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July 8, 2024

Subject: Colorado HB1215 – Professional and Facility Fee Comparison Methodology Report

Professional and Facility Fee Comparison Methodology Report - 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 comparing professional fees and hospital outpatient department (HOPD) facility fees for the same services. The Colorado All Payer Claims Database (APCD) provided by the Center for Improving Value in Healthcare (CIVHC) was utilized for this analysis across the 2017 to 2022 calendar years. 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 and compare against the comparable professional fees for the same services. The comparison focuses on Medicare Fee-for-service (FFS), Medicare Advantage, and Commercial payers for HOPD services that also can be provided in a professional setting. The HOPD facility fees will be compared to the professional fees for the same services, and professional fees will be split between independent providers and hospital affiliated providers.

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 comparing facility fees to professional fees for the same service?
- 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. We then reviewed the visit volume and

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financial field volume on a monthly longitudinal basis by service type and payer. 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.

Optumas also received benchmarks from CIVHC that estimate they have about 75% of all Commercial 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

Optumas also compared the Medicare-specific data within APCD to determine what proportion of Medicare members were reflected within the dataset. That analysis indicated that for the 2017-2022 time period, the APCD reflects 95% of both Medicare and Medicare Advantage members. See Table 1 below.

Table 1. Medicare Membership Benchmark

	Total Medicare Membership		
Period	**CMS Reported Medicare Enrollment**	**APCD**	**% of Benchmark**
2017	847,702	807,492	95%
2018	881,043	834,766	95%
2019	911,545	860,660	94%
2020	938,949	886,492	94%
2021	961,592	921,281	96%
2022	983,947	946,661	96%

HOPD Facility Fee and Professional Fee Identification

HOPD Facility Fee Data

Each outpatient visit at a HOPD will generate a facility fee billed to the patient, and in many cases an additional bill for the individual physicians professional fees. The following discusses the identification of the HOPD facility fee portion of the HOPD related outpatient visits.

Optumas first identified all HOPD claims within the APCD using a delineation provided by CIVHC to identify hospital outpatient claims. Optumas validated that delineation by reviewing the Bill Type provided on each claim to confirm they were appropriately identified. Bill Type is a nationally standardized set of codes for institutional/facility-based services that provides information on the type of bill the provider is submitting to the payer. Optumas found that the Bill Types were all generally related to an outpatient-type setting, however; we further delineated that data for this comparison to claims that had the following Bill Type:

- "131" - Hospital, outpatient, admit through discharge[1].
- "851" – Critical Access Hospital, outpatient, admit through discharge[1].

Additionally, Optumas limited the data to non-Emergency Room outpatient claims within the APCD. After discussion with the Hospital Facility Fee Steering Committee, it was determined to exclude all Emergency Room claims from the analytics. Optumas also removed any services that had been denied by the payer. This final HOPD data set services as the basis for identifying the facility fees for Colorado based providers.

On-campus/Off-campus

To identify the on-campus and off-campus visits, Optumas first looked to the Place of Service on each claim. Place of Service is a nationally standardized set of codes for that provides information on the location of the visit between the patient and provider. While this field is provided in the data, unfortunately there is a data limitation due to it being sparsely populated for facility-related claims within the APCD. Optumas explored the following alternative approaches by payer type. The results are that an alternative option was identified for Medicare, however; the off-campus clinic visits were not able to be delineated within the Commercial data. Optumas will delineate on-campus HOPD for the Medicare comparison, and look at a combination of on and off campus HOPD for the Commercial payer comparison. Additional analytics will be provided regarding off-campus locations for hospital systems for the final Steering Committee report.

Professional Fee Data

The professional claims to be used for the comparison were also delineated within the APCD by CIVHC. Optumas validated that delineation by reviewing the Place of Service (POS) provided on each claim to confirm they were appropriately identified. Optumas found that the POS were all generally related to a

[1] https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types

professional setting, however; we further delineated that data for this comparison to claims that had the following Place of Service[2] codes:

- 11 – Office
- 12 – Home
- 81 – Independent Laboratory

Optumas also found Places of Service for the professional fee component of a HOPD outpatient visit. These were excluded so that the comparison focused on the professional fees provided during a patient visit that was independent of an outpatient visit. Finally, Optumas removed any services that had been denied by the payer. This final professional data set services as the basis for identifying the professional fees for Colorado based providers.

Independent/Affiliated Providers

To identify independent and hospital-affiliated providers, Optumas leveraged an additional dataset called IQVIA for the same 2017 to 2022 time period. This data set provides information on each individual provider and if they are affiliated with a hospital or health system for each year, including which health system they are affiliated with at that time. This information was aligned with the APCD by the servicing provider NPI, which identifies the individual practitioner present for the visit. The IQVIA dataset includes physicians that are either Medical Doctors (MDs) or Doctors of Osteopathy (DOs).

[2] https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Comparison Methodology and Analytics

The comparison of the facility fee and professional fees for the same services is based on using the allowed amount in APCD for the datasets and provider splits identified above. The comparison focuses on the same service provided in either a HOPD setting or a professional setting. It should be noted that the professional fees in this comparison are for services provided in a professional setting only, and do not reflect the professional fee component of an outpatient visit. The allowed amount reflects the contracted rate between the provider and payer, and reflects the total reimbursement for the services provided. The following identifies additional data adjustments and methodology for the comparison.

Grouped Payments

Optumas is aware that some HOPD visits are paid on a grouped basis, which means that all services provided during a visit are grouped together into one overall payment. The result is that the allowed amount listed on a claim for an individual CPT code may not reflect the payment for that individual service, but rather for the entire visits as a whole which may include other services. Inclusion of these grouped payments would skew the HOPD cost per service upward for those individual codes, and would not be appropriate for the comparison. Optumas identified these instances by comparing the overall allowed amount for a visit to the individual allowed amount for each service (CPT code) during a visit. In the instances where they were the same amount, we removed those from the data prior to performing the comparison analysis.

Zero ($0) Allowed Amount

If a service (CPT code) had a $0 allowed amount, in either the HOPD or Professional data, it was excluded from the analysis to avoid skewing the cost per service downward.

Modifiers

The comparison is based on the CPT codes that identify each individual service provided during a visit in the claims data, however; Optumas understands that there are also modifiers that can be associated with a CPT code that may further modify the allowed amount for that service. For this comparison, Optumas included any instances of either modifier TC (Technical Component) or 26 (Professaionl Component) along with the CPT code to ensure that variation driven by these modifiers was controlled for in the calculation of the allowed amount per service comparison.

Allowed per Service

The comparison is done at the individual CPT code level based on the allowed amount per service. The allowed amount per service is based on the allowed amount for each CPT code relative to the detailed units of that individual service that was provided as reported on the claim in APCD. The service units itemize the number of units associated with each individual CPT code (service provided), which indicates how much to reimburse the provider for that service. the majority of cases, the detailed units are one (1) based on providing one instance of that individual service, but in some cases may be greater than one (1) depending on the type of service provided and the billing guidelines for that service. This

approach ensures that we are accounting and controlling for those instances for an accurate comparison when calculating the allowed amount per service.

Outliers

Once the above data adjustments were taken into account, the allowed amount per service was reviewed for any outliers. This was done for each unique combination of the following:

- Payer
  - Commercial
  - Medicare
  - Medicare Advantage
- CPT and modifier combination
- For each of the three comparison groups:
  - HOPD
  - Professional (affiliated)
  - Professional (independent)

The result allowed Optumas to isolate and remove the top 5% of the allowed amount per service for each of the combinations above. This was done to remove any data anomalies or outlier contracting agreements that could further skew the comparison.

Weighted Average

After outliers were removed, Optumas calculated the average allowed amount per service for each of the unique combinations noted above. The approach reflects the weighted average of the allowed amount per service based on the utilization of each code within the APCD. Optumas also reviewed the use of the median allowed amount per service, which returned similar results for higher utilized services, but had more variability for lower utilized services included in the comparison. The result was the selection of the utilization weighted average allowed amount per service.

Final Code Selection

In order to ensure an informative comparison, an initial selection of the top 50 codes were selected based on highest frequency of utilization and also highest allowed amount within the HOPD data between each payer. The result is a list of codes that reflects highly utilized services, along with services that may have lower overall utilization but that reflect a higher proportion of expenses due to the higher cost nature of those services. The list excludes injectable drugs (J-series codes) due to the additional complexity around the pricing of those codes.

We then looked for those top HOPD codes within the Professional data, and only included the codes that were in both datasets for the final comparison. Additionally, Optumas set a minimum limit of at least twenty-five (25) individual instances of each code within the either dataset to account for credibility and stability of the contracted amount for those codes. The final list was limited to the top 25 codes that were found in both datasets, by payer, that also met the minimum utilization threshold.

Appendices I.A.i to I.C.ii include the list of the final top 25 codes for Medicare FFS, Medicare Advantage, and Commercial comparison aggregated across the six years of data. The codes are in numerical order.

Appendices II.A.i to II.C.ii include the list of the final top 25 codes for Medicare FFS, Medicare Advantage, and Commercial comparison for each year. The codes are in numerical order. These are provided in a separate Excel appendix.

Appendices III.A to III.C include the full definition of each code used for the comparison by payer type.

Results & Key Findings

Overall

The overall observation was that HOPD facility fees were higher than the professional fees for the same services when provided in a professional site of service. This was the case for both hospital affiliated and independent providers. The resulting impact indicates that the HOPD facility fees contributed approximately $50.8M to $53.7M in additional health care expenditures when compared against either affiliated or independent professional fees, respectively, for the top 25 codes reviewed across Medicare and Commercial payers. This is based on using the HOPD volume of utilization and mix of services. This impact is intended to highlight reimbursement differences, and does not comment on feasibility of impacting actual expenditures due to utilization shifting between sites of service.

Hospital Resource Billing Note

The top codes listed for Medicare FFS and Medicare Advantage are those that may also be associated with a visit that also had a G0463 code billed, which identifies hospital facility resources per Medicare billing guidelines. The result is that in addition to the individual codes being compared, the final total amount the patient and payer are responsible for could be higher in a HOPD setting due to the inclusion of G0463 for the overall visit reimbursement.

Similarly for Commercial, the presence of an E&M code on a HOPD claim may be similar to the G0463 billing guidelines for Medicare, given that E&M codes were the predecessor for G0463 for hospitals to bill for facility resources. So while the E&M fees for HOPD are lower than professional based on the comparison results, those HOPD E&M fees would be in addition to any professional E&M fees for that same HOPD visit, which would generally increase the overall cost of the visit for the consumer.

Medicare FFS

For the top codes reviewed for Medicare FFS, HOPD facility fees were about 95% higher than both independent and affiliated providers. The independent and affiliated providers had comparable reimbursement, driven by Medicare FFS billing guidelines that are consistent across professional fees. The resulting impact indicates that the HOPD facility fees contributed an additional $11.0M in member and payer expenses relative to the same professional fees for both types of providers, based on using the HOPD volume of utilization and mix of services.

At the more detailed service level, it was observed that:

- *Laboratory* - were reimbursed 30% to 150% higher for HOPD facility fees than professional fees based on the site of service.
- *Radiology* - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- *Chemotherapy and other infusion/injection* - were 90% to 270% higher for HOPD facility fees than professional fees.

Medicare Advantage

For the top codes reviewed for Medicare Advantage, HOPD facility fees were about 14% higher than independent providers and 36% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between $1.6M and $3.4M in additional health care expenses relative to independent affiliated or professional fees, respectively. This is based on using the HOPD volume of utilization and mix of services for both comparisons.

The difference between affiliated and independent providers is driven by independent providers having higher average reimbursement than affiliated providers under Medicare Advantage. Medicare Advantage allows for payers to contract at varying rates among their provider network, which would explain the difference between results compared to Medicare FFS.

At the more detailed service level, it was observed that:

- *Laboratory* - had higher HOPD facility fees than affiliated provider professional fees, but lower HOPD facility fees when compared to independent professional fees.
    - The HOPD facility fees for Medicare Advantage were comparable to Medicare FFS, so the variation is driven by varying contracting rates for professional fees.
- *Radiology* - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees.
- *Chemotherapy and other infusion/injection* - were 10% to 115% higher for HOPD facility fees than professional fees.

Commercial

For the top codes reviewed for Commercial, HOPD facility fees were 90% higher than independent providers and 95% higher than affiliated providers. The resulting impact indicates that the HOPD facility fees contributed between $38.2M and $39.2M in additional health care expenses relative to independent affiliated or professional fees, respectively. This is based on using the HOPD volume of utilization and mix of services for both comparisons.

The difference between affiliated and independent providers is driven by independent providers having slightly higher average reimbursement than affiliated providers for the top codes, although the results were mixed at the code level. For evaluation and management codes, which are the primary professional fees billed by those providers, we observed that affiliated providers had higher average contracting.

At the more detailed service level, it was observed that:

- *Laboratory* - were on average 200% higher for HOPD facility fees than professional fees for both groups, however; the variation at the code level was much higher for affiliated providers ranging from 20% to 880% higher for HOPD facility fees.
- *Radiology* - had mixed comparisons with some services having higher HOPD facility fees and some having higher professional fees. The highest utilized radiology services had lower HOPD facility fees than professional fees.
- *Chemotherapy and other infusion/injection* - were 115% to 225% higher for HOPD facility fees than professional fees.

- *Physical Therapy* - showed that HOPD facility fees were 150% to 250% higher than professional fees for both comparison groups.
- *Evaluation and management (E&M)* - observed to have lower HOPD facility fees compared to professional fees.
    - The E&M codes on the HOPD claim portion of the visit are in addition to and separate from any E&M codes billed as part of the professional fees portion of an outpatient visit.
        - This is comparable to the use of G0463 in Medicare, which allows for HOPD to bill for hospital resources in addition to the services provided. As a note, Medicare allowed the use of E&M codes for billing for hospital resources prior to the implementation of G0463 in 2014.
    - While the average allowed amount is lower for HOPD facility fees for E&M codes, it should be noted that the E&M codes may be being billed twice to the member: once for the physicians professional fees, and again on a second bill for the HOPD facility fees for their hospital resources.

Changes over Time

Overall, Medicare Advantage had the most volatility in average reimbursement over time for both HOPD and professional sites of service for the top codes, while Medicare FFS and Commercial were slightly more stable. The result is that it is challenging for consumers to understand potential future health care expenditures because of the changes in contracting between provider and payer from year to year.

The results from the HOPD by year comparison indicate the following by payer type based on the top codes reviewed:

- *Medicare FFS*
    - The average HOPD facility fees increased by about 3.4% on average annually.
    - The average professional fees had a slight reduction of -0.5% to -1.1% on average annually for affiliated and independent providers, respectively.
        - These are driven by reductions to laboratory services implemented in 2018 and 2019 by the Centers for Medicaid and Medicare (CMS) that oversee the Medicare program and billing policies.
- *Medicare Advantage*
    - The average HOPD facility fees decreased by about -6.0% on average annually, driven by reductions in 2018 and 2019.
    - The average professional fees had a slight reduction of -2.2% to -2.9% on average annually for affiliated and independent providers, respectively.

- *Commercial*
    - The average HOPD facility fees increased by about 2.5% on average annually.
    - The average professional fees had a similar increase of 2.8% on average annually for both affiliated and independent providers, respectively.
        - This is driven by a larger increase in 2021 for professional providers, potentially in response to the COVID-19 pandemic.

Appendices

Appendix I.A.i Medicare FFS HOPD Comparison to Professional (Affiliated)

Code	Category	Year	HOPD Units (avg annual)	Professional (Affiliated)	HOPD	HOPD/ Affiliated % Diff	Dollar Difference
Combined		**Average**	**551,748**	**$21.22**	**$41.14**	**93.9%**	**$10,988,667**
20610	Injection into large joint	Average	2,905	$67.97	$165.51	143.5%	$283,311
36415	Routine Venipuncture	Average	155,073	$2.96	$5.02	69.7%	$319,816
67028	Injection Of Drug Into Eye	Average	2,417	$117.38	$331.82	182.7%	$518,302
70553	Radiology	Average	838	$353.50	$785.40	122.2%	$361,796
71250	Radiology	Average	2,383	$150.29	$161.89	7.7%	$27,660
77300	Radiology	Average	2,166	$68.44	$125.29	83.1%	$123,121
77301	Radiology	Average	363	$1,957.43	$1,253.96	-35.9%	-$255,126
77334	Radiology	Average	2,169	$130.89	$327.74	150.4%	$427,040
78815	Radiology	Average	475	$1,644.41	$1,473.06	-10.4%	-$81,420
80048	Laboratory	Average	28,887	$9.10	$18.77	106.3%	$279,365
80053	Laboratory	Average	88,254	$10.94	$27.06	147.4%	$1,422,715
80061	Laboratory	Average	49,337	$14.00	$22.61	61.4%	$424,358
82306	Laboratory	Average	12,365	$32.23	$41.58	29.0%	$115,562
83036	Laboratory	Average	24,352	$10.40	$20.04	92.7%	$234,715
84443	Laboratory	Average	42,367	$18.12	$27.60	52.3%	$401,567
85025	Laboratory	Average	75,765	$8.49	$15.43	81.7%	$525,862
93306	Ultrasound	Average	4,113	$209.84	$507.94	142.1%	$1,225,920
94060	Evaluation Of Wheezing	Average	2,117	$54.06	$234.63	334.1%	$382,189
96365	Infusion and injection	Average	12,589	$73.37	$189.25	158.0%	$1,458,864
96367	Infusion and injection	Average	3,847	$31.15	$59.10	89.7%	$107,503
96372	Infusion and injection	Average	6,688	$17.24	$48.86	183.4%	$211,477
96374	Infusion and injection	Average	2,661	$44.44	$164.62	270.4%	$319,796
96375	Infusion and injection	Average	12,953	$17.58	$38.38	118.3%	$269,325
96413	Chemotherapy Infusion	Average	11,123	$139.97	$295.02	110.8%	$1,724,627
96415	Chemotherapy Infusion	Average	5,546	$30.55	$59.46	94.6%	$160,322

Appendix I.A.ii Medicare FFS HOPD Comparison to Professional (Independent)

Code	Category	Year	HOPD Units (avg annual)	Professional (Independent)	HOPD	HOPD/ Independent % Diff	Dollar Difference
Combined		**Average**	**551,748**	**$21.11**	**$41.14**	**94.8%**	**$11,046,858**
20610	Injection into large joint	Average	2,905	$64.91	$165.51	155.0%	$292,199
36415	Routine Venipuncture	Average	155,073	$2.96	$5.02	69.8%	$320,063
67028	Injection Of Drug Into Eye	Average	2,417	$115.83	$331.82	186.5%	$522,055
70553	Radiology	Average	838	$347.69	$785.40	125.9%	$366,659
71250	Radiology	Average	2,383	$148.98	$161.89	8.7%	$30,761
77300	Radiology	Average	2,166	$67.43	$125.29	85.8%	$125,321
77301	Radiology	Average	363	$1,918.52	$1,253.96	-34.6%	-$241,014
77334	Radiology	Average	2,169	$128.16	$327.74	155.7%	$432,968
78815	Radiology	Average	475	$1,579.65	$1,473.06	-6.7%	-$50,646
80048	Laboratory	Average	28,887	$9.33	$18.77	101.1%	$272,547
80053	Laboratory	Average	88,254	$11.26	$27.06	140.4%	$1,394,739
80061	Laboratory	Average	49,337	$14.35	$22.61	57.5%	$407,220
82306	Laboratory	Average	12,365	$32.52	$41.58	27.9%	$111,996
83036	Laboratory	Average	24,352	$10.69	$20.04	87.4%	$227,568
84443	Laboratory	Average	42,367	$18.57	$27.60	48.6%	$382,308
85025	Laboratory	Average	75,765	$8.43	$15.43	83.0%	$530,366
93306	Ultrasound	Average	4,113	$206.07	$507.94	146.5%	$1,241,429
94060	Evaluation Of Wheezing	Average	2,117	$53.99	$234.63	334.6%	$382,328
96365	Infusion and injection	Average	12,589	$70.28	$189.25	169.3%	$1,497,673
96367	Infusion and injection	Average	3,847	$31.27	$59.10	89.0%	$107,064
96372	Infusion and injection	Average	6,688	$16.60	$48.86	194.4%	$215,778
96374	Infusion and injection	Average	2,661	$43.38	$164.62	279.5%	$322,626
96375	Infusion and injection	Average	12,953	$17.69	$38.38	116.9%	$267,910
96413	Chemotherapy Infusion	Average	11,123	$140.07	$295.02	110.6%	$1,723,560
96415	Chemotherapy Infusion	Average	5,546	$30.00	$59.46	98.2%	$163,382

Appendix I.B.i Medicare Advantage HOPD Comparison to Professional (Affiliated)

Code	Category	Year	HOPD Units (avg annual)	Professional (Affiliated)	HOPD	HOPD/ Affiliated % Diff	Dollar Difference
Combined		**Average**	**123,774**	**$76.92**	**$104.76**	**36.2%**	**$3,446,198**
20610	Injection into large joint	Average	1,052	$85.26	$249.67	192.8%	$172,878
36430	Blood Transfusion Service	Average	1,000	$72.70	$387.76	433.3%	$315,003
67028	Injection Of Drug Into Eye	Average	649	$194.20	$328.24	69.0%	$86,928
70553	Radiology	Average	586	$814.23	$443.94	-45.5%	-$217,057
71250	Radiology	Average	3,203	$295.53	$130.61	-55.8%	-$528,270
77300	Radiology	Average	2,001	$70.14	$124.65	77.7%	$109,072
77301	Radiology	Average	464	$2,049.08	$1,268.24	-38.1%	-$362,440
77334	Radiology	Average	2,188	$134.58	$293.91	118.4%	$348,620
78815	Radiology	Average	419	$2,489.20	$1,201.49	-51.7%	-$539,123
80048	Laboratory	Average	8,901	$7.51	$19.87	164.7%	$110,054
80053	Laboratory	Average	21,186	$9.94	$23.10	132.5%	$278,869
80061	Laboratory	Average	11,906	$12.13	$21.11	74.1%	$106,942
82306	Laboratory	Average	2,907	$25.12	$39.03	55.4%	$40,435
83036	Laboratory	Average	6,039	$7.56	$14.67	94.1%	$42,943
84443	Laboratory	Average	9,592	$15.19	$24.06	58.4%	$85,072
85025	Laboratory	Average	18,063	$6.43	$12.66	97.0%	$112,586
93306	Ultrasound	Average	8,579	$261.01	$531.08	103.5%	$2,317,069
94060	Evaluation Of Wheezing	Average	1,215	$65.18	$218.86	235.8%	$186,639
96365	Infusion and injection	Average	4,210	$117.41	$181.44	54.5%	$269,548
96367	Infusion and injection	Average	1,471	$31.20	$59.74	91.5%	$41,979
96372	Infusion and injection	Average	2,162	$21.45	$46.28	115.8%	$53,679
96374	Infusion and injection	Average	2,850	$88.18	$168.79	91.4%	$229,742
96375	Infusion and injection	Average	6,687	$31.89	$38.38	20.4%	$43,408
96413	Chemotherapy Infusion	Average	4,141	$262.49	$292.35	11.4%	$123,632
96415	Chemotherapy Infusion	Average	2,305	$52.62	$60.42	14.8%	$17,989

Appendix I.B.ii Medicare Advantage HOPD Comparison to Professional (Independent)

Code	Category	Year	HOPD Units (avg annual)	Professional (Independent)	HOPD	HOPD/ Independent % Diff	Dollar Difference
Combined		**Average**	**123,774**	**$91.78**	**$104.76**	**14.1%**	**$1,606,978**
20610	Injection into large joint	Average	1,052	$104.91	$249.67	138.0%	$152,219
36430	Blood Transfusion Service	Average	1,000	$70.06	$387.76	453.4%	$317,644
67028	Injection Of Drug Into Eye	Average	649	$173.99	$328.24	88.7%	$100,030
70553	Radiology	Average	586	$714.86	$443.94	-37.9%	-$158,805
71250	Radiology	Average	3,203	$382.54	$130.61	-65.9%	-$806,960
77300	Radiology	Average	2,001	$88.95	$124.65	40.1%	$71,443
77301	Radiology	Average	464	$2,679.37	$1,268.24	-52.7%	-$655,000
77334	Radiology	Average	2,188	$174.06	$293.91	68.9%	$262,249
78815	Radiology	Average	419	$2,590.79	$1,201.49	-53.6%	-$581,652
80048	Laboratory	Average	8,901	$15.11	$19.87	31.5%	$42,408
80053	Laboratory	Average	21,186	$14.10	$23.10	63.8%	$190,681
80061	Laboratory	Average	11,906	$21.82	$21.11	-3.3%	-$8,465
82306	Laboratory	Average	2,907	$47.56	$39.03	-17.9%	-$24,803
83036	Laboratory	Average	6,039	$16.34	$14.67	-10.2%	-$10,066
84443	Laboratory	Average	9,592	$27.42	$24.06	-12.3%	-$32,220
85025	Laboratory	Average	18,063	$12.47	$12.66	1.5%	$3,442
93306	Ultrasound	Average	8,579	$357.62	$531.08	48.5%	$1,488,172
94060	Evaluation Of Wheezing	Average	1,215	$91.63	$218.86	138.8%	$154,514
96365	Infusion and injection	Average	4,210	$97.87	$181.44	85.4%	$351,816
96367	Infusion and injection	Average	1,471	$36.93	$59.74	61.8%	$33,552
96372	Infusion and injection	Average	2,162	$25.57	$46.28	81.0%	$44,769
96374	Infusion and injection	Average	2,850	$85.14	$168.79	98.3%	$238,414
96375	Infusion and injection	Average	6,687	$25.06	$38.38	53.2%	$89,076
96413	Chemotherapy Infusion	Average	4,141	$217.97	$292.35	34.1%	$308,011
96415	Chemotherapy Infusion	Average	2,305	$44.59	$60.42	35.5%	$36,509

Appendix I.C.i Commercial HOPD Comparison to Professional (Affiliated)

Code	Category	Year	HOPD Units (avg annual)	Professional (Affiliated)	HOPD	HOPD/ Affiliated % Diff	Dollar Difference
Combined		**Average**	**594,589**	**$69.60**	**$135.60**	**94.8%**	**$39,242,048**
19083	Breast Biopsy	Average	1,089	$904.75	$1,868.15	106.5%	$1,048,656
36415	Routine Venipuncture	Average	110,724	$3.23	$24.96	672.5%	$2,405,900
45380	Colonoscopy And Biopsy	Average	2,990	$915.55	$1,649.46	80.2%	$2,194,256
73721	Radiology	Average	2,523	$604.28	$1,220.60	102.0%	$1,554,872
74177	Radiology	Average	3,459	$825.67	$1,122.45	35.9%	$1,026,410
77063	Radiology	Average	22,392	$97.23	$48.24	-50.4%	-$1,096,970
77067	Radiology	Average	29,395	$255.62	$232.24	-9.1%	-$687,275
78452	Radiology	Average	1,505	$563.73	$2,109.81	274.3%	$2,326,085
78815	Radiology	Average	744	$2,958.25	$3,313.93	12.0%	$264,450
80048	Laboratory	Average	18,752	$6.45	$63.77	888.6%	$1,074,823
80053	Laboratory	Average	58,843	$13.50	$80.73	498.1%	$3,956,334
84443	Laboratory	Average	29,446	$12.25	$64.35	425.2%	$1,533,983
85025	Laboratory	Average	53,972	$6.82	$40.24	489.9%	$1,803,505
88305	Laboratory	Average	18,309	$144.07	$171.21	18.8%	$496,791
93005	Electrocardiogram Tracing	Average	12,789	$13.77	$188.06	1265.7%	$2,228,907
93306	Ultrasound	Average	8,766	$346.09	$1,151.50	232.7%	$7,060,062
96365	Infusion and injection	Average	6,545	$138.20	$319.14	130.9%	$1,184,236
96375	Infusion and injection	Average	12,248	$34.69	$105.90	205.3%	$872,242
96413	Chemotherapy Infusion	Average	9,550	$278.23	$599.78	115.6%	$3,070,878
97110	Physical Therapy	Average	72,342	$24.03	$81.86	240.6%	$4,183,106
97140	Physical Therapy	Average	43,443	$23.45	$81.52	247.6%	$2,522,836
97530	Physical Therapy	Average	24,644	$28.36	$77.33	172.7%	$1,206,991
99212	Evaluation & Management	Average	14,005	$66.83	$91.73	37.3%	$348,783
99213	Evaluation & Management	Average	25,272	$105.25	$77.95	-25.9%	-$689,915
99214	Evaluation & Management	Average	10,846	$152.73	$93.00	-39.1%	-$647,897

Appendix I.C.ii Commercial HOPD Comparison to Professional (Independent)

Code	Category	Year	HOPD Units (avg annual)	Professional (Independent)	HOPD	HOPD/ Independent % Diff	Dollar Difference
Combined		**Average**	**594,589**	**$71.41**	**$135.60**	**89.9%**	**$38,166,482**
19083	Breast Biopsy	Average	1,089	$1,106.65	$1,868.15	68.8%	$828,893
36415	Routine Venipuncture	Average	110,724	$4.18	$24.96	497.6%	$2,301,164
45380	Colonoscopy And Biopsy	Average	2,990	$833.06	$1,649.46	98.0%	$2,440,888
73721	Radiology	Average	2,523	$644.15	$1,220.60	89.5%	$1,454,309
74177	Radiology	Average	3,459	$938.21	$1,122.45	19.6%	$637,203
77063	Radiology	Average	22,392	$91.48	$48.24	-47.3%	-$968,155
77067	Radiology	Average	29,395	$252.66	$232.24	-8.1%	-$600,152
78452	Radiology	Average	1,505	$862.89	$2,109.81	144.5%	$1,875,999
78815	Radiology	Average	744	$2,890.43	$3,313.93	14.7%	$314,871
80048	Laboratory	Average	18,752	$14.90	$63.77	327.9%	$916,355
80053	Laboratory	Average	58,843	$12.15	$80.73	564.7%	$4,035,974
84443	Laboratory	Average	29,446	$25.70	$64.35	150.4%	$1,138,004
85025	Laboratory	Average	53,972	$11.63	$40.24	246.1%	$1,544,258
88305	Laboratory	Average	18,309	$110.83	$171.21	54.5%	$1,105,501
93005	Electrocardiogram Tracing	Average	12,789	$13.62	$188.06	1280.3%	$2,230,774
93306	Ultrasound	Average	8,766	$396.43	$1,151.50	190.5%	$6,618,814
96365	Infusion and injection	Average	6,545	$123.64	$319.14	158.1%	$1,279,470
96375	Infusion and injection	Average	12,248	$32.78	$105.90	223.1%	$895,609
96413	Chemotherapy Infusion	Average	9,550	$243.03	$599.78	146.8%	$3,407,101
97110	Physical Therapy	Average	72,342	$31.80	$81.86	157.4%	$3,621,163
97140	Physical Therapy	Average	43,443	$25.35	$81.52	221.5%	$2,440,252
97530	Physical Therapy	Average	24,644	$30.72	$77.33	151.7%	$1,148,684
99212	Evaluation & Management	Average	14,005	$58.66	$91.73	56.4%	$463,109
99213	Evaluation & Management	Average	25,272	$96.28	$77.95	-19.0%	-$463,215
99214	Evaluation & Management	Average	10,846	$139.13	$93.00	-33.2%	-$500,391

Appendices II.A.i to II.C.ii
HOPD Comparison to Professional by year

Please see attached Excel file CO HB1215 - Comparison by Year 2024.07.08_Top Codes.xlsx.

Appendix III.A Medicare FFS Code Definitions

Code	Long Description
20610	Aspiration And/Or Injection Of Large Joint Or Joint Capsule
36415	Insertion Of Needle Into Vein For Collection Of Blood Sample
67028	Injection Of Drug Into Eye
70553	Mri Scan Of Brain Before And After Contrast
71250	Ct Scan Chest
77300	Calculation Of Radiation Therapy Dose
77301	Management Of Modulation Radiotherapy Planning
77334	Radiation Treatment Devices, Design And Construction, Complex
78815	Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh
80048	Blood Test, Basic Group Of Blood Chemicals
80053	Blood Test, Comprehensive Group Of Blood Chemicals
80061	Blood Test, Lipids (Cholesterol And Triglycerides)
82306	Vitamin D-3 Level
83036	Hemoglobin A1C Level
84443	Blood Test, Thyroid Stimulating Hormone (Tsh)
85025	Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test
93306	Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function
94060	Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration
96365	Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour
96367	Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour
96372	Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention
96374	Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention
96375	Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention
96413	Infusion Of Chemotherapy Into A Vein Up To 1 Hour
96415	Infusion Of Chemotherapy Into A Vein

Appendix III.B Medicare Advantage Code Definitions

Code	Description
20610	Aspiration And/Or Injection Of Large Joint Or Joint Capsule
36430	Transfusion Of Blood Or Blood Products
67028	Injection Of Drug Into Eye
70553	Mri Scan Of Brain Before And After Contrast
71250	Ct Scan Chest
77300	Calculation Of Radiation Therapy Dose
77301	Management Of Modulation Radiotherapy Planning
77334	Radiation Treatment Devices, Design And Construction, Complex
78815	Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh
80048	Blood Test, Basic Group Of Blood Chemicals
80053	Blood Test, Comprehensive Group Of Blood Chemicals
80061	Blood Test, Lipids (Cholesterol And Triglycerides)
82306	Vitamin D-3 Level
83036	Hemoglobin A1C Level
84443	Blood Test, Thyroid Stimulating Hormone (Tsh)
85025	Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test
93306	Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function
94060	Measurement And Graphic Recording Of The Amount And Speed Of Breathed Air, Before And Following Medication Administration
96365	Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour
96367	Infusion Into A Vein For Therapy Prevention Or Diagnosis Additional Sequential Infusion Up To 1 Hour
96372	Injection Beneath The Skin Or Into Muscle For Therapy, Diagnosis, Or Prevention
96374	Injection Of Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention
96375	Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention
96413	Infusion Of Chemotherapy Into A Vein Up To 1 Hour
96415	Infusion Of Chemotherapy Into A Vein

Appendix III.C Commercial Code Definitions

Code	Description
19083	Biopsy Of Breast Accessed Through The Skin With Ultrasound Guidance
36415	Insertion Of Needle Into Vein For Collection Of Blood Sample
45380	Biopsy Of Large Bowel Using An Endoscope
73721	Mri Scan Of Leg Joint
74177	Ct Scan Of Abdomen And Pelvis With Contrast
77063	Screening Digital Tomography Of Both Breasts
77067	Mammography Of Both Breasts
78452	Nuclear Medicine Study Of Vessels Of Heart Using Drugs Or Exercise Multiple Studies
78815	Nuclear Medicine Study With Ct Imaging Skull Base To Mid-Thigh
80048	Blood Test, Basic Group Of Blood Chemicals
80053	Blood Test, Comprehensive Group Of Blood Chemicals
84443	Blood Test, Thyroid Stimulating Hormone (Tsh)
85025	Complete Blood Cell Count (Red Cells, White Blood Cell, Platelets), Automated Test
88305	Pathology Examination Of Tissue Using A Microscope, Intermediate Complexity
93005	Routine Electrocardiogram (Ekg) With Tracing Using At Least 12 Leads
93306	Ultrasound Examination Of Heart Including Color-Depicted Blood Flow Rate, Direction, And Valve Function
96365	Infusion Into A Vein For Therapy, Prevention, Or Diagnosis Up To 1 Hour
96375	Injection Of Different Drug Or Substance Into A Vein For Therapy, Diagnosis, Or Prevention
96413	Infusion Of Chemotherapy Into A Vein Up To 1 Hour
97110	Therapeutic Exercise To Develop Strength, Endurance, Range Of Motion, And Flexibility, Each 15 Minutes
97140	Manual (Physical) Therapy Techniques To 1 Or More Regions, Each 15 Minutes
97530	Therapeutic Activities To Improve Function, With One-On-One Contact Between Patient And Provider, Each 15 Minutes
99212	Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes
99213	Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes
99214	Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes