibit IV.a. Laboratory services, which account for over 40% of the top 25 most frequent procedure codes, are the most common services that are performed during a HOPD visit. Appendix 1 contains the detailed descriptions of the top 25 most frequent procedure codes for which HOPD visits were charged to Commercial payers.

The top 25 most frequent revenue codes for which HOPD visits were charged to Commercial payers are displayed in Exhibit IV.b. Revenue code '0301', which designates Laboratory/Chemistry related services, account for over 14% of the top 25 most frequent revenue codes for which HOPD visits are charged.

Exhibit IV.a – Top 25 CPT codes for which Facility Fees were charged.

		Procedure Code: Counts						
CPT Code	**Description**[2]	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
36415	Laboratory	145,435	148,244	125,282	96,818	122,250	127,977	766,006
80053	Laboratory	79,217	78,720	67,346	55,841	71,158	72,528	424,810
85025	Laboratory	76,086	75,015	63,719	54,549	68,735	69,796	407,900
97110	Physical Therapy	46,831	55,039	50,354	47,251	60,406	62,040	321,921
J3490	Injectables	10,330	13,882	19,217	47,475	71,293	133,085	295,282
77067	Mammogram	23,461	56,673	52,843	45,593	52,872	54,524	285,966
99213	Office Visit	45,439	56,618	51,369	36,374	43,919	48,419	282,138
90999	Dialysis	40,881	44,098	32,970	37,495	43,114	41,123	239,681
77063	X-Ray	25,320	35,815	38,287	38,301	47,437	50,188	235,348
84443	Laboratory	42,522	40,769	35,280	27,401	38,145	37,349	221,466
97140	Therapy	31,965	37,471	35,579	31,792	39,646	39,807	216,260
80061	Laboratory	37,034	35,227	30,399	23,863	34,408	37,450	198,381
J2704	Injectables	23,832	25,696	21,646	24,092	40,953	52,927	189,146
90945	Dialysis	24,604	30,269	25,532	23,894	22,435	23,774	150,508
99212	Office Visit	23,474	27,712	25,973	20,959	23,933	24,784	146,835
J1100	Injectables	22,160	22,813	19,780	18,556	28,512	33,404	145,225
J3010	Injectables	23,628	23,152	19,240	17,886	28,995	31,525	144,426
J2405	Injectables	22,128	22,100	19,580	18,536	27,821	30,527	140,692
85027	Laboratory	24,548	25,845	22,383	18,712	23,126	25,148	139,762
80048	Chemical Screen	25,083	25,539	21,149	18,070	21,655	23,126	134,622
J2250	Injectables	21,743	22,090	18,490	20,156	24,628	25,650	132,757
99214	Office Visit	21,716	23,378	20,672	15,605	23,521	26,861	131,753
83036	Laboratory	21,523	22,153	19,056	16,522	24,157	27,746	131,157
J1644	Injectables	15,426	16,498	15,840	20,110	26,938	23,928	118,740
88305	Pathology	22,079	21,634	18,488	15,790	19,317	20,441	117,749

[2] For Injectables, counts are based on the frequency of the procedure codes within the APCD.

Exhibit IV.b – Top 25 revenue codes for which Facility Fees were charged.

		Revenue Code: Counts						
Rev. Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
0301	Laboratory - Chemistry	365,665	391,397	353,161	292,938	393,588	421,691	2,218,440
0636	Pharmacy	287,552	314,679	296,477	338,167	451,546	473,144	2,161,565
0300	Laboratory - General	304,699	245,088	197,329	202,631	259,716	246,919	1,456,382
0250	Pharmacy - General	119,639	177,183	163,644	162,950	184,698	242,831	1,050,945
0305	Hematology	135,700	151,297	131,897	111,163	135,059	136,984	802,100
0510	Outpatient Hospital	111,501	140,902	136,470	104,336	128,605	135,957	757,771
0490	Ambulatory Surgical Care	147,775	133,259	105,924	94,583	112,523	115,335	709,399
0420	Physical Therapy	108,862	116,100	101,533	91,723	120,104	124,670	662,992
0306	Bacteriology	80,481	95,051	89,727	122,601	142,712	118,168	648,740
0403	Screening Mammography	65,399	90,367	91,020	85,307	102,724	107,117	541,934
0320	X-Ray	126,265	85,515	73,770	65,187	78,707	81,431	510,875
0302	Immunology	69,183	77,294	75,495	70,891	88,931	96,483	478,277
0360	Operating Room	49,785	55,827	57,777	51,532	61,822	66,496	343,239
0402	Ultrasound	40,814	52,747	51,053	49,145	57,639	60,130	311,528
0272	Sterile Supplies	51,993	48,069	40,904	39,689	52,643	56,161	289,459
0771	Preventive Care	14,484	18,801	19,333	20,195	162,254	45,366	280,433
0258	IV Solutions	48,738	46,556	43,438	37,382	47,687	39,605	263,406
0710	Recovery Room	33,849	38,211	38,607	34,914	43,657	49,011	238,249
0821	Hemodialysis - Composite	39,568	40,419	32,888	36,543	42,294	40,630	232,342
0370	Anesthesia	33,781	34,850	32,828	30,517	40,200	44,549	216,725
0333	Home Health	27,495	37,497	34,859	33,699	37,871	38,582	210,003
0761	Treatment Room	30,743	33,190	31,124	29,229	35,693	35,629	195,608
0270	Medical Supplies - General	33,181	30,163	25,378	28,529	37,074	34,448	188,773
0260	IV Therapy	23,645	25,656	27,662	27,647	34,653	36,583	175,846
0278	Medical Supplies - Implants	22,310	23,274	26,323	26,089	34,135	36,377	168,508

25.5-4-216(6)(a)(V)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, with the highest total allowed amounts from facility fees.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest allowed amount would be expanded to the top twenty-five (25) codes. This is intended to align with the provider surveys and the level of detail requested from providers for other components of the final report.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim.** This data was then used to analyze the codes with the highest allowed amount.

Results

The top 25 procedure codes for which HOPD visits were charged to Commercial payers, based on allowed amount by code, are displayed in Exhibit V.a. Dialysis, Medical Devices/Supplies, Arthroplasty, and Colonoscopy services account for over 50% of the allowed amount for the top 25 codes. Appendix 2 contains the detailed descriptions of the top 25 procedure codes for which facility fees were charged to Commercial payers, based on allowed amount by code.

The top 25 most frequent revenue codes for which HOPD visits were charged to Commercial payers are displayed in Exhibit V.b. Revenue code '0360' is related to Operating Room services, which aligns with the observation that the top procedure codes are related to Dialysis, Medical Devices/Supplies, Arthroplasty, and Colonoscopy services.

Exhibit V.a – Top 25 procedure codes with the highest total allowed amounts on same visit as a facility fees.

		Procedure Code: Allowed Amounts						
CPT Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
90999	Dialysis	$27,207,634	$30,242,734	$26,870,241	$29,195,803	$33,862,759	$33,409,374	$180,788,545
C1713	Devices/Supplies	$14,811,775	$16,682,317	$17,604,170	$18,911,968	$26,593,041	$29,146,998	$123,750,269
27447	Arthroplasty	$5,763,179	$12,207,762	$17,687,001	$21,937,516	$29,635,535	$35,668,170	$122,899,163
C1776	Devices/Supplies	$2,990,366	$6,982,341	$14,044,650	$20,663,166	$28,857,446	$32,044,270	$105,582,238
45380	Colonoscopy	$16,526,323	$17,528,522	$17,230,819	$13,702,406	$18,344,499	$19,708,831	$103,041,400
93306	Echocardiography	$14,624,481	$15,177,954	$15,349,852	$15,149,076	$19,769,142	$21,404,624	$101,475,130
27130	Arthroplasty	$5,257,927	$7,006,591	$9,277,616	$17,830,494	$21,542,374	$26,835,207	$87,750,209
43239	Endoscopy	$12,614,304	$13,793,064	$14,545,963	$12,517,381	$15,857,356	$16,210,475	$85,538,543
45385	Colonoscopy	$11,431,881	$11,980,645	$12,454,059	$11,264,219	$16,225,476	$21,378,910	$84,735,190
77386	Radiation Treatment	$9,192,113	$10,755,100	$12,427,393	$12,163,322	$12,812,247	$12,930,531	$70,280,706
J2350	Injectables	$0	$17,541,652	$16,177,211	$10,117,123	$12,395,986	$11,044,823	$67,276,795
J9271	Chemotherapy Drug	$4,426,605	$4,962,097	$8,636,873	$12,837,951	$14,113,087	$20,766,275	$65,742,888
45378	Colonoscopy	$10,119,105	$10,408,571	$10,364,134	$7,589,274	$11,217,861	$14,330,314	$64,029,259
90945	Dialysis	$8,543,774	$10,880,246	$10,816,880	$10,541,698	$10,657,017	$11,643,991	$63,083,606
77067	Mammogram	$5,544,498	$11,613,812	$11,724,622	$10,004,706	$11,606,995	$11,721,798	$62,216,430
58571	Laparoscopy	$8,106,885	$9,509,503	$8,550,701	$8,301,036	$10,900,151	$11,784,497	$57,152,772
97110	Physical Therapy	$5,724,250	$7,809,358	$8,487,944	$7,713,752	$9,450,062	$10,076,322	$49,261,687
G0378	Outpatient Observation	$6,849,508	$5,974,080	$9,722,144	$8,264,600	$8,562,020	$8,998,981	$48,371,334
96413	Chemotherapy Drug	$6,787,888	$7,774,158	$7,460,047	$8,159,000	$8,544,054	$8,525,045	$47,250,192
J1745	Injectables	$9,499,561	$9,076,980	$7,986,056	$7,649,411	$6,507,006	$4,081,166	$44,800,182
J2505	Immunostimulant	$7,639,432	$10,016,811	$9,877,808	$10,075,395	$6,074,197	$0	$43,683,644
J9299	Chemotherapy Drug	$2,713,192	$6,058,322	$8,935,221	$7,393,128	$8,955,433	$9,353,028	$43,408,325
29888	Ligament Repair	$5,726,532	$6,819,699	$7,276,249	$6,234,432	$7,756,891	$9,554,531	$43,368,333
80053	Laboratory	$6,485,283	$6,638,891	$7,108,318	$6,948,309	$7,933,682	$7,851,851	$42,966,334
66984	Vision	$7,400,270	$7,343,032	$6,863,620	$5,803,427	$7,369,186	$7,363,651	$42,143,185

Exhibit V.b – Top 25 revenue codes with the highest total allowed amounts on same visit as a facility fees.

		Revenue Code: Allowed Amounts						
Rev. Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
0360	Operating Room	$147,651,501	$192,731,435	$235,643,683	$223,743,899	$273,302,107	$295,803,254	$1,368,875,877
0490	Ambulatory Surgical Care	$244,079,576	$219,744,097	$166,476,400	$167,633,043	$197,124,919	$203,558,234	$1,198,616,269
0636	Pharmacy	$96,963,334	$147,566,195	$178,598,237	$184,305,362	$213,550,800	$212,898,170	$1,033,882,098
0278	Medical Supplies - Implants	$54,942,231	$61,666,424	$71,917,802	$75,116,336	$97,034,146	$101,694,327	$462,371,266
0333	Home Health	$33,305,742	$41,949,588	$48,057,682	$48,870,291	$49,914,346	$55,319,740	$277,417,389
0250	Pharmacy - General	$50,095,236	$43,112,319	$40,314,985	$36,943,498	$38,438,116	$41,426,908	$250,331,062
0710	Recovery Room	$26,314,879	$31,642,942	$37,207,948	$33,308,311	$39,070,832	$42,862,305	$210,407,217
0481	Cardiology	$19,180,612	$23,287,254	$34,088,340	$30,272,628	$35,924,117	$37,681,195	$180,434,146
0821	Hemodialysis - Composite	$27,587,061	$28,613,153	$26,223,375	$29,345,599	$34,106,246	$33,295,242	$179,170,676
0272	Sterile Supplies	$30,671,700	$27,393,988	$27,879,161	$22,796,210	$28,834,411	$29,123,163	$166,698,634
0320	X-Ray	$42,079,934	$25,156,560	$25,068,006	$20,739,583	$24,884,404	$25,985,787	$163,914,274
0301	Laboratory - Chemistry	$23,361,480	$25,477,284	$26,470,400	$24,659,389	$29,852,355	$31,930,003	$161,750,910
0750	Gastrointestinal Services	$16,733,012	$22,500,479	$28,273,945	$23,098,856	$31,969,126	$39,060,471	$161,635,888
0370	Anesthesia	$20,535,662	$21,791,086	$22,517,889	$20,206,880	$26,455,968	$27,623,898	$139,131,383
0361	Operating Room	$14,307,517	$21,107,514	$23,398,751	$20,443,923	$21,997,321	$25,197,772	$126,452,796
0483	Echocardiology	$14,401,976	$18,443,591	$18,717,164	$18,291,500	$24,055,118	$25,506,489	$119,415,837
0402	Ultrasound	$13,702,881	$18,652,422	$19,661,372	$18,708,112	$21,632,786	$23,067,339	$115,424,912
0761	Treatment Room	$15,955,024	$17,452,900	$18,669,173	$17,321,504	$21,127,549	$20,868,856	$111,395,006
0352	CT Scan	$14,865,757	$16,792,764	$17,636,036	$16,632,558	$18,368,489	$19,069,007	$103,364,611
0480	Cardiology	$21,433,692	$13,742,023	$13,183,544	$11,864,835	$15,022,771	$13,216,373	$88,463,238
0420	Physical Therapy	$13,335,988	$12,993,262	$14,002,451	$12,525,830	$15,486,002	$16,277,294	$84,620,827
0403	Screening Mammography	$10,471,744	$13,603,848	$14,564,157	$13,050,275	$15,516,663	$15,978,547	$83,185,234
0300	Laboratory - General	$17,056,700	$10,298,455	$9,928,860	$12,278,511	$13,996,374	$13,820,638	$77,379,538
0610	Magnetic Resonance Tech	$12,048,292	$13,316,471	$12,718,280	$11,263,490	$13,314,207	$13,892,021	$76,552,761
0240	Ancillary	$38,259,331	$26,544,989	$361,930	$1,272,248	$1,565,243	$5,877,047	$73,880,788

25.5-4-216(6)(a)(VI)

Description

The top ten CPT codes, revenue codes, or combination thereof, at the steering committee's discretion, for which facility fees are charged with the highest member cost sharing.

Methodology

After discussion with the Hospital Facility Fee Steering Committee, it was determined that the top ten (10) codes with the highest member cost sharing would be expanded to the top twenty-five (25) codes. This is intended to align with the provider surveys and the level of detail requested from providers for other components of the final report.

Once the HOPD visit was identified, Optumas identified all services performed during the visit based on the claim ID that the HOPD visit was billed. **This is exclusive of the professional component that may be billed in conjunction with the HOPD claim**. This data was then used to analyze the codes with the highest member cost sharing.

Results

Exhibit VI.a represents the top 25 procedure codes for which HOPD visits were charged to Commercial payers with the highest member cost sharing amounts. Dialysis, Medical Devices/Supplies, Arthroplasty, and Colonoscopy services account for the greatest member cost sharing. This will be partially driven by the individual cost of those services, and the timing of a member meeting their deductible which contributes to how much the member owes. If the member is below their deductible, and the service is not covered under a fixed copay, the member will pay 100% of the service cost up to their deductible. After they meet their deductible, the member will pay their responsible portion based on their benefit package design, and the Commercial payer will cover the remainder. The member portion may continue to be reflective of copay levels, or may reflect co-insurance which is reflective of a percentage of the total service allowed amount. Appendix 3 contains the detailed descriptions of the top 25 procedure codes for which HOPD visits were charged with the highest member cost sharing amounts.

Exhibit VI.b displays the top 25 revenue codes for which HOPD visits were charged to Commercial payers with the highest member cost sharing. Revenue codes '0360' (Operating Room), '0636' (Pharmacy), and '0490' (Ambulatory Surgical Care) represent over 50% of the top 25 revenue codes with the highest member cost sharing.

Exhibit VI.a – Top 25 procedure codes for which Facility Fees are charged with the highest member cost sharing.

		Procedure Code: Member Cost Sharing Amounts						
CPT Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
90999	Dialysis	$26,138,585	$29,344,046	$25,968,319	$28,102,430	$32,692,803	$32,257,490	$174,503,674
C1713	Devices/Supplies	$13,116,963	$14,656,378	$15,615,442	$16,876,836	$23,809,667	$25,928,037	$110,003,324
27447	Arthroplasty	$5,419,037	$11,539,238	$16,718,741	$20,643,308	$27,803,897	$33,673,791	$115,798,013
C1776	Devices/Supplies	$2,777,359	$6,536,042	$13,375,664	$19,575,481	$27,154,422	$29,982,819	$99,401,787
45380	Colonoscopy	$14,622,564	$15,387,508	$15,006,307	$11,763,881	$15,873,071	$17,591,499	$90,244,831
93306	Echocardiography	$10,376,506	$10,806,287	$10,926,612	$10,499,636	$14,176,563	$15,198,167	$71,983,770
27130	Arthroplasty	$4,828,033	$6,414,936	$8,398,647	$16,569,180	$19,970,673	$24,932,478	$81,113,948
43239	Endoscopy	$8,587,697	$9,499,625	$10,029,667	$8,641,850	$11,066,598	$11,550,808	$59,376,245
45385	Colonoscopy	$10,580,325	$10,979,056	$11,421,181	$10,106,744	$14,829,760	$19,956,442	$77,873,507
77386	Radiation Treatment	$9,106,863	$10,643,815	$12,295,238	$12,025,270	$12,682,779	$12,768,299	$69,522,265
J2350	Injectables	$0	$17,115,598	$15,720,871	$9,778,267	$12,086,555	$10,744,269	$65,445,560
J9271	Chemotherapy Drug	$4,367,312	$4,896,120	$8,521,529	$12,693,418	$13,978,217	$20,617,249	$65,073,844
45378	Colonoscopy	$9,092,146	$9,353,108	$9,240,421	$6,732,769	$10,039,789	$13,313,511	$57,771,744
90945	Dialysis	$8,225,652	$10,518,170	$10,529,901	$10,189,537	$10,409,042	$11,243,396	$61,115,698
77067	Mammogram	$5,530,294	$11,584,849	$11,693,106	$9,974,382	$11,576,533	$11,696,677	$62,055,841
58571	Laparoscopy	$7,235,570	$8,380,468	$7,506,906	$7,312,745	$9,583,194	$10,389,258	$50,408,140
97110	Physical Therapy	$4,586,448	$6,340,605	$6,812,131	$6,166,230	$7,514,962	$8,141,152	$39,561,528
G0378	Outpatient Observation	$5,942,195	$5,082,958	$8,582,873	$7,116,601	$7,491,183	$7,960,046	$42,175,856
96413	Chemotherapy Drug	$6,441,857	$7,355,455	$7,043,480	$7,731,686	$8,097,130	$8,041,999	$44,711,607
J1745	Injectables	$9,173,502	$8,775,251	$7,725,695	$7,371,619	$6,304,914	$3,939,680	$43,290,662
J2505	Immunostimulant	$7,533,511	$9,905,758	$9,766,963	$9,903,603	$5,972,454	$0	$43,082,289
J9299	Chemotherapy Drug	$2,685,055	$6,009,049	$8,834,262	$7,315,522	$8,872,941	$9,251,388	$42,968,218
29888	Ligament Repair	$4,835,124	$5,822,881	$6,260,888	$5,388,006	$6,662,951	$8,365,101	$37,334,952
80053	Laboratory	$4,967,564	$5,137,599	$5,530,149	$5,483,599	$6,199,317	$6,055,214	$33,373,440
66984	Vision	$5,195,111	$5,113,495	$4,646,294	$3,932,058	$4,900,370	$4,958,550	$28,745,879

Exhibit VI.b – Top 25 revenue codes for which Facility Fees are charged with the highest member cost sharing.

		Revenue Code: Member Cost Sharing Amounts						
Rev. Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
0360	Operating Room	$128,367,967	$168,496,934	$206,138,670	$196,358,555	$241,278,626	$262,146,743	$1,202,787,494
0636	Pharmacy	$93,352,460	$142,281,788	$170,704,987	$176,820,364	$204,725,028	$203,601,087	$991,485,714
0490	Ambulatory Surgical Care	$200,294,586	$177,678,538	$131,650,256	$134,128,866	$157,939,331	$165,929,198	$967,620,775
0278	Medical Supplies - Implants	$50,286,845	$56,541,561	$66,428,986	$69,270,139	$89,088,779	$92,863,223	$424,479,534
0333	Home Health	$32,823,414	$41,226,364	$47,152,290	$47,980,477	$48,925,821	$54,225,744	$272,334,111
0250	Pharmacy - General	$44,686,523	$38,465,837	$35,364,831	$33,142,337	$34,487,411	$36,686,259	$222,833,198
0710	Recovery Room	$24,353,610	$29,366,917	$34,460,428	$30,775,766	$35,915,237	$39,582,429	$194,454,387
0821	Hemodialysis - Composite	$26,368,230	$27,703,215	$25,325,738	$28,241,728	$32,924,670	$32,112,907	$172,676,488
0481	Cardiology	$18,073,613	$22,168,725	$32,122,031	$28,496,098	$33,919,580	$35,689,605	$170,469,652
0272	Sterile Supplies	$27,356,142	$24,298,361	$24,800,849	$20,317,485	$25,862,291	$25,120,741	$147,755,869
0750	Gastrointestinal Services	$14,798,491	$19,949,731	$24,594,366	$19,982,610	$28,137,344	$35,100,930	$142,563,473
0370	Anesthesia	$19,116,970	$20,237,472	$20,898,688	$18,863,394	$24,537,605	$25,688,584	$129,342,713
0301	Laboratory - Chemistry	$17,623,679	$19,250,444	$19,748,092	$18,544,952	$22,158,365	$23,623,401	$120,948,933
0320	X-Ray	$28,967,600	$16,324,867	$16,110,605	$13,006,085	$15,673,144	$16,567,425	$106,649,726
0361	Operating Room	$12,106,407	$18,259,513	$19,469,937	$16,652,848	$17,727,261	$20,705,758	$104,921,724
0761	Treatment Room	$13,678,722	$15,011,803	$15,661,356	$14,255,961	$17,766,476	$17,397,914	$93,772,232
0483	Echocardiology	$10,272,134	$13,365,852	$13,548,637	$13,084,341	$17,889,270	$18,350,952	$86,511,186
0403	Screening Mammography	$10,418,700	$13,565,765	$14,517,744	$12,999,872	$15,471,547	$15,938,117	$82,911,745
0480	Cardiology	$17,647,427	$12,306,015	$11,769,064	$10,411,710	$13,134,607	$11,577,450	$76,846,273
0352	CT scan	$10,980,568	$12,106,201	$12,761,103	$11,857,258	$12,976,326	$13,479,035	$74,160,491
0851	CCPD	$9,179,926	$13,188,547	$12,224,941	$11,589,267	$12,501,756	$11,789,101	$70,473,539
0402	Ultrasound	$8,132,593	$11,163,561	$11,754,611	$10,826,438	$12,946,259	$14,211,849	$69,035,311
0420	Physical Therapy	$10,919,790	$10,533,491	$11,248,173	$10,039,234	$12,341,990	$13,180,838	$68,263,516
0240	Ancillary	$35,066,256	$24,237,290	$359,315	$1,264,899	$1,552,576	$4,730,299	$67,210,636
0335	Chemotherapy	$8,740,374	$9,509,029	$9,563,902	$9,920,580	$10,243,973	$10,703,203	$58,681,061

25.5-4-216(6)(a)(VII)

Description

The total number of facility fee claim denials, by site of service.

Methodology

As noted above, the APCD does not include denied claims when the entire visit was denied. This data limitation prevents Optumas from reporting on claim denials by site of service. Optumas can report on instances when the facility fee line was denied during a visit that was otherwise approved. This has been captured in the analytics above under 25.5-4-216(6)(a)(III), and the corresponding Appendix III.

Appendices

Appendix 1

CPT Code	Description[3]
36415	Collection of venous blood by venipuncture.
80053	Comprehensive metabolic panel.
85025	Complete blood count with automated differential white blood cell count.
97110	Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion.
J3490	Meloxicam injection.
77067	Bilateral screening mammogram that includes computer-aided detection.
99213	Level three office visit with an established patient, 20-29 minutes.
90999	Unlisted dialysis procedure, either inpatient or outpatient.
77063	Bilateral screening digital breast tomosynthesis.
84443	Blood test measuring thyroid stimulating hormone level.
97140	Manual therapy techniques used for 15 minutes or more in one or more body regions.
80061	Lipid panel test to measure the level of triglycerides in blood.
J2704	10 mg injection of propofol, an anesthetic and sedative used to help patients relax or sleep.
90945	Dialysis procedures other than hemodialysis or other continuous renal replacement therapies.
99212	Office visit, other outpatient visits, evaluation and management.
J1100	1 mg injection of dexamethasone sodium phosphate.
J3010	0.1 mg injection of fentanyl citrate.
J2405	1 mg injection of ondansetron hydrochloride, used for chemotherapy drugs
85027	Blood count on the red and white blood cells and platelets and hemoglobin test.
80048	Basic metabolic panel.
J2250	Injection up to 50 mg of promethazine HCl, to treat nausea and vomiting caused by motion sickness.
99214	Office or outpatient visit that evaluates and manages an established patient, 30-39 minutes.
83036	Glycated hemoglobin/Glycated protein.
J1644	1,000 units of heparin sodium injection.
88305	Level 4 surgical pathology and microscopic examination.

Appendix 2

CPT Code	Description[3]
90999	Unlisted dialysis procedure, either inpatient or outpatient.
C1713	Implantable anchor or screw that opposes bone-to-bone or soft tissue-to-bone.
27447	Total knee arthroplasty, replacing the condyle and plateau of the knee as well as the medial and lateral compartments.
C1776	Implantable joint device, such as an artificial joint in a patient's ankle, knee, hip, or shoulder.
45380	Examination of the entire colon.
93306	Transthoracic echocardiography, complete study.
27130	Total hip arthroplasty, or acetabular and proximal femoral prosthetic replacement.
43239	Esophagogastroduodenoscopy with biopsy.
45385	Flexible colonoscopy with the removal of polyps, tumors, or other lesions using a snare technique.
77386	Radiation therapy to deliver radiation doses to a malignant tumor.
J2350	1 mg injection of ocrelizumab.
J9271	Injection, pembrolizumab - Chemotherapy Drugs.
45378	Flexible diagnostic colonoscopy that involves collecting specimens by brushing or washing.
90945	Dialysis procedures other than hemodialysis or other continuous renal replacement therapies.
77067	Bilateral screening mammogram that includes computer-aided detection.
58571	Surgical laparoscopy with a total hysterectomy, for uterus weighing 250 grams or less.
97110	Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion.
G0378	Hospital observation used by facilities to report hospital outpatient observation.
96413	Injection and intravenous infusion chemotherapy.
J1745	10 mg injection of infliximab, excluding biosimilars.
J2505	Injection, pegfilgrastim - Chemotherapy Drugs.
J9299	Injection, nivolumab - Chemotherapy Drugs.
29888	Arthroscopically aided anterior cruciate ligament repair, augmentation, or reconstruction.
80053	Comprehensive metabolic panel.
66984	Removing a cataract and inserting an intraocular lens prosthesis.

Appendix 3

CPT Code	Description[3]
90999	Unlisted dialysis procedure, either inpatient or outpatient.
C1713	Implantable anchor or screw that opposes bone-to-bone or soft tissue-to-bone.
27447	Total knee arthroplasty, replacing the condyle and plateau of the knee as well as the medial and lateral compartments.
C1776	Implantable joint device, such as an artificial joint in a patient's ankle, knee, hip, or shoulder.
45380	Examination of the entire colon.
93306	Transthoracic echocardiography, complete study.
27130	Total hip arthroplasty, or acetabular and proximal femoral prosthetic replacement.
43239	Esophagogastroduodenoscopy with biopsy.
45385	Flexible colonoscopy with the removal of polyps, tumors, or other lesions using a snare technique.
77386	Radiation therapy to deliver radiation doses to a malignant tumor.
J2350	1 mg injection of ocrelizumab.
J9271	Injection, pembrolizumab - Chemotherapy Drugs.
45378	Flexible diagnostic colonoscopy that involves collecting specimens by brushing or washing.
90945	Dialysis procedures other than hemodialysis or other continuous renal replacement therapies.
77067	Bilateral screening mammogram that includes computer-aided detection.
58571	Surgical laparoscopy with a total hysterectomy, for uterus weighing 250 grams or less.
97110	Therapeutic exercise that helps patients develop or maintain strength, endurance, flexibility, or range of motion.
G0378	Hospital observation used by facilities to report hospital outpatient observation.
96413	Injection and intravenous infusion chemotherapy.
J1745	10 mg injection of infliximab, excluding biosimilars.
J2505	Injection, pegfilgrastim - Chemotherapy Drugs.
J9299	Injection, nivolumab - Chemotherapy Drugs.
29888	Arthroscopically aided anterior cruciate ligament repair, augmentation, or reconstruction.
80053	Comprehensive metabolic panel.
66984	Removing a cataract and inserting an intraocular lens prosthesis.

[3] Procedure Code Definitions: https://www.aapc.com/