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FEATURE STORY

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Medicare's site-neutral payment impact on hospital outpatient services

The U.S. government's actions aimed at moving to a site-neutral payment system for outpatient services present strategic challenges for health systems that operate provider-based outpatient departments.

AT A GLANCE

Medicare is beginning to limit the "reimbursement arbitrage" that hospitals enjoy for most outpatient services, starting in 2017 with new off-campus locations and services. Hospital leaders should:

> Prepare for billing and regulatory compliance implications for any applicable hospital outpatient departments (HOPDs) in 2017
> Reevaluate the financial viability of every planned off-campus HOPD expansion and practice acquisition
> Explore how to mitigate the effects of this change by leveraging the current exemptions (on-campus growth, freestanding emergency departments)
> Revise their long-term financial projections for the impact of Medicare's eventual extension of site-neutral reimbursement across all settings

Medicare historically paid hospitals more than other entities—including physicians and ambulatory surgery centers (ASCs)—for outpatient services. This policy has been challenged in recent years, and recent legislation has eliminated this rate premium for new, off-campus locations. Valuable insight into this policy can be gained through a review of Medicare outpatient reimbursement, analysis of the effects of the legislation (and potential modifications), and consideration of strategic implications.

Outpatient Reimbursement Policy for Hospitals

Medicare's payment rates for the same service vary based on the setting. Services provided in a physician's office are paid a single "global" fee from the physician fee schedule (PFS), which covers physician time, malpractice costs, and practice (or technical) costs. For services provided in facilities, such as hospital outpatient departments (HOPDs) or ambulatory surgical centers (ASCs), Medicare pays the practitioner a fee from the PFS—lower than the comparable fee had the services been delivered in the professional's office—because the physician does not bear any practice (or technical) costs—and also pays a fee to the facility. Generally, the total payment rate for services provided in HOPDs is much higher than the rate for the same service provided in an office or ASC. Indeed, under the current payment system, total payment for services delivered in an HOPD often is 30 to 50 percent higher than payment for the same type of services delivered in the two other settings, and sometimes two to three times higher. The exhibit below shows the total payments by setting and the *reduction* from HOPD rates to the lowest-cost setting.

HOPDs do not need to be located on the campus of an inpatient facility. Rather, acute care hospitals (other than critical access hospitals) can operate HOPDs within 35 miles of the inpatient campus and structure them as "provider-based" hospital outpatient departments.

The Government Accountability Office (GAO) noted in December 2015 that this payment difference has encouraged hospitals to acquire physician practices, because hospitals could earn a much higher rate on office visits.[a] This strategy, which we refer to as "reimbursement arbitrage," is commonly pursued on ancillary services. For example, by acquiring a cardiology practice with in-office diagnostics, the purchasing health system would be paid $1,189 rather than $495 (for an increase of $694, or 140 percent) per Nuclear Stress Test/TMST procedure using the same facility and staff after designating the diagnostics room as an HOPD. (For additional explanatory detail, see "Medicare's Site-Neutral Payment for New Off-Campus Locations: Payment Details" on page 8.)

a. Government Accountability Office, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform,* Dec. 18, 2015.

New Law Takes Effect

On Nov. 2, 2015, the Bipartisan Budget Act of 2015 was enacted. Section 603 of this legislation changes the current payment policy, providing that new off-campus HOPDs are to be reimbursed at the lowest possible rate. An analysis of Section

TOTAL MEDICARE PAYMENT FOR COMMON OUTPATIENT PROCEDURES BY SETTING: SITE-OF-SERVICE DIFFERENTIAL

			Total Medicare Payment (Physician and Facility) by Setting			Reduction from Hospital to Lowest-Cost Setting	
Service	**Procedure**	**CPT**	**Outpatient Hospital**	**ASC/ Other**	**Physician Office**	**Payment Reduction**	**Percentage Reduction**
Evaluation and Management	Office visit, established patient, Level 4	99214	$181	n/a	$108	$73	40%
Cardiology	Cardiac Rehab	93798	$118	n/a	$25	$93	78%
	Echo	93306	$481	n/a	$231	$250	52%
	Nuclear stress test/TMST	78452	$1,189	n/a	$495	$694	58%
	Pulmonary stress test/simple	94620	$122	n/a	$57	$65	53%
	Stress ECHO	93351	$503	n/a	$275	$228	45%
Gastrointestinal	Diagnostic colonoscopy	45378	$952	$620	$386	$566	59%
Imaging	Bone density/DEXA	77080	$111	$112	$42	$69	62%
	CT abdomen and pelvis w/ contrast	74177	$441	$418	$314	$126	29%
	CT abdomen and pelvis w/wo contrast	74178	$450	$428	$357	$94	21%
	Diagnostic X-ray (hip unilateral 2 views)	73502	$72	$73	$42	$31	42%
	MRI joint lower ext w/o contrast	73721	$343	$222	$239	$121	35%
	Mammogram, screen/yearly	G0202	$135	$35	$135	$100	74%
	Ultrasound abdomen complete	76700	$195	$200	$125	$70	36%
Orthopedics	Knee arthroscopy/surgery	29881	$2,952	$1,896	n/a	$21,056	36%
	Wrist endoscopy/surgery	29848	$1,979	$1,337	n/a	$642	32%
Pain Management	Inject foramen epidural l/s	64483	$701	$443	$225	$477	68%
	Inject foramen epidural add-on	64484	$54	$54	$90	$0	0%
	Inject trigger points =/> 3	20553	$268	$79	$65	$203	76%
Physicial Therapy	Manual therapy (per 15 minutes)	97140	$30	n/a	$30	$0	0%
	PT evaluation	97001	$76	n/a	$76	$0	0%
	Therapeutic exercises	97110	$33	n/a	$33	$0	0%
Pulmonary	Sleep lab	95810	$980	n/a	$633	$347	35%

603 issued by the law firm McDermott Will & Emory in October 2015 describes the change as follows: "Effective Jan. 1, 2017, Medicare payments for most items and services furnished at an off-campus department of a hospital that was not billing as a hospital service prior to the date of enactment will be made under the applicable non-hospital payment system."[b]

To clarify, Section 603 applies to off-campus outpatient departments of a hospital that were not billing as a hospital department prior to Nov. 2, 2015. There is no restriction on the ability for hospitals to open new outpatient facilities and bill Medicare as HOPDs.[c] The hospital outpatient services that are affected by Section 603 are services rendered in a new off-campus location, beginning after Nov. 2, 2015, that initially billed and were paid for by Medicare under the outpatient prospective payment system (OPPS). Below are some common outpatient services that are/were not paid under OPPS and hence are *not* affected by Section 603, because their Medicare reimbursement is already "site-neutral":

> Ambulance services
> Clinical diagnostic laboratory
> Physical, occupational, and speech therapy
> Routine dialysis service for patients with end-stage renal disease (ESRD)
> Diagnostic and screening mammography

The only exceptions to this site-neutral policy are the services delivered by a dedicated off-campus emergency department (i.e., a freestanding ED). Under Title 42 of the Code of Federal Regulations (CFR), a dedicated ED must meet at least one of the following requirements:[d]

> It must be licensed as an ED by the state in which it is located under applicable state law.
> It must be presented to the public (using its name, posted signs, advertising, or some other means) as a place where patients can access services to treat emergency medical conditions on an urgent basis without the need for a previously scheduled appointment.
> At least one-third of all of its outpatient visits (based on a representative sample of patient visits) occurring in the previous year (i.e., the year prior to the year in which the determination is made as to whether the ED is a *dedicated ED*) were for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Of course, freestanding EDs face certificate-of-need limits and other hurdles in most states.

In summary, hospitals will see no change to payment in off-campus locations that were operating prior to Nov. 2, 2015. However, for new off-campus locations—which include newly developed sites and acquisitions of physician practices, but not freestanding EDs—Medicare payment will be reduced to the lowest applicable amount (i.e., physician practice ["non-provider"] or ASC).

The Rationale for the Change

Various entities recommended this payment change for a variety of reasons. The Medicare Payment Advisory Commission (MedPAC) has recommended since 2012 that, for certain outpatient services, the Centers for Medicare & Medicaid Services (CMS) pay hospitals at the same Medicare rates as other entities. MedPAC initially focused on evaluation and management services (office visits) but expanded its recommendation in 2013 to other outpatient services. MedPAC estimated in 2013 that this policy change would save $1.5 billion per year, although it expressed concern over the impact on hospitals that depend on Medicare outpatient margins for their survival (e.g., rural, teaching, and DSH hospitals).[e]

b. Cook, E.J., DiVarco, S.M., Wallace, M., Zimmerman, E., "Congress Takes Step Toward Site-Neutral Medicare Payments in Bipartisan Budget Act of 2015," McDermott Will & Emery LLP, Oct. 29, 2015.

c. American Hospital Association, AHA Factsheet: Site-neutral HOPD Technical Corrections*,* Nov. 16, 2015.

d. CMS, "*Special Responsibilities of Medicare Hospitals in Emergency Cases,"* Title 42 of the Code of Federal Regulations, Chapter IV, Subcategory G, § 489.24(b), *Federal Register*, June 22, 1994.

e. MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, Chapter 2, June 2013.

The Congressional Budget Office estimated that Section 603 would save $9.3 billion over 10 years.[f] In its December 2015 report, the GAO commented that hospital acquisition of physician practices was correlated with the higher payment for hospitals and that due to trends in increased hospital-physician consolidation, CMS should "equalize payment rates between settings."

Trade associations representing nonhospital interests, including the American Medical Association, have supported the law change, likely because physicians wanted to have their ancillary services paid at the same rate as hospitals.[g]

Even before the 2015 legislative change, CMS has been preparing for site-neutral payment. In 2014, as part of the CY15 Outpatient Prospective Payment System Final Rule, CMS required a new billing modifier on a facility ("provider") claim and a new place-of-service code on professional claims for services furnished in any off-campus provider-based outpatient departments (e.g., HOPDs), for Medicare billing. Use of the modifier (by the hospital) and place-of-service code (by the physician) was voluntary during 2015, and it became mandatory as of Jan. 1, 2016. However, the billing modifier and Section 603 are complementary, as CMS could not implement some form of "grandfathered" site-neutral reimbursement without being able to differentiate off-campus from on-campus HOPDs or identifying those off-campus HOPDs that are already (as of Jan. 1, 2016) billing Medicare.

The billing modifier itself is not directly tied to payment. Rather, it constitutes CMS's method for segmenting off-campus from on-campus HOPD activity for future policy setting. Prior to the Bipartisan Budget Act, it was seen by many as a sign that within a few years CMS would eliminate or greatly reduce the site-of-service premium that HOPDs enjoy, per MedPAC's recommendation. Thus, many expect that CMS will study the volume data in 2017 and recommend payment reductions to some or all "grandfathered" HOPDs in 2018 or 2019. Because such a change would affect "existing" hospital margins (and not just planned or potential HOPDs), the change would have political repercussions.

Changes to Come

When the Bipartisan Budget Act of 2015 passed, the American Hospital Association (AHA) immediately lobbied for amending a few issues not addressed in the bill, instead of seeking to have the overall payment change repealed. The AHA's primary objective was to protect new facilities that were under development when the act was signed into law. These cases would involve hospitals that had made substantial investments in the facilities at the time of the signing, and AHA's recommendation would result in protection consistent with "past precedent." In February 2016, the AHA argued in an open letter to Congressional leaders that "changes in ownership of a facility, or the addition of services, do not impact the grandfathered status of a [provider-based] HOPD and that grandfathered HOPDs may relocate. . . ."[h]

On June 7, 2016, the U.S. House of Representatives passed the Helping Hospitals Improve Patient Care Act of 2016. Regarding Section 603, this bill addresses only the AHA's first objective: protecting HOPDs that were "mid-build" from the changing payment rates. To claim this status, a hospital must prove that a new off-campus department is both "mid-build" (where "before Nov. 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of such department") and provider-based. HOPDs that meet the requirements would receive full payments beginning Jan. 1, 2018 (but not during 2017).[i] Even if this

f. CBO, "Estimate of the Budgetary Effects of H.R. 1314, the Bipartisan Budget Act of 2015, as Reported by the House Committee on Rules on October 27, 2015," Oct. 28, 2015.
g. "AMA Voices Support for OPPS Site-Neutral Payment Proposal," *AHA News Now*, July 8, 2016.

h. Nickels, T.P., AHA correspondence to Fred Upton, Chairman, Committee on Energy and Commerce, and Joseph Pitts, Chairman, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, Feb. 12, 2016.
i. The Helping Hospitals Improve Patient Care Act of 2016 (H.R. 5273), 114 Cong., Received in Senate, June 8, 2016.

bill is enacted into law, it will leave many issues unresolved.

On July 11, 2016, CMS released its draft rule to address issues regarding off-campus HOPDs, which it refers to as "off-campus provider-based departments (PBDs)."[j] The proposed rule includes provisions addressing the following considerations.

Relocation. A "grandfathered" off-campus PBD will lose its exemption from site-neutral payment on all services if the PBD is moved to a new location.

Location expansion. Grandfathered sites that expand their footprint (e.g., occupy more units in a multi-suite building) would be reimbursed at the site-neutral rate.

New services. Services added to a PBD after Nov. 2, 2015, would be reimbursed at the site-neutral rate. Regarding *new services*, CMS proposes that "service types be defined by … 19 clinical families of hospital outpatient services" (e.g., advanced imaging, diagnostic tests) on the basis of ambulatory payment classifications (APCs); only expansion of APCs *within* existing service families will be exempt from site-neutral payment. To explain how tight this rule is, CMS notes, "[W]e are proposing not to limit the volume of excepted items and services within a clinical family of services that an excepted off-campus PBD could furnish." In essence, however, everything else is limited regarding exemption from site-neutral reimbursement.

Ownership. If an individual PBD is sold, it will not retain its exemption from site-neutral reimbursement. However, if the "main provider" (i.e., hospital) changes ownership, then its PBDs that are also purchased will retain their exempt status.

Reimbursement. The Medicare PFS will be used to determine the payment for non-exempt PBDs.

Payment process. CMS was uncertain how payment actually will work. It has indicated that the existing payment processing systems cannot handle the Medicare PFS as the sole payment for services at an HOPD.

On Nov. 1, 2016, CMS released its final rule. Key changes from the draft rule include the following:[k]

> Relocation is limited to "extraordinary circumstances outside of the hospital's control, such as natural disasters."
> Regarding new services in exempt PBDs, CMS is not finalizing (i.e., adopting) this proposal, but it will monitor future expansion. It should be noted that limits on exempt PBD footprint growth appear to remain.
> Regarding payment, for nonexempt PBDs, the payment rate to hospitals "will generally paid at "50 percent of the OPPS rate" for CY17, across all services.

Strategic Implications for Hospitals and Health Systems

It is widely perceived that payment drives strategy in health care. Thus, practice acquisitions or new outpatient locations by hospitals that depend upon Medicare "reimbursement arbitrage" to make their investment financially viable will be hard to justify. Instead, the focal points of outpatient facility growth for services that require relatively high Medicare payment will be on hospital campuses and—pending final CMS regulations—in existing HOPD locations. Building HOPDs in new sites will likely be limited to services that meet one or more of the following four criteria.

j. CMS, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program," Proposed Rule, *Federal Register*, July 14, 2016.

k. CMS, "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; etc." Final Rule, Filed at Nov. 1, 2016.

The service is projected to remain profitable across all payers. An example is physical therapy, for which payment rates have not changed.

The service can drive downstream volume or value. Such services include:

> Primary care, including urgent care
> Low-end imaging
> Specialist care (for nondiagnostic office visits)
> Physical therapy
> Medical specialist offices and chronic condition clinics (for 340B prescription drug margin)

The service addresses "system" care management needs, even if the HOPD itself is not profitable. Such needs include geographic coverage, low-cost facilities across the entire continuum of care, and care management intervention services (rendered while performing a fee-for-service task). Examples of care management include dispensing of medication (with medication therapy management) to patients with chronic conditions, and physical therapy reevaluations at milestones during an orthopedic bundled payment episode to assist with managing and improving reported outcomes, which drives the bonus payment.

The service complements a freestanding ED. For example, the diagnostics capabilities of an ED might be expanded by modality (e.g., adding magnetic resonance imaging) and designed to also serve nonemergent patients from orders made by local physicians. More strategically, the ED might be expanded into a "nano-hospital," with observation beds and scheduled services that generate a high margin per visit (such as outpatient surgery, colonoscopies, and pain procedures), subject to CMS limits.

APPROXIMATE REDUCTION IN MEDICARE PAYMENT FOR NEWLY ESTABLISHED HOSPITAL OUTPATIENT DEPARTMENTS

Service	Total Reduction	Reduction in Facility Fee Only
Cardiac Diagnostics	50%	50%-70%
Office Visits	30%-50%	70%
Pain Management	40%	70%-90%
Surgery	35%	40%-50%
Imaging	30%	20%-60%
Physical Therapy	0%	0%

From a business perspective, Medicare payment reductions may be large enough to make many prospective outpatient initiatives financially nonviable, particularly if the patient mix is heavily weighted toward Medicare and if the "reimbursement arbitrage" would have been significant. Setting aside the freestanding ED exclusion, the impact of the new Medicare payment rules varies substantially by service. In general, Medicare rates will drop for many common services, except for physical therapy, particularly when only the facility fee (or the technical component of a bundled physician office payment) is evaluated, as shown in the exhibit below. For services accessed primarily by Medicare patients (e.g., cardiac diagnostics, and particularly for cardiac rehab), off-campus growth (either via practice acquisition or new construction) is likely not viable.

The Outlook Regarding Other Payers

As one would expect, the hospital outpatient rate "premium" that can be gained from other payers likely varies according to whether the payer is Medicare Advantage, commercial, or Medicaid.

Medicare Advantage. These plans typically offer providers a slight premium on Medicare payment (i.e., 3 to 5 percent). Thus, these plans likely will be able to access Medicare's effective rate reduction on *new* sites in 2017. However, because the vast majority of services will be performed at either existing campus-based or grandfathered off-campus locations, little change will be seen initially in actual total payments made by Medicare Advantage plans. It should be noted that CMS has not yet promulgated the means by which its fiscal intermediaries will identify grandfathered off-campus sites after Jan. 1, 2017, when the payment system begins paying "new" sites at the site-neutral rates.

Commercial payers. The actions of commercial health plans will depend on negotiations between hospitals and the health plans, and cannot be mandated by the plans. Hospital outpatient departments already face pricing competition from lower-paid providers, and this shift in Medicare policy will heighten awareness of the rate premium. Already, we have seen instances where commercial payers no longer recognize the site-of-service differential for the evaluation and management code (e.g., charging a separate "facility fee" for "office visits").

Medicaid. Historically, Medicaid has followed Medicare policy in many payment areas, but because Medicaid is managed at the state level, any impact will necessarily be state-specific.

Across all payers, including Medicare fee-for-service, the biggest risk for hospitals may be increased patient knowledge of differences in payment rates among various locations. Those differences exist today among HOPDs, ASCs, and physician offices, but beginning Jan. 1, 2017, HOPD rates for Medicare will differ between new sites and those on hospital campuses or in grandfathered locations.

Transparency is the enemy of large rate differences for apparently identical services. Already, payers and employers direct patients to firms (e.g., CastLight, Healthcare Blue Book) and websites where they can find lower-priced outpatient services (e.g., www.saveonmedical.com). We have seen examples of physician-owned Medicare Shared Savings Plans publishing materials that highlight the potential savings generated by shifting from HOPDs to physician offices (or physician-owned ASCs). The competition-based movement away from HOPDs and the possibility of further CMS action both provide good reason for hospital leadership not to base long-term financial projections on the hope of generating a meaningful reimbursement arbitrage on outpatient Medicare services. ■

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Medicare Payment and Different Sites of Services: Payment Details

To understand the potential impact of site-neutral Medicare payment for outpatient services, it is helpful to understand the current differences in Medicare outpatient services payment between sites of service. This appendix provides payment detail to illustrate the nature of these differences.

In the "physician office" setting, which the Centers for Medicare & Medicaid Services (CMS) refers to as a "nonfacility" setting, Medicare's payments for professional and facility services are paid via a global fee, as a Part B claim. In an ambulatory surgery center (ASC) or hospital outpatient department (HOPD), which CMS refers to as a "provider" setting, a Part A facility fee is paid to the facility and the Part B fee is reduced to the physician.

The exhibit on the top of page 9 illustrates how Medicare pays physicians and hospitals, by setting, for a common cardiac diagnostic, a nuclear stress test/treadmill stress test.

Medicare's total payments increase by about $694, or 140 percent, when a case is shifted from the physician office to the HOPD setting. The physician group loses about $415 for the "technical component" of the Part B claim, but in return, the HOPD is paid about $1,108 for a diagnostic test. This is a roughly $694 (167 percent) increase in the payment for the diagnostic itself.

The exhibit below details payments by common procedure terminology (CPT) code and related ambulatory payment classification (APC) for a range of outpatient services.

The exhibit on the bottom of page 9 shows payments by procedure for the facility fee (in an ASC or HOPD) or for the technical component of a global fee paid for services in a physician office, showing the payment reduction for the hospital to the lowest-cost setting.

MEDICARE PAYMENT TO FACILITIES AND PHYSICIANS BY SETTING AND MEDICARE BENEFIT

			Part B		Part A			
			Physician Fee		Facility Fee			
Service	**Procedure**	**CPT**	**Nonfacility**	**Facility (professional only)**	**Ambulatory Surgery Center**	**Outpatient Hospital**	**APC***	**SI***
Evaluation & Management	Office visit, established patient, Level 4	99214	$108.18	$79.03	$0.00	$102.12		B
	Hospital Outpatient Clinic Visit	G0463		$79.03	$0.00	$102.12	5012	J2
Cardiology	Cardiac Rehab	93798	$25.45	$14.30	$0.00	$103.92	5771	S
	Echo	93306	$230.98	$63.43	$0.00	$416.80	5533	S
	Nuclear stress test/TMST	78452	$494.91	$80.16	$619.83	$1,108.46	5593	S
	Pulmonary stress test/simple	94620	$57.01	$31.12	$0.00	$91.18	5734	Q1
	Stress ECHO	93351	$274.76	$86.27	$0.00	$416.80	5533	S
Gastrointestinal	Diagnostic colonoscopy	45378	$385.87	$199.12	$420.93	$752.76	5312	T
Imaging	Bone density/DEXA	77080	$41.66	$10.38	$101.33	$100.69	5522	S
	CT abdomen & pelvis w/contrast	74177	$314.28	$93.01	$325.34	$347.72	5572	Q3
	CT abdomen & pelvis w w/o/contrast	74178	$356.67	$102.67	$325.34	$347.72	5572	Q3
	Diagnostic X-ray (hip unilateral 2 views)	73502	$41.66	$11.45	$61.57	$60.80	5521	Q1
	MRI joint lower ext w/o contrast	73721	$238.83	$69.39	$152.96	$273.54	5581	Q3
	Mammogram, screen/yearly	G0202	$135.42	$35.41	$0.00	$100.01	0	A
	Ultrasound abdomen complete	76700	$124.61	$41.15	$159.11	$153.58	5532	Q3
Orthopedics	Knee arthroscopy/surgery	29881	$556.64	$556.64	$1,339.58	$2,395.59	5122	T
	Wrist endoscopy/surgery	29848	$523.69	$523.69	$813.76	$1,455.26	5121	T
Pain Management	Inject foramen epidural l/s	64483	$224.56	$116.25	$327.22	$585.17	5442	T
	Inject foramen epidural add-on	64484	$89.60	$53.62	$0.00	$0.00		N
	Inject trigger points =/> 3	20553	$64.82	$44.31	$35.10	$223.76	5441	T
Physical Therapy	Manual therapy (per 15 minutes)	97140	$30.13	$0.00	$0.00	$30.13		A
	PT evaluation	97001	$75.96	$0.00	$0.00	$75.96		A
	Therapeutic exercises	97110	$32.62	$0.00	$0.00	$32.62		A
Pulmonary	Sleep lab	95810	$633.49	$123.81	$0.00	$856.44	5724	S

* APC = ambulatory payment classification; SI = status indicator

MEDICARE PAYMENT FOR NUCLEAR STRESS TESS/TREADMILL STRESS TEST PERFORMED IN A PHYSICIAN OFFICE VERSUS A HOSPITAL OUTPATIENT DEPARTMENT (HOPD)

		Medicare Payment by Setting			
	Claim Type	Physician Office ("nonprovider")	HOPD ("provider")	Difference	
Payment to Entity					
Physician Organization	Part B	$494.91	$80.16	–$414.75	–84%
Hospital	Part A	n/a	$1,108.46	$1,108.46	n/a
Total		$494.91	$1,188.62	$693.71	140%
Attribution by Function					
Physician's Professional Service		$80.16	$80.16	$0.00	0%
Technical Component		$414.75	$1,108.46	$693.71	167%
Total		$494.91	$1,188.62	$693.71	140%

TOTAL MEDICARE PAYMENT FOR COMMON OUTPATIENT PROCEDURES: FACILITY FEE OR TECHNICAL COMPONENT (TC) OF GLOBAL FEE

			Medicare Payment by Setting			Reduction From Hospital to Lowest-Cost Setting	
			Facility Fee		TC only		
Service	**Procedure**	**CPT**	**Outpatient Hospital**	**ASC/ Other**	**Physician Office**	**Payment Reduction**	**Percentage Reduction**
Evaluation & Management	Office visit, established patient, Level 4	99214	$102	n/a	$29	$73	71%
Cardiology	Cardiac Rehab	93798	$104	n/a	$11	$93	89%
	Echo	93306	$417	n/a	$167	$250	60%
	Nuclear stress test/TMST	78452	$1,108	n/a	$415	$694	63%
	Pulmonary stress test/simple	94620	$91	n/a	$26	$65	72%
	Stress ECHO	93351	$417	n/a	$188	$228	55%
Gastrointestinal	Diagnostic colonoscopy	45378	$753	$421	$187	$566	75%
Imaging	Bone density/DEXA	77080	$101	$101	$31	$69	69%
	CT abdomen & pelvis w/contrast	74177	$348	$325	$221	$126	36%
	CT abdomen & pelvis w w/o/contrast	74178	$348	$325	$254	$94	27%
	Diagnostic X-ray (hip unilateral 2 views)	73502	$61	$62	$30	$31	50%
	MRI joint lower ext w/o contrast	73721	$274	$153	$169	$121	44%
	Mammogram, screen/yearly	G0202	$100	n/a	$100	$0	0%
	Ultrasound abdomen complete	76700	$154	$159	$83	$70	46%
Orthopedics	Knee arthroscopy/surgery	29881	$2,396	$1,340	n/a	$1,056	44%
	Wrist endoscopy/surgery	29848	$1,455	$814	n/a	$642	44%
Pain Management	Inject foramen epidural l/s	64483	$585	$327	$108	$477	81%
	Inject foramen epidural add-on	64484	$0	$0	$36	$0	0%
	Inject trigger points =/> 3	20553	$224	$35	$21	$203	91%
Physical Therapy	Manual therapy (per 15 minutes)	97140	$30	n/a	$30	$0	0%
	PT evaluation	97001	$76	n/a	$76	$0	0%
	Therapeutic exercises	97110	$33	n/a	$33	$0	0%
Pulmonary	Sleep lab	95810	$856	n/a	$510	$347	40%

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