

New Hampshire Acute Care Hospital Comparison

A Commercial Insurance Relative Cost Comparison



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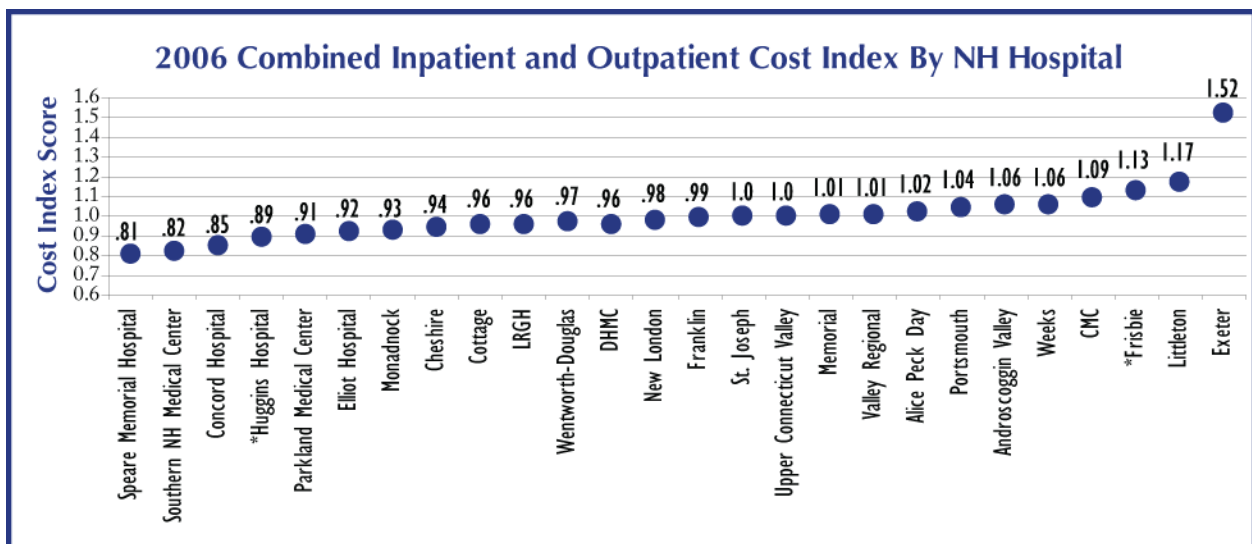
Summary

This analysis was performed by the New Hampshire Insurance Department (NHID) to compare short term general hospital costs incurred by commercial insurance carriers in New Hampshire (NH). The term “costs” is used to describe the amount due to the hospital for commercially insured patients, and includes the amounts paid by the health insurance carrier and the total patient liability (deductibles, coinsurance, and co-payments). Payments to hospitals are considered “costs” from an insurance perspective, but do not necessarily reflect internal hospital costs to deliver the services.

The 26 New Hampshire hospitals were analyzed separately on an inpatient and outpatient basis using data from calendar year 2006 (2005 was also used to analyze changes occurring between years). Payment for hospital services, referred to as “reimbursement,” is determined by the contract between the carrier and the hospital and is often referred to as the “allowed” rate. The allowed rate includes health plan and patient payment responsibilities (i.e., co-payments and coinsurance) to the hospital.

The cost measure in this analysis considers both the allowed rates and the utilization of services. The cost measure does not distinguish between carriers or health plan product type (e.g. HMO, POS, PPO, and Indemnity). Cost differences are likely to differ between carriers, but this analysis focuses on comparing hospitals in aggregate.

The results are shown below, listing hospitals with the lowest composite score to the highest. Relative costs are expressed in the form of an index value. A value of 1.00 represents a hospital with average relative costs when compared to other NH hospitals. A value of 1.10 means the hospital is ten percent more expensive than the average hospital for patients of similar resource intensity.



*These results are influenced by hospital billed physician services. Please see the Notes on Analysis section for a full explanation.

The results show that the majority of hospitals are ranked within twenty percent of the average. Based on the composite score, 14 hospitals fall below the average, two are average, and ten are above average.

Purpose of the Analysis

This analysis was performed for the purpose of informing NH Citizens Health Initiative (the Initiative) stakeholders about the relative costs between NH hospitals. Participants of the Initiative understand that hospital costs contribute substantially to the price of health insurance premiums, and a better understanding of costs drivers may assist with efforts to reduce the escalation of health insurance premiums.

The primary source of the data is the New Hampshire Comprehensive Health Care Information System (NHCHIS), and the purpose of this analysis is consistent with the statute that created the NHCHIS:

To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices...
(RSA 420-G:11-a)

Background

Both nationally and locally there is a strong interest in understanding health care cost drivers. The pressures to control health insurance premium increases and make the system more efficient continue to grow. Since the NHID released the HealthCost website that shows patient cost estimates for common health care services, the NHID has received requests to provide more generalized information on community and hospital costs.

This analysis satisfies one component of the health cost driver question in NH: how do NH hospitals compare to one another? It does not attempt to quantify hospital costs nor offer insight about how much hospital costs are growing. Likewise, the analysis does not attempt to summarize health care costs by community.

Efforts to generalize hospital costs are often compared to creating a market basket index. This is probably the closest analogy, but the term *market basket* refers to a fixed list of items used specifically to track the progress of inflation in an economy or specific market. We instead compare hospitals to one another, not over a period of time.

Data Sources

The data used to perform this analysis came from the NH Comprehensive Health Care Information System (NHCHIS) and the NH Hospital Discharge Data Set, calendar years 2005 and 2006. Both the claims data and the hospital discharge data include commercially insured patients and patients covered by self insured employers that contract with third party administrators for processing of claims and managing health insurance benefits.

Methodology

The analysis of inpatient and outpatient data was performed separately, using different methodologies. In both cases, cost amounts include amounts due to the hospital for services billed by the hospital. Unless physician services are billed by the hospital as a hospital service, they are not included.

Inpatient

The NHCHIS data provide the opportunity to analyze hospital charges and payments at a very detailed level, including by provider name, health insurance status, patient encounter, by claim, and diagnosis and procedure. The detailed data provide for analyses that can focus on very specific comparisons between elements. The disadvantage of the detail is the requirement to organize data and costs in such a way as to make a useful comparison.

When patients are admitted for several days in a hospital, they receive many services and often have several diagnoses and co-morbidities that contribute to the cost of their care. Additionally, multiple procedures are likely to take place during the hospital stay. In order to effectively compare hospital costs, an analysis needs to consider differences with patient populations and services between hospitals. The NH hospital discharge data include the diagnosis related group (DRG) and charges for commercially insured patients by hospital. DRGs are used by Medicare and other payers to reimburse hospitals for care provided to patients on a per admission basis. The payment is determined using a “weight” that determines the expected relative difference in resources necessary to treat a patient based on the DRG assignment. The DRG weights are based on estimates of the average cost structure among hospitals. Using the hospital discharge dataset, an overall average charge per case and an overall average DRG weight can be calculated. This allows us to compare the average charges to the average expected resources needed to treat a patient at each hospital. The average DRG weight per case is referred to as the case mix index.

The NHCHIS data does not include DRGs collected from the providers or carriers, nor the corresponding DRG weights. However, the database includes charges and the allowed payments. In performing this analysis, an average charge and the corresponding average allowed amount is calculated for each hospital.

The charges per case are derived from both databases during the same time frame: calendar year 2006. However, the NHCHIS does not include every patient discharged from NH hospitals. The NHCHIS contains patients who have obtained their insurance as a NH policyholder. This means if the employer is in NH, or the policy is for a NH individual, than most likely the patient is included in the database. For a NH resident that works in Massachusetts, Maine or Vermont, they are most likely not in the NHCHIS database, even when they obtain care from a NH hospital. In contrast, the hospital discharge data includes all patients, including those without insurance. This means the NHCHIS contains a sample of the patients treated by NH hospitals.

It is unlikely the charges per case derived from the NHCHIS and the discharge data will match. The goal of the analysis is to compare the relative costs between hospitals, and the charges per case do not need to match between datasets for this purpose, as long as an adjustment is made to compensate for the

differences. There is a strong relationship between DRG weights and the average charge per case and when measured in aggregate by hospital, higher average charges per case will correlate with a higher case mix index. Using the hospital discharge data, we establish the relationship between charges and case mix intensity (measured by DRG weights) and the relationship between charges and payment levels. It is these relationships that are used to compare the relative costs between hospitals.

The relative costs are measured using an adjusted allowed amount. The unadjusted allowed amount will differ between hospitals partly because the case mix intensity is different. Before adjusting for the differences in case mix intensity, we adjust the hospital specific average DRG weight according to the hospital specific difference in charges.

Below is an example of the calculations. All discharge data calculations use only commercially insured patients.

- “DD Avg Chg” is the discharge data average charge per case.
- “DD Avg CMI” is the discharge data average case mix index, or average DRG weight.
- “CHIS Avg Chg” is the average charge per case calculated from the NHCHIS database. This is a subset, or sample, of the commercially insured patients in the discharge database.
- “Chg % Diff” is the difference measured as a percent between the DD Avg Chg and the CHIS Avg Chg. For CMC, the calculation is: $(24,300 - 23,632)/24,300$.
- Since the CHIS Avg Chg is less than the DD Avg Chg, then the “Adj Avg CMI” is the DD Avg CMI reduced by 2.7% to reflect the less resource intensive patients in the calculation.
- The “CHIS Avg Pd” is the allowed amount and is based on the average amount paid per case when the carrier payments are added to the patient liabilities.
- The “Adj Avg Pd” is the CHIS Avg Pd adjusted by the adjusted case mix index. This column is adjusted so that the average amount paid to the hospital can be compared to other hospitals without regard for differences in case mix intensity. The adjusted value of \$7,711 represents a value that CMC would be paid per case if CMC’s case mix intensity was average, represented by a CMI value of 1.00.
- The “Cost Indx” is the Adj Avg Pd divided by the average amount paid per case at each hospital. Therefore, CMC’s Cost Indx is equal to 87% of the average in the state, when adjusted for the high case mix intensity of CMC’s patients.

Hospital Name	DD Avg Chg	DD Avg CMI	CHIS Avg Chg	Chg % Diff	Adj Avg CMI	CHIS Avg Pd	Adj Avg Pd	Cost Indx
CMC	\$24,300	1.418	\$23,632	2.7%	1.379	\$10,633	\$7,711	0.87
Concord	\$17,512	1.090	\$16,514	5.7%	1.028	\$9,124	\$8,875	1.00
Cottage	\$12,711	1.026	\$13,595	-7.0%	1.097	\$10,240	\$9,335	1.05
DHMC	\$27,608	1.711	\$22,727	17.7%	1.408	\$14,184	\$10,072	1.14

Outpatient

Patients with the same outpatient procedures were used as the basis of measurement for comparing patient costs between hospitals. The focus was on the cost of the patient experience when patients had a procedure in common. Reimbursement to hospitals and other providers depends on both the primary procedure and the frequency of ancillary services that are provided at the same time. From a payer point of view, the actual unit cost of any single item is less important than the cost of the visit. Therefore, the methodology chosen for this analysis is based on a bundled rate for the patient experience. The bundled rate includes only services billed by the hospital, as a hospital service.

Using this approach, the comparison is better than taking a random sample of patients at each hospital and comparing their costs. Patients receive different services based on their needs, and hospitals provide different services based on their physicians' expertise and market focus. By comparing only patients to one another when they have had the same procedure, the potential bias in the populations that may exist with a random sample is reduced.

A selection of the most common outpatient procedures at NH hospitals was made based on procedure volume as well as aggregate charges. A total of one hundred forty-one procedures were used in the analysis (Appendix C). In many cases these are procedures that every hospital does. The average patient cost (cost defined as carrier payment plus member liabilities) was calculated for each hospital, specific for each procedure that identified a patient for comparison. The percentage difference between the hospital specific average and the simple average among hospitals was calculated to come up with the procedure specific cost index. If a hospital's average was 25 percent less than the average for all hospitals, that hospital's procedure specific cost index is .75. This calculation is repeated for every procedure that data exists for at the hospital. The hospital's procedure specific cost index is then weighted by the frequency of patients who receive that service. If the hospital did not have any experience with the procedure, then there is no cost index value calculated for that procedure.

The following is an example of the calculations. The rates are inclusive of any hospital service billed at the same time as the procedure. Therefore, they typically reflect charges for multiple services.

- The "CH Avg Chg" is the Concord Hospital average charge.
- The "CH Avg Pd" is the Concord Hospital average amount allowed (based on carrier and patient liabilities).
- The "All Hosp Avg Chg" is the average charge among all hospitals.
- The "All Hosp Avg Pd" is the average allowed among all hospitals.
- The "Cost Index" is the comparison value for the procedure of interest. This is calculated by dividing CH Avg Pd by All Hosp Avg Pd.

Provider	CPT	Procedure Definition	CH Avg Chg	CH Avg Pd	All Hosp Avg Chg	All Hosp Avg Pd	Cost Index
Concord Hospital	36415	Collection of venous blood by venipuncture	\$474	\$243	\$980	\$653	0.371
Concord Hospital	83036	Hemoglobin; glycosylated (A1C)	\$421	\$225	\$646	\$420	0.536
Concord Hospital	58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	\$3,774	\$2,064	\$3,415	\$2,550	0.810

IP & OP Composite

The overall composite index is a calculated simple average between the inpatient and outpatient composite scores. This calculation is based on the expectation that half of the dollars paid to hospitals will be on an inpatient and outpatient basis.

Notes on Analysis

Any claims data analysis is subject to “sampling error.” This term refers to the fact that a sample of data may not have identical characteristics to the population as a whole. The number of cases in the NHCHIS is less than in the hospital discharge data. A form of sampling error may also exist when data is used for a particular year that is used to make assumptions about a future year. This analysis of hospital costs includes methods assigned to reduce sampling error, but cannot eliminate it entirely.

Using a sample of data to make determinations about a larger population is the basis for inferential statistics and most data driven decisions. What’s unique about the NHCHIS data is that the patients are not randomly selected. They are based on a designated policyholder location, e.g. New Hampshire. Because of the nature of the sample, systemic bias is expected, rather than random errors that on average are likely to cancel each other out. Fully understanding the underlying systemic bias of the sample is beyond the scope of this analysis, but adjusting for differences in the sample through the use of discharge data charges and service mix is an integral component to the analysis.

The costs include services billed by the hospital as hospital services. In some cases, hospitals submit bills for physician services that would otherwise be separately billed. In reviewing the billing patterns, it was determined that physician services billed on hospital claims were an immaterial factor in the cost comparison with two exceptions: Frisbie Memorial Hospital and Huggins Hospital. The analyses suggest that the cost index for Frisbie may be inflated approximately six percent and Huggins 1.4 percent due to the inclusion of physician services. Since these services were billed on hospital claims and the analysis compares hospitals, the data were not removed from the calculations. Adjusting for these differences would reduce Frisbie’s IP cost index from 1.24 to 1.17, OP would changed from 1.02 to .96, and overall would be

reduced from 1.13 to 1.06. Huggins would change from IP .80 to .79, OP would shift from .99 to .97, and the overall would change from .89 to .88. These adjustments assume the impact of the physician services are constant across all procedures (unlikely), so are somewhat imprecise.

The number of data observations is included in Appendix A.

Inpatient

The inpatient cost estimates are based on several assumptions. First, that costs are static. Costs are not. The calculations of charges per case and allowed payments per case will fluctuate over the year. Changes in rates over time are not addressed. However, the inpatient methodology is based on the hospital rate regulation system used in Maryland. Charges per case and the case mix index are the two measures used to establish and control hospital costs and the system has been successfully operating for years.

High cost outliers are not removed. One definition of an outlier is a case that does not represent the typical patient and may inflate observed costs. If an outlier exists, the case mix index may not accurately account for the patient population served and may inflate the resulting cost index. The NHID did not remove outliers for this analysis. Outliers are often very important in understanding how a hospital handles more complex cases and what happens to costs in an “unusual” situation. Also, many analysts identify cases as outliers because they are rare, but these cases are not really “outliers” at all. Most of the time “unusual” cases appear on a fairly routine basis.

There is an assumption about the relationship between DRG weights and charges. The assumption is that if the average charge per case when all patients are pooled increases, there will be a corresponding increase in the case mix intensity (as measured by average DRG weight). Although the DRG weights are based on hospital charges, there will be substantial variation between each patient’s specific charges and the DRG weight assigned. When multiple patient experiences are combined, the relationship between average charges and average case mix intensity improves dramatically. Using the hospital discharge data and performing a plotted linear regression analysis for each hospital, the NHID reviewed the relationship between DRG weights and the actual to predicted values of average hospital charges. Correlation statistics were reviewed, but more importantly, the distribution of observations generally showed an even clustering around the predicted values. An indicator of a problem with using the DRG weights and charges to adjust for the case mix intensity would be if the average hospital charge by DRG increased exponentially in relationship to the DRG weights; for example, if the average DRG charges quadrupled every time the DRG weights doubled. This was not the result.

Outpatient

The challenge with comparing hospital costs on an outpatient basis is the range and frequency of procedures that are performed. Medicare has used DRGs to reimburse hospitals for inpatient services for more than twenty years, but only recently adopted a similar system for outpatients (APCs). Therefore, reimbursement systems by commercial carriers and most “cost” analyses are based on specific procedure codes.

Although the procedure coding system often includes subsidiary services that are considered a part of the primary procedure, most of the time other procedures or services are billed under a separate code. Therefore, the procedure code alone for primary procedure is insufficient when assessing the “costs” associated with an outpatient visit.

This analysis focuses on the cost to the commercial insurance system, and the unit of measurement is the patient encounter. The methodology used adjusts for the differences in services provided and indirectly, case mix intensity. We expect that patients’ who’s primary reason for a hospital visit is an MRI are going to be more resource intensive than patients primarily visiting for a chest x-ray. Therefore, comparisons are made between patients who received an MRI and separately a chest x-ray.

By bundling services together to calculate costs associated with providing an outpatient service, the same patients may be included in different cost comparisons. If a hospital routinely provides an x-ray when an MRI is ordered, and both the MRI and x-ray are included as separate items in our analysis, then the patient will be used more than once. There are several advantages to this approach. Essentially this is a form of statistical analysis called “sampling with replacement.” By NOT removing a patient that is selected under the analysis of one of the codes, the samples for each procedure are independent, not affecting each other, and the covariance is zero. By choosing to remove a patient when one of the codes identified, we would impact the subsequent procedure analysis. Even by creating rules that would determine when patients are removed, the impact on the cost calculation would affect hospitals differently based on practice patterns.

Another challenge with outpatient cost analyses is determining which services will be purchased at what hospital location. An analogy is the purchase of groceries from one store versus another because the price of meat is less at one location, but the price of dairy is lower at another. In many cases relative hospital outpatient costs will be higher or lower at different hospitals depending on the service. Our goal with this analysis is to make a generalized comparison. By selecting the most common services, we create a more even comparison, but even within those common procedures practice patterns vary by site.

The solution is to analyze enough procedures that patterns of cost differences will become apparent. As these are common services, the volume of patients included is substantial, and the effect of unusually high or low costs at one hospital will be smoothed when pooled with many other cost comparisons at the same hospital. Using a smaller subset of data, such as just radiology, could lead to an incorrect conclusion. Another issue with selecting a single type of service for comparison is the carriers’ specific reimbursement method for select services. Radiology is a good example of a service type that carriers may contract for on a fixed fee schedule rather than a discount off charges. Often the fee schedules equate to a lower percent of charges than other services paid for by the carrier, and only reviewing radiology would understate the overall costs at a particular hospital.

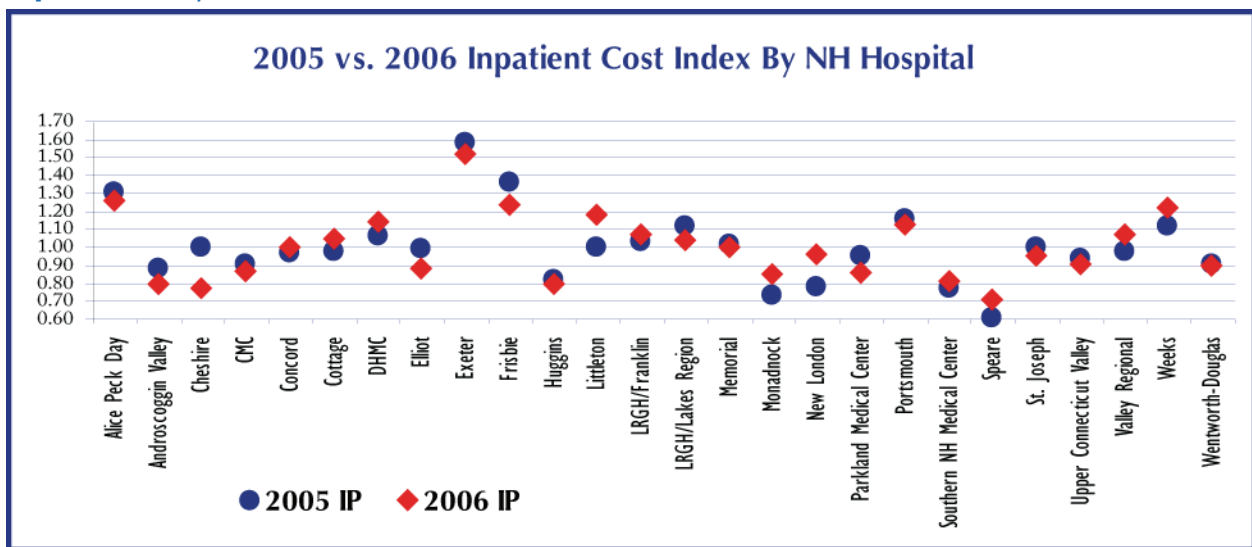
IP & OP Composite

Averaging the IP and OP cost indexes is necessary to generalize the relative costs between hospitals, but doing so reduces the value of the detailed information that is also available. This is true about any generalization, but as the difference between a hospital's relative cost on an inpatient and outpatient basis may be dramatic, and the details may be quite important.

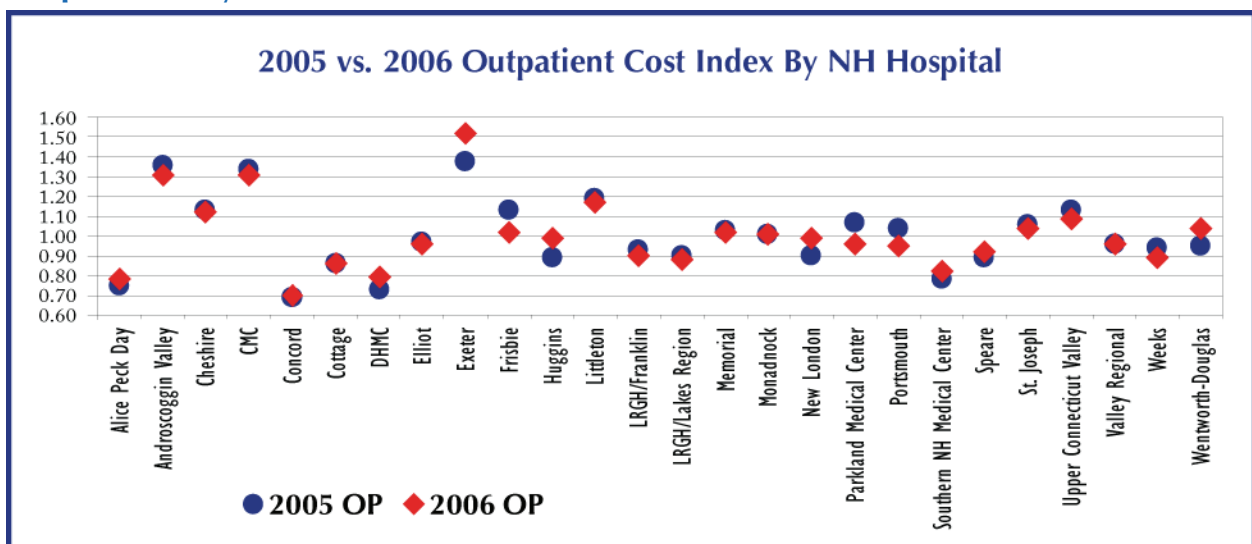
2005 vs. 2006

Health care costs are not static, and hospital charges and reimbursement change from year to year. The analysis uses the same methodology for calendar year 2005 and 2006. The results for inpatient and outpatient are reported below (full tables shown in appendix B):

Inpatient Only



Outpatient Only



Changes from year to year were not the focus of this analysis, but substantial increases of ten percent or more in average charge per case in both the hospital discharge data and the NHCHIS were observed. The increases in charges were often mirrored by a change in carrier reimbursement levels.

Conclusion

The NHID will continue to work with the Initiative and other groups to better understand health care costs and make information available to the public. This report will form one basis for performing additional work using the NHCHIS and other available data sources.

Contact Info

Questions should be directed to the NHID health care statistician: Tyler Brannen
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Appendix A

Data Observations

Inpatient Volume

Hospital Name	Commercially Insured Hospital Discharge Data Cases	NHCHIS Cases	Percent
Alice Peck Day Memorial Hospital	541	351	64.9%
Androscoggin Valley Hospital	317	183	57.7%
The Cheshire Medical Center	1,784	898	50.3%
CMC	3,483	2,019	58.0%
Concord Hospital	5,420	2,916	53.8%
Cottage Hospital	241	98	40.7%
Dartmouth Hitchcock Medical Center	7,159	3,126	43.7%
Elliot Hospital	6,897	3,649	52.9%
Exeter Hospital	2,408	1,143	47.5%
Frisbie Memorial Hospital	1,147	477	41.6%
Huggins Hospital	420	236	56.2%
Littleton Regional Hospital	617	248	40.2%
Franklin Regional Hospital	268	143	53.4%
Lakes Region General Hospital	1,646	976	59.3%
The Memorial Hospital	536	319	59.5%
Monadnock Community Hospital	818	444	54.3%
New London Hospital	136	116	85.3%
Parkland Medical Center	1,548	565	36.5%
Portsmouth Regional Hospital	3,582	1,700	47.5%
Southern NH Medical Center	4,956	2,437	49.2%
Speare Memorial Hospital	504	271	53.8%
St. Joseph Hospital	2,255	1,002	44.4%
Upper Connecticut Valley Hospital	85	21	24.7%
Valley Regional Hospital	422	242	57.3%
Weeks Medical Center Hospital	252	152	60.3%
Wentworth-Douglas Hospital	2,927	1,304	44.6%

Outpatient Volume

Hospital	Patient Observations
Alice Peck Day Memorial Hospital	14,555
Androscoggin Valley Hospital	13,304
The Cheshire Medical Center	19,193
CMC	23,342
Concord Hospital	90,601
Cottage Hospital	7,279
Dartmouth Hitchcock Medical Center	95,380
Elliot Hospital	98,478
Exeter Hospital	36,074
Frisbie Memorial Hospital	15,890
Huggins Hospital	12,912
Littleton Regional Hospital	11,622
Franklin Regional Hospital	11,806
Lakes Region General Hospital	48,984
The Memorial Hospital	12,642
Monadnock Community Hospital	17,320
New London Hospital	19,079
Parkland Medical Center	23,519
Portsmouth Regional Hospital	28,563
Southern NH Medical Center	63,693
Speare Memorial Hospital	16,970
St. Joseph Hospital	48,270
Upper Connecticut Valley Hospital	4,037
Valley Regional Hospital	13,144
Weeks Medical Center Hospital	10,895
Wentworth-Douglas Hospital	19,652

Appendix B

Cost Index Inpatient Only

Hospital	2005 IP	2006 IP
Alice Peck Day	1.31	1.26
Androscoggin Valley	0.88	0.80
Cheshire	1.00	0.77
CMC	0.91	0.87
Concord	0.97	1.00
Cottage	0.98	1.05
DHMC	1.06	1.14
Elliot	0.99	0.88
Exeter	1.58	1.52
Frisbie	1.36	1.24
Huggins	0.82	0.80
Littleton	1.00	1.18
LRGH/Franklin	1.03	1.07
LRGH/Lakes Region	1.12	1.04
Memorial	1.02	1.00
Monadnock	0.73	0.85
New London	0.78	0.96
Parkland Medical Center	0.95	0.86
Portsmouth	1.16	1.13
Southern NH Medical Center	0.77	0.81
Speare	0.61	0.71
St. Joseph	1.00	0.95
Upper Connecticut Valley	0.94	0.91
Valley Regional	0.98	1.07
Weeks	1.12	1.22
Wentworth-Douglas	0.91	0.90

Outpatient Only

Hospital	2005 OP	2006 OP
Alice Peck Day	0.75	0.78
Androscoggin Valley	1.36	1.31
Cheshire	1.13	1.12
CMC	1.34	1.31
Concord	0.69	0.70
Cottage	0.86	0.86
DHMC	0.73	0.79
Elliot	0.97	0.96
Exeter	1.38	1.52
Frisbie	1.13	1.02
Huggins	0.89	0.99
Littleton	1.19	1.17
LRGH/Franklin	0.93	0.90
LRGH/Lakes Region	0.90	0.88
Memorial	1.03	1.02
Monadnock	1.01	1.01
New London	0.90	0.99
Parkland Medical Center	1.07	0.96
Portsmouth	1.04	0.95
Southern NH Medical Center	0.78	0.82
Speare	0.89	0.92
St. Joseph	1.06	1.04
Upper Connecticut Valley	1.13	1.09
Valley Regional	0.96	0.96
Weeks	0.94	0.89
Wentworth-Douglas	0.95	1.04

Appendix C

Outpatient Procedures

CPT

Procedure

Code	Description
29881	ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG
36415	COLLJ VEN BLD VNPXNR
43235	UPR GI NDSC DX +-COLLJ SPEC BR/WA SPX
43239	UPR GI NDSC BX 1/MLT
45378	COLSC FLX PROX SPLENIC FLXR DX COLLJ SPEC&DCMPRN
45380	COLSC FLX PROX SPLENIC FLXR BX 1/MLT
45384	COLSC FLX PROX SPLENIC FLXR RMVL LES CAUT
45385	COLSC FLX PROX SPLENIC FLXR RMVL LES SNARE TQ
47562	LAPS SURG CHOLECSTC
58558	HYSTSC BX ENDOMETRIUM&/POLYPC +-D&C
59025	FTL NON-STRS TST
62311	NJX C+-DX/THER SBST EDRL/SARACH LMBR SAC
66984	XCAPSL CTRC RMVL INSJ LENS PROSTH 1 STG
70486	CT MAXLFCL AREA C-MATRL
70491	CT SOFT TISS NCK C+ MATRL
70544	MRA HEAD C-MATRL
70551	MRI BRN BRN STEM C-MATRL
70553	MRI BRN BRN STEM C-/C+
71020	RADEX CH 2 VIEWS FRNT&LAT
71250	CT THORAX C-MATRL
71260	CT THORAX C+ MATRL
71275	CTA CH C-/C+ POST-PXESSING
72050	RADEX SPI CRV MINIMUM 4 VIEWS
72100	RADEX SPI LUMBOSAC 2/3 VIEWS
72125	CT CRV SPI C-MATRL
72141	MRI SPI CANAL&CNTS CRV C-MATRL
72148	MRI SPI CANAL&CNTS LMBR C-MATRL
72156	MRI SPI CANAL&CNTS C-/C+ CRV
72158	MRI SPI CANAL&CNTS C-/C+ LMBR
72192	CT PELVIS C-MATRL
73030	RADEX SHO COMPL MINIMUM 2 VIEWS
73110	RADEX WRST COMPL MINIMUM 3 VIEWS
73130	RADEX HAND MINIMUM 3 VIEWS
73221	MRI ANY JT UXTR C-MATRL
73222	MRI ANY JT UXTR C+ MATRL
73630	RADEX FOOT COMPL MINIMUM 3 VIEWS
73721	MRI ANY JT LXTR C-MATRL
74150	CT ABD C-MATRL
74160	CT ABD C+ MATRL

74170 CT ABD C-/C+
76075 DXA B1 DNS STD 1+ SITS AXIAL SKEL
76083 CPTR AIDED DETCJ SCR MAMMOGRAPY
76092 SCR MAMMOGRAPY BI 2 VIEW FLM STD EA BRST
76700 US ABDL B-SCAN&/R-T IMG COMPL
76705 US ABDL B-SCAN&/R-T IMG LMTD
76805 US PG UTER F&MAT AFTER 1ST TRI 1/1ST GESTATION
77300 BASIC RADJ DOSIM CAL
77334 TX DEV DESIGN&CONSTJ CPLX
77336 CONTINUING MEDICAL PHYSICS CONSLTJ PR WK
77414 RADJ DLVR 3/> AREAS CUSTOM BLKING 11-19MEV
77418 NTSTY MODUL DLVR 1/MLT FLDS/ARCS PR TX SESSION
78306 B1&/JT IMG WHBDY
78465 MYOCDR PRFUJ IMG TOMOG SPECT MLT STD
78478 MYOCDR PRFUJ STD WALL MOTION QUAL/QUAN STD
78480 MYOCDR PRFUJ STD EJEC FXJ
80048 BASIC METAB PANEL
80051 ELECTROLYTE PANEL
80053 COMPRE METAB PANEL
80061 LIPID PANEL
80076 HEPATC FUNCJ PANEL
81001 URNLS DIP STICK/TABLET RGNT AUTO MIC
81003 URNLS DIP STICK/TABLET RGNT AUTO W/O MIC
82150 AMYLASE
82550 CREATINE KINASE TOT
82565 CREATININE BLD
82728 FERRITIN
82947 GLUC QUAN BLD
83036 HGB GLYCOSYLATED
83690 LIPASE
83721 LIPOPROTEIN DIR MEAS LDL CHOLESTEROL
84153 PRST8 SPEC AG TOT
84436 THYROXINE TOT
84439 THYROXINE FR
84443 THYR STIMULATING HORM
84450 TRANSFERASE ASPARTATE AMINO
84460 TRANSFERASE ALANINE AMINO
84484 TROPONIN QUAN
84520 UREA N QUAN
84702 GONAD CHORNC QUAN
85025 BLD# COMPL AUTO HHRWP&AUTO DIFFIAL
85027 BLD# COMPL AUTO HHRWP
85610 PROTHROMBIN TM

85651 SEDIMENTATION RATE RBC NON-AUTO
 85652 SEDIMENTATION RATE RBC AUTO
 85730 THROMBOPLASTIN TM PRTL PLSM/WHL BLD
 87070 CUL BACT XCPT URINE BLD/STL AERC ISOL
 87077 CUL BACT AERC ADDL METHS DEFINITIVE EA ISOL
 87081 CUL PRSMPTV PTHGNC ORGANISMS SCR
 87086 CUL BACT QUAN COLONY CNT URINE
 87186 SC ANTMCRB MICRODIL/AGAR EA MULTI-ANTMCRB PLATE
 88142 CYTP C/V FLU AUTO THIN MNL PHYS
 88175 CYTP C/V AUTO THIN LYR PREPJ SCR MNL RESCR PHYS
 88305 LVL IV-SURG PATH GROSS&MCRSCP XM
 90760 IV NFS HYDRATION 1ST >1 HR
 90761 IV NFS HYDRATION EA HR >8 HR
 90765 IV NFS THER PROPH/DX 1ST >1 HR
 90766 IV NFS THER PROPH/DX EA HR >8 HR
 90772 THER PROPH/DX NJX SUBQ/IM
 90774 THER PROPH/DX NJX IV PUSH 1ST SBST/DRUG
 90775 THER PROPH/DX NJX EA SEQL IV PUSH SBST/DRUG
 90937 HEMO REPEATED EVAL +-REVJ DIAL RX
 93005 ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R
 93017 CV STRS TST XERS&/OR RX CONT ECG TRCG ONLY
 93320 DOP ECHO COMPL
 93325 DOP ECHO COLOR FLO VEL MAPG
 93350 TEE R-T 2D +-M-MODE REST&STRS I&R
 93510 L HRT CATHJ RTRGR F/BRACH ART AX ART/FEM ART PRQ
 93880 DUP-SCAN XTRC ART COMPL BI STD
 93971 DUP-SCAN XTR VEINS UNI/LMTD STD
 95810 POLYSM SLEEP STAGING 4/> ADDL PARAM
 95811 POLYSM SLEEP STAGING 4/> ADDL PARAM W/CPAP TX
 96413 CHEMOTX ADMN IV NFS TQ UP 1 HR 1/1ST SBST/DRUG
 97001 PHYSICAL THER EVAL
 97010 APPL MODALITY 1+ AREAS HOT/COLD PACKS
 97033 APPL MODALITY 1+ AREAS IONTOPHORESIS EA 15 MIN
 97035 APPL MODALITY 1+ AREAS US EA 15 MIN
 97110 THER PX 1+ AREAS EA 15 MIN THER XERSS
 97113 THER PX 1+ AREAS EA 15 MIN AQUATIC THER W/XERSS
 97140 MNL THER TQS 1+ REGIONS EA 15 MIN
 99211 OFFICE O/P EST 5 MIN
 99213 OFFICE OUTPT EST 15 MIN
 99214 OFFICE OUTPT EST 25 MIN
 99218 1ST OBS CARE PR D LOW SEVERITY
 99219 1ST OBS CARE PR D MODERATE SEVERITY
 99281 EMER DEPT SELF LIMITED/MINOR
 99282 EMER DEPT LOW TO MODERATE SEVERITY

99283	EMER DEPT MODERATE SEVERITY
99284	EMER DEPT HI SEVERITY&URGENT EVAL
99285	EMER DEPT HIGH SEVERITY&THREAT FUNCJ
G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR
J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ES
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 100
J0886	INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON
J1745	INJECTION INFLIXIMAB, 10 MG
J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J3010	INJECTION, FENTANYL CITRATE, 0.1 MG
J3490	UNCLASSIFIED DRUGS
J9265	PACLITAXEL, 30 MG
J9355	TRASTUZUMAB, 10 MG
Q9949	LOW OSMOLAR CONTRAST MATERIAL, 300-349 MG/ML IOD