APPENDIX B: COLORADO MEDICAID PAID CLAIMS ANALYSIS

Appendix B presents the findings from our review of Colorado Medicaid paid claims. We presented this analysis to the Task Force in advance of the first April 20, 2007 meeting. Based on the discussion at the first Task Force meeting and requests from Task Force members to implement select changes to our analysis (e.g., compare paid claims to Medicare instead of physician charges), we updated our analyses and re-issued this report to the Task Force in advance of the May 30, 2007 meeting.

Introduction to the Paid Claims Analysis

To assess provider payment levels under the current fee schedule, we analyzed the claims paid by the Department to Medicaid providers for services rendered during July 1, 2005 to June 30, 2006. We excluded claims related to those recipients who are dually eligible for Medicaid and Medicare (also called Medicare crossover claims).

We studied claims with CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes. Similar to CPT codes, providers use HCPCS codes for billing. HCPCS codes identify medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supplies. We adjusted all claims to account for any Colorado Medicaid or provider adjustments to billed units, charges or reimbursements. We then conducted our analysis without regard to the co-payments or other third-party liability associated with claims.

Colorado Medicare Data

The analysis of the Task Force focused primarily on the comparison of the Medicaid fee schedule to the Medicare fee schedule.[1] The Task Force agreed that provider charges are not a meaningful measure, because providers are free to determine their own charges and there is such variability in charges with no explanation as to why that variability exists. Some Task Force members suggested that provider "costs" be determined and used for a benchmark, however, they concurred that such data is currently not available and would be difficult to collect in any timely manner.

To conduct the comparisons of Medicare and Medicaid fees, we compared Colorado Medicaid claims with the Medicare physician fee schedule after adjusting for:

- Medicare geographic practice cost index for Colorado — To adjust the Medicare RBRVS fee schedule for the regional variation in Medicare reimbursement. For Colorado, the

[1] Analyses compare the allowed charge amount (i.e., the fee schedule) paid by Colorado Medicaid to the allowed charge amount paid by Medicare (i.e., the geographically adjusted Medicare fee).

Medicare geographic practice cost index for 2006 was 1.00 for the Work component, 1.014 for the Practice component and .803 for the Malpractice component.

- 2006 RBRVS conversion factor — To convert the Medicare fees to Federal Fiscal Year 2006 payment levels. For Federal Fiscal Year 2006, the RBRVS conversion factor was 37.8975.
- Changes in American Medical Association CPT codes — To account for those CPT codes that were changed or updated in the 2006 fee schedule.

Analyses

We considered the claims data with regard to CPT and HCPCS codes, provider type, provider specialty and geographic area. The sections that follow present the results of these analyses and key findings.

FINDING #1: Evaluation and Management codes represent the major category of CPT codes by frequency and by overall reimbursement. CPT codes for Surgery represent a small percent of all codes by frequency, but almost one-fourth of all reimbursement. Conversely, Radiology represents a larger percentage of all codes by frequency, but a smaller percentage of codes by reimbursement.

Exhibit B-1: Frequency of CPT Codes by Category[2]

Evaluation and Management CPT codes represent the majority — 44 percent — of all billed services. ***Medicine*** (23 percent) and ***Radiology*** (12 percent) represent the second and third most commonly billed services, respectively.

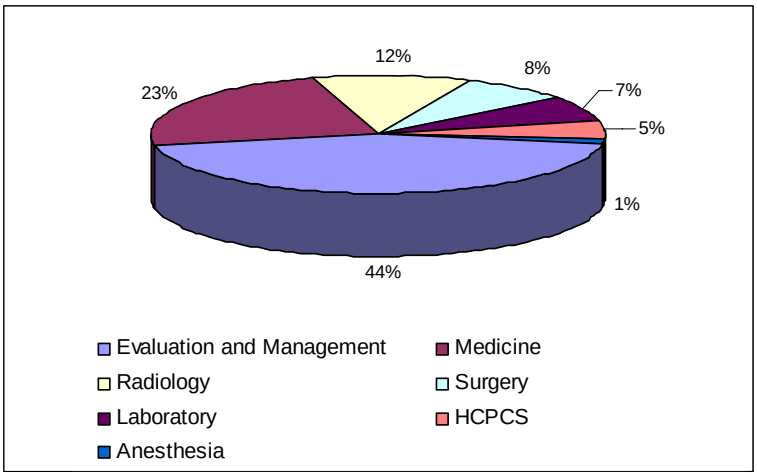
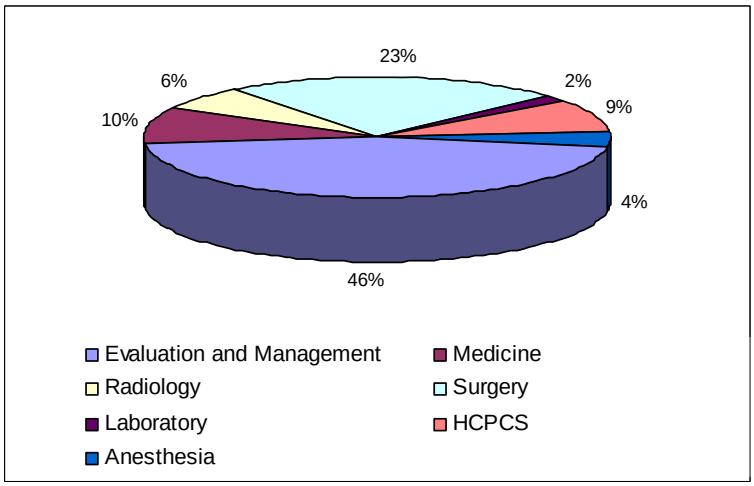


Exhibit B-2: Reimbursement of CPT Codes by Category[3]

The Department spends 46 percent of all physician and other practitioner reimbursement on ***Evaluation and Management*** services. The Department spends 23 percent of reimbursement on ***Surgery*** services, 10 percent on ***Medicine*** and 9 percent on ***HCPCS*** services.



[2] Anesthesia claims represent those anesthesia services that are billed on a CPT code basis. Other anesthesia services that are associated with hospital claims are not included in this analysis.
[3] *Ibid.*

FINDING #2: HCPCS codes and Evaluation and Management codes were reimbursed the highest percent of Medicare fees (76 percent and 74 percent, respectively). Laboratory and Radiology were reimbursed the lowest percentage of Medicare fees (38 percent and 23 percent, respectively).

Exhibit B-3: Medicaid Fees as a Percent of Medicare Fees by CPT Category[4]

CPT Category	Medicaid Fees as a Percent of Medicare[5]
HCPCS	76%
Evaluation and Management	74%
Medicine	52%
Surgery	45%
Laboratory	38%
Radiology	23%

[4] Analysis excludes anesthesia codes because of the different payment methodology used by Medicare.
[5] Analyses do not reflect SFY payment increases to anesthesia, surgery and therapeutic services.

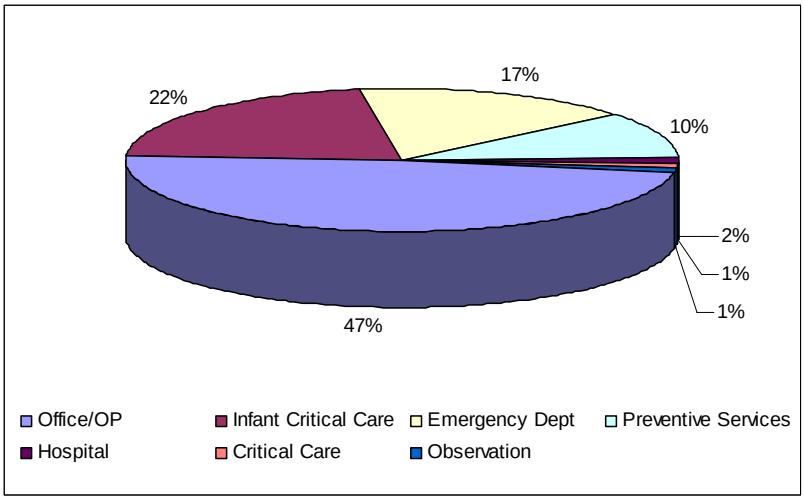
FINDING #3: Outpatient Office Visit codes accounted for nearly half of all Evaluation and Management codes, but a smaller comparative proportion of total reimbursement. Codes related to Infant Critical Care services had a greater proportion of reimbursement than frequency.

Exhibit B-4: Frequency of Evaluation and Management Codes

Outpatient Office (48 percent) codes are the majority of Evaluation and Management codes. ***Emergency Department*** (17 percent) and ***Preventive Services*** (10 percent) were the second largest code categories.

Top Outpatient Office codes include:

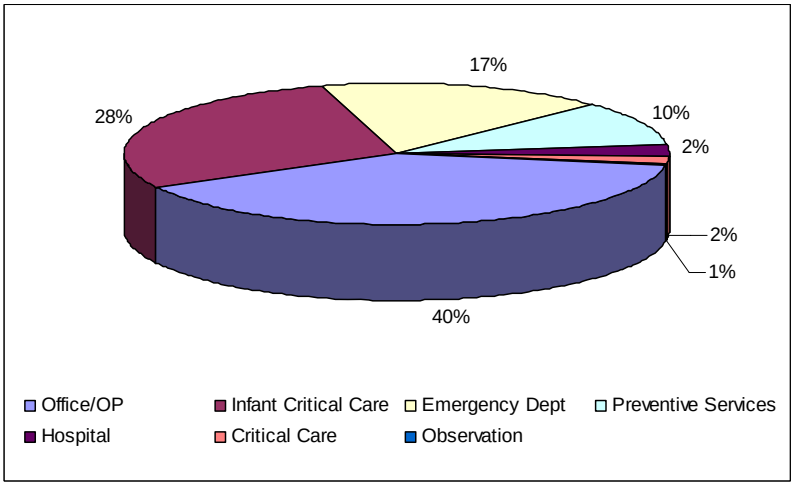
- Office/outpatient visit, new: 99204, 99203, 99201, 99205, 99202
- Office/outpatient visit, established: 99215, 99214, 99213, 99212, 99211



Note: *Infant Critical Care* includes Neonatal Critical Care, Pediatric Critical Care and Low Birth Weight Infant and Observation.

Exhibit B-5: Reimbursement of Evaluation and Management Codes

The Department spends 40 percent of all Evaluation and Management reimbursement for ***Office/Outpatient*** services. ***Infant Critical Care*** and ***Emergency Department*** services represent 28 percent and 17 percent, respectively.



FINDING #4: Within Evaluation and Management codes, Newborn Care and Neonatal Critical Care were reimbursed at the highest percent of Medicare fees. Preventive Services, Critical Care and Observation were reimbursed at the lowest percent of Medicare.

Exhibit B-6: Medicaid Fees as a Percent of Medicare Fees by Type of Evaluation and Management CPT Service

Evaluation and Management Type	Medicaid Fees as a Percent of Medicare
Newborn Care	92%
Neonate Critical Care	89%
Emergency Department	77%
Office/Outpatient	76%
Hospital	74%
Other (Subsequent Hospital Care)	71%
Low Birth Weight Infant	69%
Pediatric Critical Care	67%
Preventive Services	66%
Critical Care	58%
Observation	50%

FINDING #5: There is significant variation in Colorado Medicaid fees in comparison to Colorado Medicare fees; there is also variation in fees in comparison to Colorado Medicare within the same type of services.

We analyzed frequently occurring Medicaid CPT codes and compared the Medicaid fees to the Colorado Medicare fees. Exhibit 7 presents Medicaid fees as a percent of Medicare fees for the top 200 CPT codes for Colorado.

Exhibit B-7:
Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
99213	Office/outpatient visit, est	296,136	41.75	52.68	79%
99214	Office/outpatient visit, est	98,763	65.18	82.62	79%
99283	Emergency dept visit	91,619	47.74	61.77	77%
99284	Emergency dept visit	60,216	73.02	96.26	76%
99212	Office/outpatient visit, est	55,812	29.93	38.66	77%
99391	Prev visit, est, infant	51,951	62.97	79.21	79%
99232	Subsequent hospital care	46,214	41.83	55.71	75%
36415	Routine venipuncture	39,477	3.00	n/a	n/a
92507	Speech/hearing therapy	37,930	56.70	62.91	90%
90669	Pneumococcal vacc, ped <5	37,620	6.50	n/a	n/a
71020	Chest x-ray	37,011	6.72	36.38	18%
90700	Dtap vaccine, < 7 yrs, im	29,439	6.50	n/a	n/a
94760	Measure blood oxygen level	29,150	11.20	2.27	493%
99392	Prev visit, est, age 1-4	28,807	70.53	88.68	80%
99233	Subsequent hospital care	28,433	58.27	79.21	74%
99203	Office/outpatient visit, new	26,935	75.96	97.02	78%
71010	Chest x-ray	26,250	4.03	28.04	14%
97532	Cognitive skills development	25,835	19.74	24.63	80%
99000	Specimen handling	23,608	3.00	n/a	n/a
90713	Poliovirus, ipv, sc/im	23,090	6.50	n/a	n/a
99238	Hospital discharge day	22,539	49.39	70.87	70%
92340	Fitting of spectacles	22,400	16.80	41.31	41%
97112	Neuromuscular reeducation	21,294	10.50	29.18	36%

Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
99285	Emergency dept visit	20,269	115.14	150.45	77%
99211	Office/outpatient visit, est	19,904	12.18	21.60	56%
93010	Electrocardiogram report	19,378	10.64	9.10	117%
99204	Office/outpatient visit, new	18,178	107.41	137.19	78%
99282	Emergency dept visit	16,665	26.07	27.29	96%
90723	Dtap-hep b-ipv vaccine, im	15,330	6.50	n/a	n/a
90707	Mmr vaccine, sc	14,786	6.50	n/a	n/a
99231	Subsequent hospital care	14,665	28.28	34.11	83%
97533	Sensory integration	14,433	41.66	26.15	159%
99215	Office/outpatient visit, est	13,866	94.53	120.14	79%
90658	Flu vaccine age 3 & over, im	13,688	6.50	n/a	n/a
99431	Initial care, normal newborn	13,463	57.06	60.64	94%
90633	Hep a vacc, ped/adol, 2 dose	13,437	6.50	n/a	n/a
97110	Therapeutic exercises	13,433	10.50	28.04	37%
99243	Office consultation	11,780	75.46	122.41	62%
99299	Ic, lbw infant 1500-2500 gm	11,772	91.28	132.64	69%
99202	Office/outpatient visit, new	11,590	43.26	65.18	66%
90657	Flu vaccine, 6-35 mo, im	11,529	6.50	n/a	n/a
59025	Fetal non-stress test	11,429	34.10	41.69	82%
99393	Prev visit, est, age 5-11	10,981	40.15	87.16	46%
70450	Ct head/brain w/o dye	10,968	36.29	233.45	16%
99244	Office consultation	10,731	135.21	172.81	78%
76805	Ob us >/= 14 wks, sngl fetus	10,335	38.64	136.43	28%
90645	Hib vaccine, hboc, im	10,313	6.50	n/a	n/a
92004	Eye exam, new patient	9,396	28.59	129.99	22%
90748	Hep b/hib vaccine, im	9,383	6.50	n/a	n/a
99223	Initial hospital care	8,888	113.29	156.90	72%
99433	Normal newborn care/hospital	8,814	35.50	31.83	112%
90716	Chicken pox vaccine, sc	8,622	6.50	n/a	n/a
36416	Capillary blood draw	8,173	3.00	n/a	n/a
97535	Self care mngment training	7,779	15.76	29.94	53%
90648	Hib vaccine, prp-t, im	7,759	6.50	n/a	n/a
76815	Ob us, limited, fetus(s)	7,539	23.18	91.33	25%
93325	Doppler color flow add-on	7,529	37.52	122.41	31%
59400	Obstetrical care	7,214	1168.38	1629.97	72%

Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
76811	Ob us, detailed, sngl fetus	6,716	69.35	251.26	28%
93320	Doppler echo exam, heart	6,710	62.44	89.82	70%
99291	Critical care, first hour	6,617	149.32	256.57	58%
76817	Transvaginal us, obstetric	6,602	26.81	99.67	27%
99381	Prev visit, new, infant	6,406	55.05	104.22	53%
90647	Hib vaccine, prp-omp, im	6,339	6.50	n/a	n/a
72193	Ct pelvis w/dye	6,338	58.46	334.63	17%
99222	Initial hospital care	6,326	88.37	112.56	79%
74160	Ct abdomen w/dye	6,190	67.20	340.70	20%
99394	Prev visit, est, age 12-17	6,148	40.15	96.64	42%
92014	Eye exam & treatment	6,110	28.00	96.64	29%
97140	Manual therapy	5,983	12.60	26.15	48%
74000	X-ray exam of abdomen	5,864	4.03	29.94	13%
76830	Transvaginal us, non-ob	5,836	33.60	97.40	34%
76816	Ob us, follow-up, per fetus	5,517	52.28	90.20	58%
59409	Obstetrical care	5,503	708.72	812.90	87%
99242	Office consultation	5,484	58.16	91.71	63%
92526	Oral function therapy	5,430	23.10	84.51	27%
94640	Airway inhalation treatment	5,406	12.60	12.13	104%
99239	Hospital discharge day	5,391	67.56	96.64	70%
73630	X-ray exam of foot	5,255	3.36	29.94	11%
99296	Neonate critical care subseq	5,250	428.01	410.43	104%
73610	X-ray exam of ankle	5,045	4.03	29.94	13%
92567	Tympanometry	4,898	8.68	21.98	39%
54150	Circumcision	4,866	38.11	241.03	16%
90744	Hepb vacc ped/adol 3 dose im	4,840	6.50	n/a	n/a
97530	Therapeutic activities	4,628	21.00	29.18	72%
99294	Ped critical care, subseq	4,533	275.60	409.29	67%
76801	Ob us < 14 wks, single fetus	4,368	35.41	136.43	26%
11721	Debride nail, 6 or more	4,351	32.09	39.41	81%
59514	Cesarean delivery only	4,214	166.15	959.19	17%
73130	X-ray exam of hand	4,185	3.36	29.94	11%
99173	Visual acuity screen	4,182	10.08	n/a	n/a
99309	Nursing fac care, subseq	4,119	46.73	79.58	59%
99205	Office/outpatient visit, new	4,112	124.54	174.33	71%
99245	Office consultation	4,096	142.69	223.60	64%

Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
73110	X-ray exam of wrist	4,053	4.03	29.94	13%
99201	Office/outpatient visit, new	3,965	24.78	36.76	67%
99254	Initial inpatient consult	3,791	106.65	141.74	75%
99395	Prev visit, est, age 18-39	3,646	40.15	97.78	41%
93307	Echo exam of heart	3,558	49.00	205.03	24%
99354	Prolonged service, office	3,440	43.09	99.29	43%
76705	Echo exam of abdomen	3,426	20.90	87.54	24%
93000	Electrocardiogram, complete	3,420	21.28	26.91	79%
74150	Ct abdomen w/o dye	3,383	43.68	289.16	15%
95117	Immunotherapy injections	3,237	12.35	19.71	63%
72192	Ct pelvis w/o dye	3,151	36.29	294.08	12%
76856	Us exam, pelvic, complete	3,079	35.62	97.40	37%
93303	Echo transthoracic	3,078	60.84	224.73	27%
99308	Nursing fac care, subseq	3,016	38.22	56.47	68%
76818	Fetal biophys profile w/nst	2,978	30.24	121.27	25%
99382	Prev visit, new, age 1-4	2,968	55.05	112.18	49%
73090	X-ray exam of forearm	2,928	4.03	28.80	14%
99298	Ic for lbw infant < 1500 gm	2,878	100.66	145.15	69%
72100	X-ray exam of lower spine	2,869	8.06	38.28	21%
99253	Initial inpatient consult	2,844	77.56	98.53	79%
94010	Breathing capacity test	2,827	30.80	32.97	93%
71260	Ct thorax w/dye	2,816	58.46	347.90	17%
76700	Us exam, abdom, complete	2,793	35.62	121.65	29%
74022	X-ray exam series, abdomen	2,726	9.41	45.86	21%
76092	Mammogram, screening	2,673	13.44	85.65	16%
73140	X-ray exam of finger(s)	2,640	3.36	23.50	14%
76770	Us exam abdo back wall, comp	2,597	35.62	117.48	30%
99383	Prev visit, new, age 5-11	2,586	55.05	109.90	50%
73590	X-ray exam of lower leg	2,509	5.38	29.56	18%
73562	X-ray exam of knee, 3	2,506	5.38	32.59	17%
73030	X-ray exam of shoulder	2,456	5.38	32.59	17%
69436	Create eardrum opening	2,449	133.72	168.26	79%
72170	X-ray exam of pelvis	2,415	6.72	29.56	23%
69210	Remove impacted ear wax	2,377	20.06	48.89	41%
92065	Orthoptic/pleoptic training	2,363	28.00	34.87	80%
99384	Prev visit, new, age 12-17	2,283	55.05	119.38	46%

Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
99255	Initial inpatient consult	2,282	144.68	195.17	74%
20610	Drain/inject, joint/bursa	2,266	48.81	69.73	70%
58300	Insert intrauterine device	2,239	50.15	96.64	52%
12001	Repair superficial wound(s)	2,219	33.43	145.53	23%
70553	Mri brain w/o & w/dye	2,194	83.06	1121.01	7%
17000	Destroy benign/premlg lesion	2,060	46.13	61.02	76%
12011	Repair superficial wound(s)	2,033	40.12	153.86	26%
73080	X-ray exam of elbow	1,981	4.03	32.21	13%
59410	Obstetrical care	1,972	773.57	909.16	85%
92551	Pure tone hearing test, air	1,942	10.64	n/a	n/a
99221	Initial hospital care	1,937	54.35	67.84	80%
93971	Extremity study	1,922	15.51	23.88	65%
99217	Observation care discharge	1,916	37.49	70.87	53%
95115	Immunotherapy, one injection	1,871	8.93	15.54	57%
90718	Td vaccine > 7, im	1,860	6.50	n/a	n/a
72040	X-ray exam of neck spine	1,835	6.72	35.62	19%
64450	N block, other peripheral	1,810	16.72	99.67	17%
59510	Cesarean delivery	1,804	1402.39	1847.12	76%
99219	Observation care	1,778	79.24	111.80	71%
73560	X-ray exam of knee, 1 or 2	1,760	4.03	29.56	14%
92506	Speech/hearing evaluation	1,754	30.88	133.40	23%
43235	Uppr gi endoscopy, diagnosis	1,726	140.41	295.60	48%
97035	Ultrasound therapy	1,719	8.40	12.13	69%
99310	Nursing fac care, subseq	1,691	60.73	99.67	61%
99300	Ic, infant pbw 2501-5000 gm	1,690	133.03	127.71	104%
72148	Mri lumbar spine w/o dye	1,659	67.87	576.04	12%
99436	Attendance, birth	1,618	80.58	76.55	105%
73510	X-ray exam of hip	1,541	6.72	34.11	20%
73564	X-ray exam, knee, 4 or more	1,538	5.38	36.38	15%
94761	Measure blood oxygen level	1,514	16.80	4.55	369%
90715	Tdap vaccine >7 im	1,502	6.50	n/a	n/a
70551	Mri brain w/o dye	1,501	84.00	526.40	16%
73550	X-ray exam of thigh	1,481	5.38	32.21	17%
57454	Bx/curett of cervix w/scope	1,473	105.30	159.93	66%
74020	X-ray exam of abdomen	1,468	9.41	39.03	24%
73620	X-ray exam of foot	1,432	2.69	27.67	10%

Exhibit B-7: Top 200 CPT Codes by Number of Line Items: Medicaid Fees as a Percent of Medicare Fees, Continued

CPT Code	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
92552	Pure tone audiometry, air	1,413	10.64	18.19	58%
70486	Ct maxillofacial w/o dye	1,403	36.29	248.23	15%
76819	Fetal biophys profil w/o nst	1,367	24.06	105.73	23%
95819	Eeg, awake and asleep	1,364	26.07	60.26	43%
72125	Ct neck spine w/o dye	1,363	36.29	297.50	12%
76645	Us exam, breast(s)	1,363	40.32	70.11	58%
90935	Hemodialysis, one evaluation	1,359	149.52	73.14	204%
90818	Psytx, hosp, 45-50 min	1,355	60.64	99.29	61%
99435	Newborn discharge day hosp	1,335	80.75	81.48	99%
95004	Percut allergy skin tests	1,331	183.68	4.17	4405%
43239	Upper GI endoscopy, biopsy	1,314	20.06	335.77	6%
97001	Pt evaluation	1,309	33.60	75.80	44%
59426	Antepartum care only	1,300	403.83	663.96	61%
99295	Neonate crit care, initial	1,294	511.00	942.13	54%
99218	Observation care	1,283	19.60	67.08	29%
92012	Eye exam established pat	1,282	19.60	65.56	30%
62270	Spinal fluid tap, diagnostic	1,273	33.43	160.69	21%
73070	X-ray exam of elbow	1,264	3.36	28.42	12%
73721	Mri jnt of lwr extre w/o dye	1,247	47.71	513.13	9%
72050	X-ray exam of neck spine	1,245	13.44	51.92	26%
73100	X-ray exam of wrist	1,244	2.69	27.67	10%
71275	Ct angiography, chest	1,240	46.23	588.93	8%
76083	Computer mammogram add-on	1,227	2.15	19.71	11%
99281	Emergency dept visit	1,220	16.91	16.67	101%
99252	Initial inpatient consult	1,216	58.69	72.01	82%
92557	Comprehensive hearing test	1,207	28.00	49.27	57%
99234	Observ/hosp same date	1,185	83.10	135.29	61%
99241	Office consultation	1,184	36.99	50.40	73%
90734	Meningococcal vaccine, im	1,149	6.50	n/a	n/a
59425	Antepartum care only	1,141	234.68	378.22	62%
76506	Echo exam of head	1,138	40.32	92.09	44%
90655	Flu vaccine no preserv 6-35m	1,133	6.50	n/a	n/a
17003	Destroy lesions, 2-14	1,127	10.70	10.23	105%
99220	Observation care	1,127	58.80	157.27	37%

We also compared Medicaid fees as a percent of Medicare fees for selected codes identified by the Task Force as important. These are fees for codes that fall within the same type of CPT; the Task Force wanted to be able to compare new patient visits with established patient visits. Exhibit 8 provides a comparison of the Colorado Medicaid allowed amount to the Medicare allowed amount adjusted for Colorado for infants and children for new and established patient visits.

Exhibit B-8:
Selected CPT Codes: Medicaid Fees as a Percent of Medicare Fees

CPT Code[6]	CPT Description	Line Items	Medicaid Fee Schedule Allowed Amount	Colorado-specific Medicare Fee Schedule Allowed Amount	Medicaid Fee as a Percent of Colorado-specific Medicare Fee
99381	Prev visit, new, infant	6,406	55.05	104.22	53%
99382	Prev visit, new, age 1-4	2,968	55.05	112.18	49%
99383	Prev visit, new, age 5-11	2,586	55.05	109.90	50%
99384	Prev visit, new, age 12-17	2,283	55.05	119.38	46%
99385	Prev visit, new, age 18-39	745	55.05	119.38	46%
99386	Prev visit, new, age 40-64	172	55.05	140.60	39%
99387	Prev visit, new, 65 & over	28	55.05	152.35	36%
99391	Prev visit, est, infant	51,951	62.97	79.21	80%
99392	Prev visit, est, age 1-4	28,807	70.53	88.68	80%
99393	Prev visit, est, age 5-11	10,981	40.15	87.16	46%
99394	Prev visit, est, age 12-17	6,148	40.15	96.64	42%
99395	Prev visit, est, age 18-39	3,646	40.15	97.78	41%
99396	Prev visit, est, age 40-64	941	40.15	108.01	37%
99397	Prev visit, est, 65 & over	59	40.15	119.00	34%

[6] CPT codes and descriptions are a copyright of the American Medical Association, 2006.

FINDING #6: Medicaid fees as a percent of Medicare fees also vary by specialty.

We also compared Medicaid fees as a percent of Medicare fees by specialty. Exhibit 9 groups 61 provider specialties into 13 categories and shows, for each category, Medicaid fees as a percent of Medicare fees.

Exhibit B-9:
Medicaid Fees as a Percent of Medicare Fees[7] for Categories of Provider Specialties[8,9]

Provider Category	Provider Specialties	Percent of Line Items[10]	Medicaid Fees as a Percent of Colorado-specific Medicare Fees[11]
Behavioral Health	Child Psychiatry Neuropsychology Psychiatry	>1%	71%
Pediatrics	Children's Hearing Aid Program Health Care Program for Special Needs Children Neonatologist Pediatrics	17%	71%
Family Practice	Family Practice	14%	70%
Non-physician practitioner	Pediatric Nurse Practitioner Nurse Practitioner OB/GYN (Midwife) Indirect Pay (Incident to a Physician) Direct Pay (Not Incident to a Physician)	11%	64%
OB/GYN	Gynecology Obstetrics Obstetrics and Gynecology Perinatology	5%	61%
Other Specialty	Hematology Neoplastic Diseases Oncology	1%	58%

[7] Analysis includes only those CPT codes that are reimbursed by both Colorado Medicaid and Medicare; CPT codes not reimbursed by Medicare were excluded from analysis.
[8] As self-reported by providers on claims submissions. The accuracy of the provider specialty is subject to the billing provider's claim entry.
[9] Analysis excludes anesthesia codes because of the different payment methodology used by Medicare.
[10] Analysis excludes approximately 13 percent of total line items because no provider specialty was designated.
[11] Fees adjusted to Colorado geographic practice cost index.

Exhibit B-9:
Medicaid Fees as a Percent of Medicare Fees for Categories of Provider Specialties, Continued

Provider Category	Provider Specialties	Percent of Line Items	Medicaid Fees as a Percent of Colorado-specific Medicare Fees
General Medicine	Allergy Allergy, Pediatric Dermatology Emergency Services Endocrinology Free Standing Clinics Gastroenterology General Practice Geriatrics Immunology Infectious Diseases Internal Medicine Nephrology Neurology Neurology, Pediatric Nuclear Medicine Otolaryngology Peripheral, Vascular Physiatrist Physical Medicine and Rehabilitation Podiatry Preventive Medicine Proctology Public Health Clinic Pulmonary Medicine Rheumatology Urology	20%	57%
Vision Services	Ophthalmology Optometry	2%	52%
Cardiac Specialty	Cardiology, Pediatric Cardiovascular Disease Cardiovascular Surgery	1%	48%
Pathology	Pathology Pathology, Clinical Pathology, Forensic	1%	38%

Exhibit B-9:
Medicaid Fees as a Percent of Medicare Fees for Categories of Provider Specialties, Continued

Provider Category	Provider Specialties	Percent of Line Items	Medicaid Fees as a Percent of Colorado-specific Medicare Fees
Surgery	Colon and Rectal Surgery General Surgery Hand Surgery Neurological Surgery Orthopedic Surgery Orthopedics Plastic Surgery Surgery, Head and Neck Surgery, Oral and Maxillofacial Surgery, Pediatric Surgery, Traumatic Surgery, Urology Thoracic Surgery	3%	31%
Radiology	Radiology	11%	19%

This Exhibit shows that for SFY 2005, there is significant variation across provider specialty in reference to the percent of the Medicare fee schedule that is paid to a specialty.

The Task Force noted a concern that some physicians who may have low Medicaid fees in comparison to Medicare fees do not make a choice in their decisions to participate in the Medicaid program. Hospital-based physicians, such as radiologists, anesthesiologists and pathologists are on staff at hospitals, and provide services to anyone that has been admitted to the hospital. Unlike many of their physician peers, who may choose to not participate in the Medicaid program if fee schedules are viewed as too low, these physicians have no choice in accepting Medicaid patients.

Paid Claims Analysis Summary

In summary, we present the following findings regarding shortfalls and disparities for the Medicaid reimbursement analysis:

- There are pronounced differences in fees among the different *types* of CPT codes. Fees for medical, surgical and diagnostic services and procedures; durable medical equipment; orthotics; prosthetics and medical supplies billed with HCPCS (Healthcare Common Procedure Coding System) codes for example, are 76 percent of Medicare fees, while fees for surgery and radiology codes are 45 percent and 23 percent, respectively, of Medicare fees.

- Evaluation and Management services represent the majority of services with regard to frequency (i.e., number of services) and total payment. Evaluation and Management codes are reimbursed among the highest percent of Medicare of all codes, however, the reimbursement is still only 76 percent of Medicare reimbursement.

- Disparities exist within types of Evaluation and Management codes. The fees for the Observation and Critical Care code types, for example, are 50 percent and 58 percent, respectively, of the Medicare fee schedule. Fees for other Evaluation and Management services that are related to newborn care are higher, e.g., fees for newborn care and neonatal critical care are 92 and 89 percent of Medicare fees, respectively.

- Some differences occur on a code-by-code basis. For example, among some preventive visits (90000-series CPT codes[12]), the fees for established visits are generally higher as a percent of Medicare fees than the fees for new visits.

- The Medicare and Medicaid fee schedule differential affects specialties differently. Some providers are paid in aggregate at a higher percent of Medicare fees (Behavioral Health at 71 percent, Pediatrics at 71 percent, Family Practice at 70 percent), while others are paid in aggregate at a lower percentage (Pathology at 38 percent, Surgery at 31 percent, Radiology at 29 percent).

While some of the results presented above are mitigated by recent rate increases (i.e., SFY 2008 rate increases for all anesthesia and surgery services, therapeutic services, immunizations, DME repair and Paraguard contraceptive services as described in Table 1), these analyses still demonstrate shortfalls and disparities among the Colorado Medicaid physician fee schedule. Many of the disparities are the result of targeted fee increases, as opposed to systematic conversion factor updates or changes. The Department attributes the shortfalls to the constraints of the State budget.

[12] I.e., there are discrete CPT codes for preventive visits by age: infant, age 1-4, age 5-11, age 12-17, age 18-39. For each age, there are CPT codes to distinguish a new visit from an established patient visit.