# COMMITTEE ON RATES AND STANDARDS
# OKLAHOMA HEALTH CARE AUTHORITY
## Anesthesia Reimbursement Methodology Change

**Issue**

Change the reimbursement methodology for anesthesiology CPT Codes 00100 through 01966 and 01968 through 01999 from the current maximum flat fee per CPT code to:

- the industry standard reimbursement methodology based on a formula involving base units and time units multiplied by a conversion factor of $31.50 (described in detail on pages 2 and 3), and
- increase the maximum reimbursement amount for CPT Code 01967 from the current $350 to $425.

Through the appropriation process OHCA has available $1,461,633.04 general revenue appropriation and is authorized to expend $4,226,597.38 in total to implement the change in reimbursement for anesthesiologists beginning January 1, 2008 (Appendix I and II).

The changes will apply to all providers – private and public. In addition, the changes will incorporate some of the American Society of Anesthesiologist provider modifier pricing guidelines as they relate to certain providers. The guidelines limit the amount of allowable reimbursements a supervising physician and a Certified Registered Nurse anesthesiologist can receive to no more than what a supervising physician would have received had they performed the procedure by themselves.

**Explanation of Conversion Factor**

During a work group meeting involving the OHCA and OSA representatives on December 7, 2006 a proposal was introduced to use two State of Oklahoma agencies' conversion factors as a benchmark for the OHCA program.

The Oklahoma state employee insurance company, Health Choice as administered by Fiserv, reimburses anesthesiologists using a conversion factor or $45. The Oklahoma Workers Compensation Court Schedule of Medical and Hospital Fees allows for a conversion factor of $39.00.

**Effective Date**

The new methodology will be effective January 1, 2008 when the state appropriation becomes available. Anesthesiologists will continue to be reimbursed under the physician fee schedule posted on the OHCA Website until the State Plan Amendment is approved by CMS. Anesthesiologists will be able to receive reimbursements under the new methodology beginning January 1, 2008 through an adjustment process provided that they submit their time and provider modifier information accurately to OHCA beginning January 1, 2008.

## Background and Report

The Oklahoma Society of Anesthesiologists (OSA) requested that the Oklahoma Health Care Authority (OHCA) staff examine two reimbursement issues for anesthesiologists. The first was a request to increase reimbursements and the second was to determine if OHCA can adopt the industry standard reimbursement model of reimbursing anesthesiologist using a "base + time" methodology.

During the spring of 2006 OHCA and OSA teamed up to survey approximately 300 anesthesiologists across the state. The purpose of the survey was to:

- Compare reimbursement rates between Medicaid and other third party payers,
- Determine the satisfaction level of anesthesiologists with the Medicaid program,
- Determine the most common methods used by anesthesiologists to bill for reimbursements, and
- Determine if the current Medicaid reimbursement method is sufficient to meet Medicaid's basic requirements of insuring that payments are "consistent with efficiency, economy, and quality of care" (42 U .S.C. § 1396a(a)(30)(A)).

Over 80% of the 138 survey respondents reported being totally dissatisfied with Medicaid reimbursement rates. A rate surpassed only by Medicare where 93% of the respondents reported being totally dissatisfied with those rates.

In addition, 36% reported that a Medicaid rate equal to the average managed care rate would be an adequate reimbursement for anesthesiologist services. Another 13% reported that a rate of $28 to $32 per unit of service would be adequate while 51% said that any Medicaid rate increase would be an improvement over the current rates.

OSA conducted a follow-up survey of five of the largest anesthesia groups in the state. The purpose of the 5-group survey was to determine what the reimbursement rates and methods were for 3rd party payers.

The final report found that Oklahoma's current methodology for reimbursing anesthesia services is not consistent with current industry standards or with the Medicare methodology. The report also found that the Oklahoma reimbursement rates are on average less than rates paid by 3rd party payers and in some cases less than the Medicare reimbursement rates.

### *What is the Standard Industry Reimbursement Practice for Anesthesia?*

The standard industry practice for anesthesia reimbursements is to reimburse using a "base plus time" methodology which is then applied to a fee known as a "conversion factor" (CF).

The "base" amount is determined by the American Society of Anesthesiologists (ASA) through its annual Relative Value Guide for Anesthesia Values. The guide provides a value (or relative value - RVU) for each procedure listed by the American Medical

Association's Current Procedural Terminology (CPT) code book. The CPT book lists 272 anesthesia codes specifically designated for anesthesia services. The anesthesia procedure codes range from CPT codes 00100 through 01999.

In addition, time is reported in "units" where each unit is often expressed in 15 minute increments and is normally reported as follows:

| Time (in minutes) | Unit(s) Billed |
|---|---|
| 1-15 | 1.0 |
| 16-30 | 2.0 |
| 31-45 | 3.0 |
| 46-60 | 4.0 |
| 61-75 | 5.0 |
| 76-90 | 6.0 |
| 91-105 | 7.0 |
| 106-120 | 8.0 |
| Etc. | |

The following formula provides an example of how an anesthesiologist is traditionally reimbursed:

> If the ASA RVU (base) for an anesthesia procedure is 4.00 and the surgery lasts 90 minutes (time = 6 units) with a maximum allowable CF of $16.47 the reimbursement is calculated as follows:
>
> $(4_b+6_u)$ x $16.47 = $164.70

***Oklahoma's Current Reimbursement Methodology for Anesthesia Services***

The current Oklahoma Medicaid program reimburses anesthesiologist services using a flat fee schedule. The anesthesia fee schedule is part of the physician fee schedule posted on the OHCA website.

## Converting OHCA to Industry Standard

The Oklahoma Society of Anesthesiologists surveyed five (5) of the largest anesthesia group practices in the state whose total membership is approximately 100 anesthesiologists. According to the Society, these groups represent 25% to 30% of all of the anesthesiologists practicing in the state.

The survey included data for the top fifteen procedures by volume in each group's practice. The data include:

- the base units allowed per procedure code using the ASA RVU Guide,
- the number or quantity of procedures performed by procedure code,
- the total number of minutes reported per procedure code, and
- the average reimbursement rate for three private carriers along with the maximum and minimum amounts.

The procedure code data submitted by the 5-group study amounted to 34 of the 272 anesthesia CPT codes. The 34 codes accounted for $10.1 million of the $11.8 million the Oklahoma Medicaid program expended on non-state physician anesthesiologists in FY-06.

The $10.1 million represents approximately 85% of total reimbursements for anesthesia CPT Codes 00100 – 01999. As such, the CPT codes reported by the 5 groups are fairly representative of a majority of reimbursements made by OHCA to anesthesiologists and can be used to establish reasonable comparisons as well as future budget estimates.

In order to convert the current Medicaid fees for anesthesia services the survey data reported by the 5 groups was collapsed into a single report which averaged the data by units of service, the number of groups reporting the service and by reimbursements by code.

The collapsed survey data was then applied to Medicaid reimbursements by CPT Code for FY-06 through information available through the OHCA data system. The information included:

- OHCA fee schedule,
- Actual total Medicaid reimbursements by CPT code, and
- claims count by CPT Code.

The conversion formulas for each CPT Code are as follows:

$$\text{Avg. Private Units (Base + Time)} = \frac{\text{Total Number of Units by Code per Group}}{\text{Number of Codes Reported}}$$

$$\text{Avg. Medicaid Payment per Unit} = \frac{\text{OHCA Medicaid Maximum Fee by CPT Code}}{\text{Average Private Units Reported for All Groups}}$$

$$\text{Avg. Units Paid for by Medicaid} = \frac{\left\langle \dfrac{\text{Actual Total Paid by Medicaid by Code}}{\text{Average Medicaid Payment Per Unit by Code}} \right\rangle}{\text{Medicaid Claims Count Per Code}}$$

## OHCA Anesthesia Fees Comparison Report

Once OHCA fees were converted into a standard industry format they were compared to 3rd party payers, national averages and Medicare fees. The two key components of converting to a standard industry methodology are time expressed in units and the dollar value for a CF.

### *Comparison of Units*

On average, OHCA reimburses for a lower number of units per code than 3rd party payers when the 3rd party payer units are compared to the current OHCA fees. These differences

in units will be factored into any changes in reimbursement methodology that OHCA might make (Appendix III).

### *OHCA Anesthesia Fees Compared to 3rd Party Payers*

On average Oklahoma's anesthesia reimbursements are 82.07% less than the lowest third party payer's average reimbursements per CPT Code (Appendix IV). The following table indicates that Medicaid reimbursements are a little more than half of the lowest 3rd party reimbursement.

| Description | Average Per Unit Reimbursements |
|---|---|
| Average Medicaid Fee | $22.14 |
| Average Maximum Third Party Reimbursement | $63.89 |
| Average Median Third Party Reimbursement | $50.67 |
| Average Low Third Party Reimbursement | $40.31 |

Finally, the American Society of Anesthesiologists (ASA) published a survey of its members in August 2005. The ASA survey found that the average anesthesia CF in commercial managed care contracts across the United States is $52.73.

The ASA survey also reported reimbursement data by region, placing Oklahoma into the Mid-West region with 12 other states. The following chart displays the ASA findings for the Mid-West region and which states were included in the region:

| *Mid-West Region Conversion Factor 2005 (CO, IA, IL, IN, KS, MI, MN,MO, NE, OH, OK, SD, WI)* | | | |
|---|---|---|---|
| | *Low Payer* | *Median Payer* | *High Payer* |
| Mean | $44.02 | $50.47 | $57.15 |
| Minimum | $22.75 | $35.00 | $37.07 |
| 25th Percentile | $40.00 | $45.00 | $49.79 |
| Median | $44.00 | $49.00 | $53.80 |
| 75th Percentile | $48.25 | $53.00 | $63.00 |
| Maximum | $66.15 | $78.62 | $90.25 |
| # of Responses — | 59 | 59 | 62 |
| ** Source: August 2005 ASA Newsletter; Vol. 69, #8.* | | | |

In summary, this section of the report indicates that on average, OHCA reimbursements rates for anesthesia services are less than those of 3rd party payers.

### ***Oklahoma's Medicare Conversion Factor***

Medicare uses a base plus time reimbursement methodology for anesthesia services. The base is established by the ASA Relative Value Guide and time is reported in 15 minute increments expressed as units. Medicare establishes an annual fee for anesthesia services by state or location within a state.

The following table displays the Medicare CF for Oklahoma from 2003 through 2007:

| *Year* | *Oklahoma Medicare Conversion Factor* |
|---|---:|
| 2007 | $14.92 |
| 2006 | $16.47 |
| 2005 | $16.49 |
| 2004 | $16.28 |
| 2003 | $15.65 |

The above data indicate that on average OHCA pays higher than the Medicare CF. In fact, of the 34 codes listed, only three are below the Medicare CF- Codes 1844, 1926, and 1967.

# Appendix I: Cost To Convert For Private Anesthesiologists

| CPT Code | Procedure Description | 2007 Actual Medicaid Expenditures | Medicaid Reimbursements to Base plus Time | Difference: | Total Cost Effective 01/01/2008 | State Share @ 32.90% |
|---|---|---|---|---|---|---|
| 120 | Procedures On External, M | $374,002.58 | $495,895.84 | $121,893.26 | $60,946.63 | $20,051.44 |
| 126 | Procedures On External, M | $250,432.46 | $405,278.30 | $154,845.84 | $77,422.92 | $25,472.14 |
| 140 | Procedures On Eye; Not Ot | $247,613.28 | $293,430.38 | $45,817.09 | $22,908.55 | $7,536.91 |
| 160 | Procedures On Nose And Ac | $103,098.62 | $154,039.54 | $50,940.92 | $25,470.46 | $8,379.78 |
| 170 | Intraoral Procedures, Inc | $1,983,172.84 | $3,004,925.95 | $1,021,753.11 | $510,876.56 | $168,078.39 |
| 300 | All Procedures On Integum | $149,018.41 | $279,533.44 | $130,515.03 | $65,257.51 | $21,469.72 |
| 320 | Neck Organ 1 & Over | $162,783.23 | $233,100.00 | $70,316.77 | $35,158.39 | $11,567.11 |
| 400 | Procedures On Anterior In | $262,136.57 | $340,159.29 | $78,022.72 | $39,011.36 | $12,834.74 |
| 532 | Access To Central Venous | $84,540.13 | $80,967.60 | ($3,572.53) | ($1,786.26) | -$587.68 |
| 635 | Lumbar Region;Diag/Ther Lumba | $34,913.00 | $27,405.00 | ($7,508.00) | ($3,754.00) | -$1,235.07 |
| 740 | Upper Gastrointestinal En | $59,373.87 | $129,504.38 | $70,130.51 | $35,065.25 | $11,536.47 |
| 790 | Intraperitoneal Procedure | $508,400.19 | $907,647.17 | $399,246.98 | $199,623.49 | $65,676.13 |
| 810 | Intestinal Endoscopic Pro | $44,189.18 | $99,789.65 | $55,600.47 | $27,800.23 | $9,146.28 |
| 830 | Hernia Repairs In Lower A | $54,074.36 | $112,549.50 | $58,475.14 | $29,237.57 | $9,619.16 |
| 840 | Intraperitoneal Procedure | $586,128.49 | $897,832.78 | $311,704.29 | $155,852.15 | $51,275.36 |
| 851 | Intraperitoneal Procedure | $550,573.86 | $668,825.85 | $118,251.99 | $59,126.00 | $19,452.45 |
| 910 | Transurethral Procedures | $82,620.17 | $114,400.09 | $31,779.92 | $15,889.96 | $5,227.80 |
| 920 | Procedures On Male Extern | $93,344.61 | $196,030.94 | $102,686.33 | $51,343.16 | $16,891.90 |
| 940 | Vaginal Procedures (Inclu | $124,872.47 | $227,076.70 | $102,204.23 | $51,102.11 | $16,812.60 |
| 942 | Anesth, Surg On Vag/Urethral | $8,223.64 | $19,469.10 | $11,245.46 | $5,622.73 | $1,849.88 |
| 952 | Vaginal Procedures (Inclu | $24,555.71 | $43,747.20 | $19,191.49 | $9,595.75 | $3,157.00 |
| 1112 | Marrow Aspiration-Biopsy | $13,685.81 | $15,655.50 | $1,969.69 | $984.85 | $324.01 |
| 1400 | Open Procedures On Knee J | $116,307.67 | $204,804.60 | $88,496.93 | $44,248.47 | $14,557.74 |
| 1470 | Procedures On Nerves, Mus | $47,353.97 | $50,614.20 | $3,260.23 | $1,630.12 | $536.31 |
| 1480 | Open Procedures On Bones | $145,206.06 | $186,213.30 | $41,007.24 | $20,503.62 | $6,745.69 |
| 1810 | All Procedures On Nerves, | $126,021.06 | $142,568.78 | $16,547.72 | $8,273.86 | $2,722.10 |
| 1820 | All Closed Procedures On | $53,548.88 | $78,787.80 | $25,238.92 | $12,619.46 | $4,151.80 |
| 1830 | Open Procedures On Radius | $98,262.37 | $151,169.51 | $52,907.14 | $26,453.57 | $8,703.22 |
| 1844 | Vascular Shunt, Or Shunt | $14,566.47 | $48,783.00 | $34,216.53 | $17,108.27 | $5,628.62 |
| 1922 | Non-Invasive Or Radiation | $81,823.55 | $178,581.33 | $96,757.78 | $48,378.89 | $15,916.66 |
| 1926 | Therapeutic Interventiona | $17,444.40 | $46,956.00 | $29,511.60 | $14,755.80 | $4,854.66 |
| 1961 | Cesarean Delivery Only | $1,291,061.38 | $2,426,806.45 | $1,135,745.07 | $567,872.53 | $186,830.06 |
| 1968 | Cesarean Delivery Following Neuraxial La | $295,721.48 | $532,168.00 | $236,446.52 | $118,223.26 | $38,895.45 |
| | **Total for All CPT Codes except 01967** | **$8,089,070.77** | **$12,794,717.14** | **$4,705,646.37** | **$2,352,823.18** | **$774,078.83** |
| 1967 | Neuraxial Labor Analgesia | $3,322,285.03 | $5,437,450.00 | $2,115,164.97 | $1,057,582.49 | $347,944.64 |
| **Total** | | $11,411,355.80 | $18,232,167.14 | $6,820,811.34 | $3,410,405.67 | $1,122,023.47 |
| **Percent of Total for 2007 Anesthesia Reimbursements: Analysis divided by Actual Total** | | 85.64% | 85.64% | 85.64% | 85.64% | |
| **Actual 2007 Anesthesia Reimbursements** | | **$13,325,308.69** | **$21,290,130.59** | **$7,964,821.90** | **$3,982,410.95** | **$1,310,213.20** |

## Appendix II: Cost To Convert For Public Provider and Summary Total for All Anesthesiologists

| CPT Code | Procedure Description | 2007 Actual Medicaid Expenditures | Medicaid Reimbursements to Base plus Time | Difference: | Total Cost Effective 01/01/2008 | State Share @ 32.90% |
|---|---|---|---|---|---|---|
| **120** | **Procedures On External, M** | $81,652.81 | $72,564.00 | ($9,088.81) | ($4,544.41) | -$1,495.11 |
| **126** | **Procedures On External, M** | $2,144.39 | $2,430.70 | $286.31 | $143.15 | $47.10 |
| **140** | **Procedures On Eye; Not Ot** | $27,614.73 | $22,915.52 | ($4,699.22) | ($2,349.61) | -$773.02 |
| **160** | **Procedures On Nose And Ac** | $24,548.54 | $24,322.03 | ($226.51) | ($113.25) | -$37.26 |
| **170** | **Intraoral Procedures, Inc** | $264,740.40 | $264,278.78 | ($461.62) | ($230.81) | -$75.94 |
| **300** | **All Procedures On Integum** | $48,289.35 | $60,244.28 | $11,954.93 | $5,977.46 | $1,966.59 |
| **320** | **Neck Organ, 1 & Over** | $99,206.86 | $93,555.00 | ($5,651.86) | ($2,825.93) | -$929.73 |
| **400** | **Procedures On Anterior In** | $121,818.92 | $99,851.06 | ($21,967.86) | ($10,983.93) | -$3,613.71 |
| **532** | **Access To Central Venous** | $52,033.06 | $32,148.90 | ($19,884.16) | ($9,942.08) | -$3,270.94 |
| **740** | **Upper Gastrointestinal En** | $9,818.24 | $13,656.83 | $3,838.59 | $1,919.29 | $631.45 |
| **790** | **Intraperitoneal Procedure** | $98,731.07 | $116,900.28 | $18,169.21 | $9,084.61 | $2,988.84 |
| **810** | **Intestinal Endoscopic Pro** | $574.38 | $796.19 | $221.81 | $110.91 | $36.49 |
| **830** | **Hernia Repairs In Lower A** | $36,639.47 | $46,777.50 | $10,138.03 | $5,069.02 | $1,667.71 |
| **840** | **Intraperitoneal Procedure** | $96,126.07 | $98,469.57 | $2,343.50 | $1,171.75 | $385.51 |
| **851** | **Intraperitoneal Procedure** | $43,424.61 | $36,193.85 | ($7,230.76) | ($3,615.38) | -$1,189.46 |
| **910** | **Transurethral Procedures** | $26,908.29 | $24,129.91 | ($2,778.38) | ($1,389.19) | -$457.04 |
| **920** | **Procedures On Male Extern** | $58,440.46 | $76,248.56 | $17,808.10 | $8,904.05 | $2,929.43 |
| **940** | **Vaginal Procedures (Inclu** | $9,918.08 | $11,914.52 | $1,996.44 | $998.22 | $328.41 |
| **942** | **Surg On Vag/Urethral** | $2,213.25 | $3,467.10 | $1,253.85 | $626.93 | $206.26 |
| **952** | **Vaginal Procedures (Inclu** | $1,143.76 | $1,209.60 | $65.84 | $32.92 | $10.83 |
| **1400** | **Open Procedures On Knee J** | $1,339.25 | $1,501.50 | $162.25 | $81.13 | $26.69 |
| **1470** | **Procedures On Nerves, Mus** | $21,804.50 | $14,924.70 | ($6,879.80) | ($3,439.90) | -$1,131.73 |
| **1480** | **Open Procedures On Bones** | $31,419.85 | $26,972.40 | ($4,447.45) | ($2,223.73) | -$731.61 |
| **1810** | **All Procedures On Nerves,** | $21,188.43 | $15,869.88 | ($5,318.55) | ($2,659.27) | -$874.90 |
| **1820** | **All Closed Procedures On** | $3,187.92 | $3,112.20 | ($75.72) | ($37.86) | -$12.46 |
| **1830** | **Open Procedures On Radius** | $15,815.25 | $16,196.73 | $381.48 | $190.74 | $62.75 |
| **1844** | **Vascular Shunt, Or Shunt** | $475.65 | $1,272.60 | $796.95 | $398.48 | $131.10 |
| **1922** | **Non-Invasive Or Radiation** | $91,724.55 | $128,898.20 | $37,173.65 | $18,586.82 | $6,115.07 |
| **1926** | **Therapeutic Interventiona** | $17,949.38 | $34,398.00 | $16,448.62 | $8,224.31 | $2,705.80 |
| **1961** | **Cesarean Delivery Only** | $214,789.90 | $261,974.19 | $47,184.29 | $23,592.14 | $7,761.81 |
| **1968** | **Cesarean Delivery Following Neuraxial La** | $52,180.31 | $62,608.00 | $10,427.69 | $5,213.85 | $1,715.36 |
| | **Total for All CPT Codes except 01967** | **$1,577,861.73** | **$1,669,802.58** | **$91,940.85** | **$45,970.42** | **$15,124.27** |
| | | | | | | |
| **1967** | Neuraxial Labor Analgesia | $468,051.87 | $576,300.00 | $108,248.13 | $54,124.06 | $17,806.82 |
| **Total Analysis Expenditures** | | **$2,045,913.60** | **$2,246,102.58** | **$200,188.98** | **$100,094.49** | **$32,931.09** |
| Percent of Total for 2007 Anesthesia Reimbursements: Analysis divided by Actual Total | | 72.40% | 72.40% | | | |
| **2007 Actual Expenditures** | | **$2,825,831.30** | **$3,102,333.82** | **$276,502.52** | **$138,251.26** | **$45,484.67** |
| Current Payment by Public Providers for State Share | | | | $211,870.34 | $105,935.17 | $105,935.17 |
| Public Provider Costs | | | | $488,372.86 | $244,186.43 | $151,419.84 |
| **Public and Private Costs Combined** | | | | | **$4,226,597.38** | **$1,461,633.04** |

## Appendix III: Unit Comparison Table

| CPT Code | Description | Avg. Units Paid For By Medicaid | Avg. Units Paid for By 3rd Party Payers | Difference |
|---|---|---|---|---|
| *120* | *Procedures On ear* | 6.80 | 7.97 | -1.17 |
| *126* | *Tympanotomy* | 4.55 | 5.14 | -0.60 |
| *140* | *Procedure On Eye* | 8.00 | 8.87 | -0.87 |
| *160* | *Procedures On Nose* | 7.67 | 9.19 | -1.52 |
| *170* | *Intraoral Procedures* | 8.02 | 9.30 | -1.28 |
| *300* | *All Proc. On Integum* | 9.29 | 10.93 | -1.64 |
| *320* | *Anesth, Neck Organ, age 1 & Over* | 8.37 | 10.00 | -1.63 |
| *400* | *Procedures On Intergumentary System* | 5.64 | 7.04 | -1.41 |
| *532* | *Access To Central Venous* | 3.96 | 5.40 | -1.44 |
| *635* | *Diagnostic / Therapeutic Lumbar Punct.* | 5.56 | 6.00 | -0.44 |
| *740* | *Upper Gastrointestinal Endoscopic Proc.* | 6.02 | 7.48 | -1.46 |
| *790* | *Intraperitoneal Procedure* | 10.82 | 13.25 | -2.43 |
| *810* | *Lower Intestinal Endoscopic Proc.* | 6.27 | 8.43 | -2.16 |
| *830* | *Hernia Repairs In Lower Abdomen* | 7.62 | 9.00 | -1.38 |
| *840* | *Intraperitoneal Procedure – Lower Ab* | 9.49 | 11.89 | -2.40 |
| *851* | *Tubal Ligation* | 8.24 | 9.66 | -1.41 |
| *910* | *Transurethral Procedures* | 4.43 | 5.51 | -1.09 |
| *920* | *Proc. On Male External Genitalia* | 7.11 | 8.18 | -1.07 |
| *940* | *Vaginal Procedures* | 4.40 | 5.56 | -1.16 |
| *942* | *Anesth, Surgery On Vaginal/Urethral* | 6.84 | 8.47 | -1.63 |
| *952* | *Hysteroscopy* | 5.41 | 6.40 | -0.99 |
| *1112* | *Bone Marrow Aspiration-Biopsy* | 6.56 | 7.00 | -0.44 |
| *1400* | *Open or Arthroscopic Knee Surgery* | 7.92 | 9.53 | -1.61 |
| *1470* | *Proc. On Nerves, Muscles, tendons* | 5.58 | 6.87 | -1.29 |
| *1480* | *Open Procedures On Bones, Lower Leg* | 6.74 | 8.23 | -1.50 |
| *1810* | *Procedures On Nerves, muscle forearm* | 6.49 | 8.26 | -1.77 |
| *1820* | *Closed Proc. On wrist or hand bone* | 4.59 | 5.20 | -0.61 |
| *1830* | *Open or surgical Procedures On hand* | 8.46 | 10.08 | -1.62 |
| *1844* | *Vascular Shunt, Or Shunt* | 11.25 | 13.47 | -2.22 |
| *1922* | *Non-Invasive Imaging Or Radiation* | 10.00 | 11.03 | -1.03 |
| *1926* | *Intracranial , Intracardiac* | 16.52 | 17.33 | -0.82 |
| *1961* | *Cesarean Delivery Only* | 9.65 | 11.85 | -2.20 |
| *1967* | *Neuraxial Labor - planned vaginal del.* | 19.38 | 23.13 | -3.75 |
| *1968* | *Cesarean Following Neuraxial Labor* | 9.33 | 11.56 | -2.23 |
| | **Totals** | **7.85** | **9.33** | **-1.48** |

## Appendix IV: OHCA Maximum Fee Compared to Private Payers

| CPT Code | Description | Current OHCA Fee | Average High 3rd Party Payer | Average Median 3rd Party Payer | Average Low 3rd Party Payer | Percent Difference: OHCA Fee Compared to Lowest 3rd Party Payer |
|---|---|---|---|---|---|---|
| 120 | Procedures On ear | $229.76 | $458.23 | $368.61 | $278.99 | -21.43% |
| 126 | Tympanotomy | $114.88 | $338.97 | $267.43 | $189.06 | -64.57% |
| 140 | Procedure On Eye | $258.47 | $523.17 | $457.34 | $391.51 | -51.47% |
| 160 | Procedures On Nose | $229.76 | $487.18 | $404.45 | $321.72 | -40.02% |
| 170 | Intraoral Procedures | $229.76 | $580.30 | $457.77 | $362.86 | -57.93% |
| **300** | **All Proc. On Integum** | **$215.39** | **$644.65** | **$563.08** | **$481.50** | **-123.55%** |
| **320** | **Anesth, Neck Organ, age 1 & Over** | **$258.47** | **$570.00** | **$550.00** | **$530.00** | **-105.05%** |
| 400 | Procedures On Intergumentary System | $215.39 | $468.74 | $361.65 | $286.52 | -33.02% |
| 532 | Access To Central Venous | $215.39 | $469.00 | $318.00 | $217.62 | -1.04% |
| 635 | Diagnostic / Therapeutic Lumbar Punct. | $244.12 | $342.00 | $330.00 | $318.00 | -30.26% |
| **740** | **Upper Gastrointestinal Endoscopic Proc.** | **$129.24** | **$412.18** | **$372.90** | **$333.63** | **-158.15%** |
| 790 | Intraperitoneal Procedure | $272.84 | $825.66 | $652.90 | $518.60 | -90.07% |
| **810** | **Lower Intestinal Endoscopic Proc.** | **$143.59** | **$446.54** | **$370.71** | **$294.89** | **-105.37%** |
| **830** | **Hernia Repairs In Lower Abdomen** | **$172.31** | **$513.00** | **$495.00** | **$477.00** | **-176.83%** |
| 840 | Intraperitoneal Procedure – Lower Ab | $287.19 | $754.01 | $592.12 | $468.19 | -63.02% |
| 851 | Tubal Ligation | $287.19 | $561.75 | $446.80 | $337.94 | -17.67% |
| 910 | Transurethral Procedures | $157.96 | $388.78 | $287.08 | $210.70 | -33.39% |
| **920** | **Proc. On Male External Genitalia** | **$157.96** | **$451.42** | **$409.32** | **$367.22** | **-132.48%** |
| 940 | Vaginal Procedures | $114.88 | $363.35 | $275.29 | $202.42 | -76.20% |
| **942** | **Anesth, Surgery On Vaginal/Urethral** | **$143.60** | **$737.00** | **$477.00** | **$326.43** | **-127.32%** |
| 952 | Hysteroscopy | $143.60 | $390.40 | $300.80 | $224.00 | -55.99% |
| 1112 | Bone Marrow Aspiration-Biopsy | $201.04 | $399.00 | $385.00 | $371.00 | -84.54% |
| **1400** | **Open or Arthroscopic Knee Surgery** | **$201.04** | **$561.53** | **$488.07** | **$423.67** | **-110.74%** |
| 1470 | Proc. On Nerves, Muscles, tendons | $244.13 | $418.87 | $322.73 | $240.33 | 1.56% |
| 1480 | Open Procedures On Bones, Lower Leg | $244.13 | $648.03 | $428.07 | $304.38 | -24.68% |
| 1810 | Procedures On Nerves, muscle forearm | $272.84 | $595.58 | $414.68 | $296.77 | -8.77% |
| 1820 | Closed Proc. On wrist or hand bone | $129.24 | $317.20 | $244.40 | $182.00 | -40.82% |
| 1830 | Open or surgical Procedures On hand | $244.13 | $615.00 | $483.94 | $352.87 | -44.54% |
| **1844** | **Vascular Shunt, Or Shunt** | **$143.60** | **$1,206.00** | **$742.00** | **$507.78** | **-253.61%** |
| **1922** | **Non-Invasive Imaging Or Radiation** | **$186.68** | **$606.57** | **$545.81** | **$485.04** | **-159.82%** |
| **1926** | **Intracranial , Intracardiac** | **$215.40** | **$1,407.00** | **$954.00** | **$652.86** | **-203.09%** |
| **1961** | **Cesarean Delivery Only** | **$229.76** | **$742.36** | **$591.27** | **$465.10** | **-102.43%** |
| **1967** | **Neuraxial Labor - planned vaginal del.** | **$258.48** | **$1,336.93** | **$1,171.87** | **$959.83** | **-271.34%** |
| 1968 | Cesarean Following Neuraxial Labor | $229.76 | $684.80 | $541.93 | $404.44 | -76.03% |
| **Average** | | **$206.53** | **$596.04** | **$472.71** | **$376.03** | **-82.07%** |