CBIZ OPTUMAS
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April 2, 2024

Subject: Colorado HB1215 – Medicare Facility Fee Identification Methodology Report

Medicare 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 Medicare claims portion of the APCD. This covers both Medicare Fee-for-service (FFS) and Medicare Advantage.

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 Sterring 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 Medicare 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.

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Optumas will note that we did not audit the APCD data and are relying on the accuracy of the data provided.

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 MMs		
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%

Billing Guidelines Research

Optumas then researched Medicare billing guidelines to determine how facility fees may be billed by providers in that program. The federal agency that oversees Medicare, the Centers for Medicare and Medicaid Services (CMS), provided billing guidelines[1,2] that instructed prospective payment system (PPS) hospitals to report facility resources for HOPD visits using the CPT code G0463 for an in-person visit or Q3014[3] for a telehealth visit. As a note, PPS hospitals represent a large majority of hospitals and hospital visits in the state. Depending on the visit type, one of these CPT codes are included on the claim billed to the member, along with the other services provided during the visit, to delineate and reimburse the hospital for their resources during the visit. The Medicare facility fee codes are also separate and distinct from the professional fee(s) billed by the physician during the visit[4]. Optumas was able to identify these CPT codes within the APCD for the Medicare HOPD data for the PPS hospitals.

CMS also provided instruction for non-PPS hospitals, which are primarily Critical Access Hospitals (CAH), that they may either use those two codes for billing facility fees, or to bill for facility fees using evaluation and management (E&M) codes[5]. Optumas reviewed the APCD for CAH HOPD visits and found that some facilities did use the G0463 for billing facility fees. Optumas also found that all facilities had E&M codes that were billed during visits, however; we are not at this time able to delineate which of those codes are specific to a facility fee, and which are intended to cover the professional fees billed by

[1] https://www.federalregister.gov/documents/2013/07/19/2013-16555/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical
[2] https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2845cp.pdf
[3] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1026CP.pdf
[4] https://www.federalregister.gov/documents/2000/04/07/00-8215/office-of-inspector-general-medicare-program-prospective-payment-system-for-hospital-outpatient
[5] https://www.bnncpa.com/resources/clarification-of-clinic-billing-for-critical-access-hospitals/

the physician. At this time, Optumas will incorporate the G0463 information consistent with the PPS hospitals.

Analytics

Optumas identified all claims that had a Medicare facility fee code of either G0463 or Q3014. 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 that initial summary of allowed amount, visits, and cost per visit. The cost per visit serves as an additional validation point, as the amount observed in the data aligns with the Medicare fee schedule for those codes during that time period.

Table 2.A – G0463 Summary

	G0463		
CY	**Allowed Amount**	**Claim Count**	**Allowed/Claim**
2017	$32,669,424	327,098	$99.88
2018	$35,816,162	338,983	$105.66
2019	$37,270,388	374,383	$99.55
2020	$29,022,433	312,531	$92.86
2021	$35,849,508	369,521	$97.02
2022	$39,030,459	415,747	$93.88
Total	**$209,658,374**	**2,138,263**	**$98.05**

Table 2.B – Q3014 Summary

	Q3014		
CY	**Allowed Amount**	**Claim Count**	**Allowed/Claim**
2017	$7,525	366	$20.56
2018	$3,388	231	$14.67
2019	$6,189	350	$17.68
2020	$1,594,506	63,270	$25.20
2021	$1,160,527	44,964	$25.81
2022	$1,066,321	44,429	$24.00
Total	**$3,838,456**	**153,610**	**$24.99**

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. For Medicare FFS, if this field was not populated, Optumas assumed it was in-network as Medicare FFS would only pay for claims that were with an approved Medicare provider. This field was then used to summarize the volume of visits and allowed amount G0463, and Q3014, by in-network (INN) or out-of-network (OON).

Results

There were between 312,000 and 415,000 HOPD visits each year for Medicare with a facility fee, totaling over 2.1M visits across the study period. Over 95% of Medicare related facility fee visits were for an in-network provider each year of the study period. See Exhibit I for table of detailed results by year and procedure code (G0463 and Q3014).

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

	Facility Fees: In-Network			Facility Fees: Out-of-Network			All Facility Fees		
CY	G0463	Q3014	Total	G0463	Q3014	Total	G0463	Q3014	Total
2017	318,723	344	319,067	8,375	22	8,397	327,098	366	327,464
2018	328,547	195	328,742	10,436	36	10,472	338,983	231	339,214
2019	357,457	281	357,738	16,926	69	16,995	374,383	350	374,733
2020	300,579	60,338	360,917	11,952	2,932	14,884	312,531	63,270	375,801
2021	362,688	44,193	406,881	6,833	771	7,604	369,521	44,964	414,485
2022	406,531	43,471	450,002	9,216	958	10,174	415,747	44,429	460,176
Total	**2,074,525**	**148,822**	**2,223,347**	**63,738**	**4,788**	**68,526**	**2,138,263**	**153,610**	**2,291,873**

	Facility Fees: In-Network			Facility Fees: Out-of-Network		
CY	G0463	Q3014	Total	G0463	Q3014	Total
2017	97.4%	94.0%	97.4%	2.6%	6.0%	2.6%
2018	96.9%	84.4%	96.9%	3.1%	15.6%	3.1%
2019	95.5%	80.3%	95.5%	4.5%	19.7%	4.5%
2020	96.2%	95.4%	96.0%	3.8%	4.6%	4.0%
2021	98.2%	98.3%	98.2%	1.8%	1.7%	1.8%
2022	97.8%	97.8%	97.8%	2.2%	2.2%	2.2%
Total	**97.0%**	**96.9%**	**97.0%**	**3.0%**	**3.1%**	**3.0%**

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 that had a facility fee. 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 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
- CPT Codes 92002 – 92499: Ophthalmology Services
- CPT Codes 97010 – 97799: Physical Medicine and Rehabilitation Evaluations

Table 3 below illustrates an example claim structure for a member that had a professional visit and a HOPD visit with a facility fee 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 that also included a facility fee. 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 (Medicare) 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 (Medicare) 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."[6]
    - CPT 72070: ""Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Hospital outpatient clinic visit for assessment and management of a patient G0463 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."[7]
    - CPT G0463: "Hospital outpatient clinic visit for assessment and management of a patient G0463"

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
ABC123	999999002	6/5/2017	G0463	22	$102.45	$5.00	$97.45

Results

Of the roughly 68,000 facility fees that were charged by out-of-network providers to Medicare from 2017 -2022, 94.3% had a professional fee component that was also charged by an out-of-network provider. Only 5.7% of facility fees that were charged by out-of-network providers had a professional fee component that was charged by an in-network provider. See Exhibit II for detailed table of results by year and in-network vs. out-of-network professional component.

[6] https://www.aapc.com/codes/cpt-codes/72100
[7] https://www.aapc.com/codes/cpt-codes/72070

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 Fee Component In-Network			Professional Fee Component Out-of-Network			Total Facility Fees Charged Out-of-Network		
CY	G0463	Q3014	Total	G0463	Q3014	Total	G0463	Q3014	Total
2017	233	5	238	8,142	17	8,159	8,375	22	8,397
2018	844	5	849	9,592	31	9,623	10,436	36	10,472
2019	859	10	869	16,067	59	16,126	16,926	69	16,995
2020	309	101	410	11,643	2,831	14,474	11,952	2,932	14,884
2021	475	60	535	6,358	711	7,069	6,833	771	7,604
2022	945	51	996	8,271	907	9,178	9,216	958	10,174
Total	**3,665**	**232**	**3,897**	**60,073**	**4,556**	**64,629**	**63,738**	**4,788**	**68,526**

	Percentage of Professional In-Network			Percentage of Professional Out-of-Network		
CY	G0463	Q3014	Total	G0463	Q3014	Total
2017	2.8%	22.7%	2.8%	97.2%	77.3%	97.2%
2018	8.1%	13.9%	8.1%	91.9%	86.1%	91.9%
2019	5.1%	14.5%	5.1%	94.9%	85.5%	94.9%
2020	2.6%	3.4%	2.8%	97.4%	96.6%	97.2%
2021	7.0%	7.8%	7.0%	93.0%	92.2%	93.0%
2022	10.3%	5.3%	9.8%	89.7%	94.7%	90.2%
Total	**5.8%**	**4.8%**	**5.7%**	**94.2%**	**95.2%**	**94.3%**

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 facility fee, 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 facility fee 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 instances of the two facility fee codes by year in the Medicare data for the study period.

Results

About 96% of allowed dollars for facility fees were paid, and about 4% were denied across 2017 – 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, and procedure code (G0463 and Q3014).

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

	G0463: Allowed Dollars			Q3014: Allowed Dollars			All Facility Fees: Allowed Dollars		
CY	**Denied**	**Not Denied**	**Total**	**Denied**	**Not Denied**	**Total**	**G0463**	**Q3014**	**Total**
2017	$0	$32,669,424	$32,669,424	$0	$7,525	$7,525	$0	$32,676,950	$32,676,950
2018	$0	$35,816,162	$35,816,162	$0	$3,388	$3,388	$0	$35,819,551	$35,819,551
2019	$9,963	$37,260,426	$37,270,388	$0	$6,189	$6,189	$9,963	$37,266,615	$37,276,577
2020	$1,989,743	$27,032,690	$29,022,433	$102,347	$1,492,159	$1,594,506	$2,092,090	$28,524,849	$30,616,939
2021	$2,999,031	$32,850,477	$35,849,508	$76,929	$1,083,598	$1,160,527	$3,075,960	$33,934,075	$37,010,035
2022	$2,834,385	$36,196,073	$39,030,459	$57,409	$1,008,912	$1,066,321	$2,891,794	$37,204,986	$40,096,780
Total	**$7,833,121**	**$201,825,253**	**$209,658,374**	**$236,685**	**$3,601,772**	**$3,838,456**	**$8,069,806**	**$205,427,024**	**$213,496,830**

	G0463: Percentage of Total			Q3014: Percentage of Total			All Facility Fees		
CY	**Denied**	**Not Denied**	**Total**	**Denied**	**Not Denied**	**Total**	**Denied**	**Not Denied**	**Total**
2017	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%
2018	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%
2019	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	100.0%	100.0%
2020	6.9%	93.1%	100.0%	6.4%	93.6%	100.0%	6.8%	93.2%	100.0%
2021	8.4%	91.6%	100.0%	6.6%	93.4%	100.0%	8.3%	91.7%	100.0%
2022	7.3%	92.7%	100.0%	5.4%	94.6%	100.0%	7.2%	92.8%	100.0%
Total	**3.7%**	**96.3%**	**100.0%**	**6.2%**	**93.8%**	**100.0%**	**3.8%**	**96.2%**	**100.0%**

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 HCPF, 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 facility fee was identified, **Optumas identified all other services for the visit based on the claim ID that the facility fee was billed**. 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 during that same visit to Medicare are displayed in Exhibit IV.a. Laboratory services, which account for over 60% of the top 25 most frequent procedure codes, are the most common services that are performed for which facility fees are charged. Appendix 1 contains the detailed descriptions of the top 25 most frequent procedure codes for which facility fees were charged to Medicare.

The top 25 most frequent revenue codes for which facility fees were charged during that same visit to Medicare are displayed in Exhibit IV.b. Revenue code '0510', which designates a general outpatient hospital visit, account for over 25% of the top 25 most frequent revenue codes for which facility fees are charged.

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

		Procedure Code: Counts						
CPT Code	**Description**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Total**
36415	Venipuncture	50,314	56,396	63,392	56,072	64,168	67,032	357,374
80053	Laboratory	33,878	37,995	44,030	44,845	49,026	50,106	259,880
85025	Laboratory	31,345	37,849	42,786	42,075	46,675	47,649	248,379
85610	Prothrombin Time	39,126	38,045	34,730	23,608	20,869	18,702	175,080
85027	Laboratory	10,705	11,879	14,060	14,761	16,260	16,806	84,471
80048	Chemical Screen	11,514	12,387	13,591	11,848	14,273	14,667	78,280
93005	Cardiography	7,774	9,764	12,290	11,879	15,222	17,208	74,137
84443	Laboratory	10,181	10,389	11,846	11,552	13,888	14,580	72,436
83036	Laboratory	9,249	9,616	10,803	10,337	12,737	14,217	66,959
83735	Laboratory	7,121	8,819	10,799	11,322	13,007	13,050	64,118
J1642	Injectables	6,461	8,773	10,092	12,255	11,908	12,565	62,054
84100	Laboratory	7,082	8,575	9,343	9,992	11,322	10,136	56,450
96413	Chemotherapy	5,685	7,658	8,412	10,825	10,373	9,254	52,207
80061	Laboratory	6,098	6,100	6,913	7,098	8,161	8,943	43,313
J3490	Injectables	97	726	1,291	8,878	11,160	20,247	42,399
G0008	Influenza Vaccine	7,593	6,445	6,752	5,732	5,733	6,505	38,760
94375	Diagnostic Testing	10,329	9,583	10,622	3,201	2,384	2,285	38,404
81003	Urinalysis	4,961	5,003	6,141	5,826	7,397	7,897	37,225
83880	Laboratory	5,180	5,221	6,328	5,415	6,594	6,720	35,458
81001	Urinalysis	5,623	5,808	6,396	5,942	6,119	5,526	35,414
83615	Laboratory	3,707	4,822	5,043	5,943	7,115	7,327	33,957
96375	Injections/Infusions	4,108	5,131	5,188	6,626	6,495	6,205	33,753
36591	Laboratory	4,382	5,815	6,345	5,247	4,670	5,047	31,506
86140	Laboratory	4,365	4,990	5,568	4,736	5,699	5,987	31,345
92134	Ophthalmologic Exam	3,221	3,552	4,261	4,753	6,992	7,671	30,450

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**
0510	Outpatient Hospital	317,181	327,250	336,805	302,606	363,864	395,349	2,043,055
0301	Chemistry	143,454	161,726	176,766	177,051	212,124	224,017	1,095,138
0300	Laboratory - General	89,442	99,203	109,695	106,746	121,866	126,772	653,724
0305	Hematology	83,973	91,045	87,953	84,655	91,201	90,736	529,563
0636	Pharmacy	52,076	63,788	64,337	90,904	80,185	79,075	430,365
0761	Treatment Room	32,591	35,809	36,149	32,933	35,976	41,139	214,597
0302	Immunology	27,786	30,653	32,217	31,657	35,401	36,024	193,738
0780	Telemedicine	119	126	155	58,680	43,349	39,195	141,624
0320	X-Ray	20,271	21,183	21,091	20,104	24,054	26,073	132,776
0306	Bacteriology	18,720	19,887	21,015	17,030	19,763	20,941	117,356
0250	Pharmacy - General	8,184	8,880	9,706	10,775	35,023	41,498	114,066
0333	Home Health	14,752	17,756	17,029	16,235	18,484	20,657	104,913
0460	Pulmonary Function	23,204	18,385	19,069	12,265	14,770	16,149	103,842
0920	Diagnostic Services	11,707	12,875	14,372	15,009	21,069	24,023	99,055
0260	IV Therapy	10,205	13,275	13,581	16,274	17,008	16,440	86,783
0335	Chemotherapy	9,078	12,208	12,473	16,700	16,531	15,450	82,440
0307	Urology	11,785	12,465	12,907	12,670	14,659	14,596	79,082
0730	Electrocardiogram	7,805	9,790	11,402	11,779	15,232	17,210	73,218
0771	Preventive Care	12,862	11,387	10,461	8,185	8,407	10,720	62,022
0258	IV Solutions	7,467	10,383	12,634	10,003	12,438	6,329	59,254
0272	Sterile Supplies	5,168	5,827	6,579	6,794	5,556	4,970	34,894
0331	Chemotherapy Admin	2,654	3,581	3,894	4,833	5,871	4,734	25,567
0259	Pharmacy - Other	3,003	4,160	5,142	7,939	2,955	6	23,205
0352	CT Scan	2,390	2,963	3,230	4,325	4,534	4,335	21,777
0324	Chest X-Ray	2,935	2,934	3,416	2,945	3,258	4,062	19,550

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 HCPF, 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 facility fee was identified, **Optumas identified all other services for the visit based on the claim ID that the facility fee was billed**. This data was then used to analyze the codes with the highest allowed amount.

Results

The 25 procedure codes for which facility fees were charged during that same visit, based on allowed amount by code, are displayed in Exhibit V.a. Chemotherapy drugs provided via injection or infusion account for over 70% of the allowed amount for the top 25 codes. This is likely driven by the high cost of these drugs on an induvial basis. Appendix 2 contains the detailed descriptions of the top 25 procedure codes for which facility fees were charged to Medicare, based on allowed amount by code.

The top 25 most frequent revenue codes for which facility fees were charged during that same visit to Medicare are displayed in Exhibit V.b. Revenue code '0636' is related to pharmacy, which aligns with the observation that the top procedure codes are chemotherapy drugs.

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**
J9271	Chemotherapy Drug	$4,308,740	$6,075,399	$7,487,887	$12,310,735	$14,731,154	$12,717,492	$57,631,406
J9299	Chemotherapy Drug	$2,856,877	$3,368,134	$5,674,160	$6,061,468	$6,009,030	$5,659,035	$29,628,706
96413	Chemotherapy Drug	$1,524,435	$2,177,667	$2,252,517	$3,116,125	$3,077,247	$2,969,303	$15,117,294
J9144	Chemotherapy Drug	$0	$0	$0	$0	$6,266,060	$6,820,703	$13,086,762
77386	Radiation Treatment	$1,373,134	$1,968,473	$2,054,967	$2,094,033	$2,058,964	$2,378,616	$11,928,186
J9305	Chemotherapy Drug	$1,120,041	$1,542,995	$2,071,034	$1,602,566	$1,841,770	$1,649,929	$9,828,335
J0897	Osteoporosis Drug	$1,441,714	$1,733,752	$1,707,983	$1,680,144	$1,727,241	$1,531,528	$9,822,363
J9145	Chemotherapy Drug	$708,731	$1,730,594	$2,113,597	$2,775,001	$1,812,354	$578,164	$9,718,442
J2505	Immunostimulant	$1,508,236	$1,837,112	$2,113,817	$2,002,391	$1,235,779	$0	$8,697,334
J9035	Chemotherapy Drug	$1,990,095	$1,998,118	$1,727,758	$1,339,801	$597,274	$104,468	$7,757,514
J9022	Chemotherapy Drug	$4,922	$649,648	$665,309	$1,461,041	$2,192,880	$1,781,748	$6,755,548
J9312	Chemotherapy Drug	$0	$0	$2,725,391	$2,252,276	$837,961	$618,960	$6,434,588
J9355	Chemotherapy Drug	$1,003,997	$1,895,741	$1,735,204	$1,288,395	$406,133	$75,364	$6,404,835
J9228	Chemotherapy Drug	$1,232,121	$739,639	$877,965	$1,087,258	$1,360,272	$970,070	$6,267,324
93306	Echocardiography	$603,053	$809,282	$928,972	$988,490	$1,076,646	$1,043,084	$5,449,528
77334	Radiation Treatment	$723,791	$865,790	$831,760	$784,547	$825,961	$872,149	$4,903,997
J9310	Chemotherapy Drug	$2,032,651	$2,847,095	$0	$0	$0	$0	$4,879,746
77373	Radiation Treatment	$534,038	$732,238	$871,558	$723,590	$861,290	$1,020,157	$4,742,871
J2353	Hormonal Therapy	$839,602	$609,239	$674,341	$964,960	$774,790	$680,460	$4,543,392
J1930	Hormonal Therapy	$544,032	$428,373	$437,088	$773,834	$1,183,519	$1,125,184	$4,492,030
77385	Radiation Treatment	$447,768	$560,960	$702,698	$725,305	$851,652	$968,604	$4,256,986
Q5107	Chemotherapy Drug	$0	$0	$0	$1,054,338	$1,593,337	$1,507,589	$4,155,263
J9119	Chemotherapy Drug	$0	$0	$354,362	$927,870	$1,323,735	$1,538,458	$4,144,425
11042	Debridement	$614,905	$582,808	$786,828	$666,700	$629,709	$733,021	$4,013,972
J1561	Chemotherapy Drug	$354,711	$541,266	$676,491	$828,879	$934,533	$622,515	$3,958,396

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**
0636	Pharmacy	$31,063,052	$39,072,146	$41,100,621	$57,605,429	$69,709,946	$59,175,436	$297,726,630
0510	Outpatient Hospital	$31,755,313	$34,660,407	$33,843,082	$28,331,604	$35,458,149	$38,160,878	$202,209,433
0333	Home Health	$5,521,799	$7,068,359	$7,086,914	$7,174,534	$7,815,353	$9,052,087	$43,719,047
0761	Treatment Room	$3,876,592	$4,627,134	$4,200,595	$4,143,062	$4,636,006	$5,429,961	$26,913,350
0335	Chemotherapy	$1,869,910	$2,672,369	$2,579,415	$3,746,839	$3,850,344	$3,778,305	$18,497,182
0360	Operating Room	$567,729	$1,055,917	$1,784,117	$2,954,884	$2,318,777	$1,363,473	$10,044,898
0260	IV Therapy	$939,114	$1,175,071	$1,164,095	$1,527,027	$1,694,893	$1,689,569	$8,189,769
0483	Echocardiology	$533,512	$657,558	$648,228	$770,477	$918,239	$961,806	$4,489,819
0450	ER	$387,946	$528,905	$592,170	$635,160	$787,191	$829,999	$3,761,370
0780	Telemedicine	$2,175	$1,194	$2,682	$1,487,135	$1,134,438	$1,030,288	$3,657,912
0352	CT Scan	$534,288	$618,147	$644,557	$662,917	$606,542	$545,152	$3,611,603
0480	Cardiology	$270,079	$527,962	$505,737	$546,091	$560,581	$433,865	$2,844,315
0361	Operating Room	$334,785	$464,784	$463,533	$409,404	$493,616	$445,148	$2,611,269
0404	Tomography	$237,776	$374,244	$404,772	$394,582	$457,939	$544,264	$2,413,577
0771	Preventive Care	$423,972	$348,967	$327,836	$265,303	$288,590	$370,732	$2,025,400
0481	Cardiology	$211,738	$322,733	$343,802	$337,114	$231,306	$460,542	$1,907,234
0460	Pulmonary Function	$242,941	$264,005	$274,344	$304,089	$402,224	$411,466	$1,899,069
0320	X-Ray	$470,550	$345,066	$226,638	$239,217	$268,354	$273,605	$1,823,431
0300	Laboratory - General	$194,042	$187,802	$117,593	$447,540	$336,800	$389,892	$1,673,668
0390	Blood Work	$150,537	$233,671	$236,125	$284,566	$294,388	$215,089	$1,414,377
0921	Diagnostic Services	$181,343	$231,612	$241,895	$260,442	$213,142	$203,736	$1,332,170
0413	Respiratory Services	$211,777	$157,574	$251,380	$427,997	$84,987	$197,593	$1,331,308
0611	MRT - Brain	$205,815	$274,950	$230,451	$194,964	$202,580	$207,600	$1,316,360
0301	Laboratory - Chemistry	$189,069	$136,462	$135,323	$405,376	$208,772	$223,913	$1,298,914
0324	Chest X-Ray	$169,804	$173,353	$194,914	$205,845	$227,707	$280,173	$1,251,795

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 HCPF, 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 facility fee was identified, **Optumas identified all other services for the visit based on the claim ID that the facility fee was billed**. 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 facility fees were charged during that same visit with the highest member cost sharing amounts. Chemotherapy drugs provided via injection or infusion and Radiation Treatment 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 Medicare 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 20% of the remainder and Medicare will pay 80%. This is referred to as co-insurance coverage. Appendix 3 contains the detailed descriptions of the top 25 procedure codes for which facility fees were charged with the highest member cost sharing amounts.

Exhibit VI.b displays the top 25 revenue codes for which facility fees were charged during that same visit with the highest member cost sharing. Revenue codes '0636' (Pharmacy) and '0510' (Outpatient Hospital) represent nearly 80% 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**
J9271	Chemotherapy Drug	$597,425	$914,105	$988,075	$1,500,227	$1,690,741	$1,071,421	$6,761,994
J9299	Chemotherapy Drug	$546,168	$479,130	$627,425	$645,087	$644,313	$573,530	$3,515,653
96413	Chemotherapy Drug	$303,654	$424,695	$396,170	$556,828	$538,169	$451,984	$2,671,500
77386	Radiation Treatment	$277,816	$398,067	$394,804	$397,818	$389,752	$444,560	$2,302,818
J9144	Chemotherapy Drug	$0	$0	$0	$0	$889,172	$992,823	$1,881,996
J0897	Osteoporosis Drug	$274,221	$324,736	$307,308	$299,313	$298,858	$258,785	$1,763,221
J9145	Chemotherapy Drug	$112,812	$294,232	$282,636	$448,237	$282,914	$87,403	$1,508,233
J2505	Immunostimulant	$282,562	$317,725	$300,287	$299,626	$211,043	$0	$1,411,243
J9035	Chemotherapy Drug	$366,055	$331,415	$269,964	$243,778	$110,288	$18,347	$1,339,847
J9305	Chemotherapy Drug	$208,280	$192,634	$228,677	$174,970	$211,672	$213,327	$1,229,559
J9312	Chemotherapy Drug	$0	$0	$406,886	$346,481	$143,248	$111,186	$1,007,801
93306	Echocardiography	$118,474	$155,519	$165,958	$174,762	$185,565	$182,897	$983,176
J9355	Chemotherapy Drug	$163,877	$305,685	$241,825	$184,078	$49,311	$6,585	$951,361
11042	Debridement	$131,044	$148,877	$193,706	$162,062	$143,338	$168,671	$947,698
77373	Radiation Treatment	$107,545	$148,438	$171,393	$136,697	$163,547	$183,382	$911,002
J9022	Chemotherapy Drug	$1,000	$91,183	$98,646	$187,829	$297,428	$212,391	$888,477
J9310	Chemotherapy Drug	$374,702	$502,152	$0	$0	$0	$0	$876,854
77334	Radiation Treatment	$141,336	$167,066	$149,674	$127,303	$136,599	$142,285	$864,263
77385	Radiation Treatment	$91,023	$113,779	$138,184	$130,973	$158,440	$181,573	$813,971
J2353	Hormonal Therapy	$149,946	$107,107	$116,769	$161,942	$132,537	$112,933	$781,235
J1930	Hormonal Therapy	$107,004	$75,867	$84,640	$141,295	$195,566	$156,893	$761,264
Q5107	Chemotherapy Drug	$0	$0	$0	$178,974	$258,139	$274,470	$711,583
77412	Radiation Treatment	$125,239	$136,873	$127,636	$95,174	$107,747	$93,022	$685,691
J1561	Chemotherapy Drug	$63,915	$102,347	$117,395	$151,719	$144,239	$98,707	$678,323
J9047	Chemotherapy Drug	$41,560	$109,207	$97,375	$99,842	$197,228	$119,146	$664,358

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**
0636	Pharmacy	$5,080,012	$6,241,972	$5,879,129	$8,051,798	$9,445,399	$7,273,843	$41,972,153
0510	Outpatient Hospital	$7,007,740	$6,510,325	$7,053,602	$5,550,386	$6,104,717	$7,038,583	$39,265,353
0333	Home Health	$1,129,799	$1,432,101	$1,415,104	$1,310,765	$1,446,895	$1,645,385	$8,380,049
0761	Treatment Room	$721,149	$890,247	$844,244	$844,497	$929,738	$1,104,889	$5,334,765
0335	Chemotherapy	$374,318	$520,375	$476,877	$675,197	$675,728	$586,050	$3,308,544
0260	IV Therapy	$197,193	$258,317	$226,817	$290,798	$338,531	$340,530	$1,652,184
0360	Operating Room	$123,376	$196,747	$288,138	$391,271	$318,020	$206,400	$1,523,953
0780	Telemedicine	$25	$108	$413	$299,504	$302,168	$256,116	$858,334
0483	Echocardiology	$107,878	$130,440	$125,251	$140,950	$165,322	$173,769	$843,610
0352	CT Scan	$124,166	$138,808	$144,208	$152,826	$140,535	$123,803	$824,346
0450	ER	$74,645	$94,940	$106,902	$98,758	$107,335	$96,565	$579,145
0361	Operating Room	$71,605	$97,085	$87,747	$82,652	$96,093	$88,659	$523,841
0480	Cardiology	$49,509	$83,474	$89,900	$90,415	$89,080	$69,205	$471,583
0274	Prosthetic Devices	$67,129	$80,458	$44,623	$44,187	$92,498	$121,442	$450,338
0404	Tomography	$48,437	$76,634	$75,939	$69,141	$79,055	$89,436	$438,643
0320	X-Ray	$116,187	$73,953	$41,508	$42,637	$45,492	$46,724	$366,501
0481	Cardiology	$43,773	$64,269	$65,251	$56,825	$35,193	$89,874	$355,185
0413	Respiratory Services	$41,130	$30,899	$72,132	$138,917	$15,109	$34,261	$332,447
0350	CT Scan	$44,464	$40,860	$43,628	$60,163	$68,207	$62,019	$319,341
0460	Pulmonary Function	$43,230	$43,475	$48,816	$45,619	$63,702	$65,402	$310,243
0611	MRT - Brain	$56,043	$70,704	$52,799	$44,289	$42,321	$40,886	$307,042
0324	Chest X-Ray	$42,554	$37,813	$42,122	$49,215	$47,629	$60,423	$279,756
0921	Diagnostic Services	$36,385	$47,581	$52,028	$52,231	$41,264	$40,847	$270,336
0390	Blood Work	$30,851	$46,244	$43,012	$54,331	$53,367	$35,654	$263,459
0391	Blood Work	$20,527	$36,748	$33,331	$42,981	$41,824	$28,434	$203,846

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 is a data limitation and 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
36415	Collection of venous blood by venipuncture.
80053	Comprehensive metabolic panel.
85025	Complete blood count with automated differential white blood cell count.
85610	Prothrombin Time.
85027	Blood count on the red and white blood cells and platelets and hemoglobin test.
80048	Basic metabolic panel.
93005	Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report.
84443	Blood test measuring thyroid stimulating hormone level.
83036	Glycated hemoglobin/Glycated protein.
83735	Blood test measuring magnesium level.
J1642	Injection, heparin sodium.
84100	Blood test to evaluate the level of phosphate in the patient specimen.
96413	Injection and intravenous infusion chemotherapy.
80061	Lipid panel test to measure the level of triglycerides in blood.
J3490	Meloxicam injection.
G0008	Administration of Influenza virus vaccine.
94375	Pulmonary diagnostic testing using respiratory flow volume loop study.
81003	Urinalysis to read and record the chemical analytes.
83880	Blood test to measure the amount of natriuretic peptide in the patient specimen.
81001	Urinalysis to detect substances or cellular material associated with different metabolic kidney disorders.
83615	Blood test to measure the lactate dehydrogenase in a serum sample.
96375	Infusion of medication via IV push for prevention, diagnostic, or therapeutic purposes.
36591	Collection of blood specimen from a completely implantable venous access device.
86140	Blood test to analyze specimen for presence of C reactive protein.
92134	Analysis of computerized imaging of the retina to evaluate for disease.

Appendix 2

CPT Code	Description
J9271	Injection, pembrolizumab - Chemotherapy Drugs.
J9299	Injection, nivolumab - Chemotherapy Drugs.
96413	Injection and intravenous infusion chemotherapy.
J9144	Injection, daratimumab and hyalyuronidase - Chemotherapy Drugs.
77386	Radiation therapy to deliver radiation doses to a malignant tumor.
J9305	Injection, pemetrexed - Chemotherapy Drugs.
J0897	Injection, denosumab.
J9145	Injection, daratumumab - Chemotherapy Drugs.
J2505	Injection, pegfilgrastim - Chemotherapy Drugs.
J9035	Injection, bevacizumab - Chemotherapy Drugs.
J9022	Injection, atezolizumab - Chemotherapy Drugs.
J9312	Injection, rituximab - Chemotherapy Drugs.
J9355	Injection, trastuzumab, excludes biosimilar - Chemotherapy Drugs.
J9228	Injection, ipilimumab - Chemotherapy Drugs.
93306	Transthoracic echocardiography, complete study.
77334	Design, development, and construction of special and customized radiation delivery devices.
J9310	Injection, rituximab - Chemotherapy Drugs.
77373	Technical component of stereotactic body radiation therapy.
J2353	Injection, octreotide, depot form for intramuscular injection.
J1930	Injection, lanreotide.
77385	Radiation therapy to deliver radiation doses to a malignant tumor, using computer designed mapping.
Q5107	Injection, bevacizumab-awwb, biosimilar - Chemotherapy Drugs.
J9119	Injection, cemiplimab-rwlc - Chemotherapy Drugs.
11042	Removal of dead tissue in skin to the subcutaneous layer.
J1561	Injection, immune globulin, non-lyophilized.

Appendix 3

CPT Code	Description
J9271	Injection, pembrolizumab - Chemotherapy Drugs.
J9299	Injection, nivolumab - Chemotherapy Drugs.
96413	Injection and intravenous infusion chemotherapy.
77386	Radiation therapy to deliver radiation doses to a malignant tumor.
J9144	Injection, daratimumab and hyalyuronidase - Chemotherapy Drugs.
J0897	Injection, denosumab.
J9145	Injection, daratumumab - Chemotherapy Drugs.
J2505	Injection, pegfilgrastim - Chemotherapy Drugs.
J9035	Injection, bevacizumab - Chemotherapy Drugs.
J9305	Injection, pemetrexed - Chemotherapy Drugs.
J9312	Injection, rituximab - Chemotherapy Drugs.
93306	Transthoracic echocardiography, complete study.
J9355	Injection, trastuzumab, excludes biosimilar - Chemotherapy Drugs.
11042	Removal of dead tissue in skin to the subcutaneous layer.
77373	Technical component of stereotactic body radiation therapy.
J9022	Injection, atezolizumab - Chemotherapy Drugs.
J9310	Injection, rituximab - Chemotherapy Drugs.
77334	Design, development, and construction of special and customized radiation delivery devices.
77385	Radiation therapy to deliver radiation doses to a malignant tumor, using computer designed mapping.
J2353	Injection, octreotide, depot form for intramuscular injection.
J1930	Injection, lanreotide.
Q5107	Injection, bevacizumab-awwb, biosimilar - Chemotherapy Drugs.
77412	Technical component of radiation treatment using greater than or equal to 1 MeV energy level.
J1561	Injection, immune globulin, non-lyophilized.
J9047	Injection, carfilzomib - Chemotherapy Drugs.