Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers

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Inspector General

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EXECUTIVE SUMMARY

OBJECTIVE

To determine to what extent Medicare payments for the same procedure codes continue to vary between hospital outpatient departments and ambulatory surgical centers and to assess the effect of this variance on the Medicare program.

BACKGROUND

The Medicare program most frequently pays for services provided to beneficiaries in the following ambulatory settings: hospital outpatient departments (OPDs), ambulatory surgical centers (ASCs) and physician offices. Different regulations and statutes govern the methods for calculating reimbursement for each ambulatory setting.

The Office of Inspector General (OIG) issued reports in 1991 documenting that Medicare paid more for services in OPDs than for the same procedure codes provided in ASCs. In response to OIG recommendations, the Centers for Medicare & Medicaid Services (CMS) concluded that establishing uniform rates would guarantee that payment rates reflect only those costs necessary to deliver care regardless of the setting.

We selected 453 procedure codes that CMS listed as ASC-approved procedures, which represent approximately 95 percent of all ASC-approved services in all settings in 1999. We compared the 2001 facility expense for 424 different procedure codes.

FINDINGS

Variation between ASC and OPD rates continues and results in an estimated $1.1 billion in additional program payments

Despite attempts to bring OPD and ASC payments more in line, variation between these rates continues. In 66 percent of the procedure codes examined, outpatient department rates are higher than ambulatory surgical center rates. The median difference was $282.33. For the remaining 145 procedure codes, Medicare reimbursed ASCs more. As a result of paying higher rates, Medicare paid an estimated $1.1 billion more for services provided in settings with higher reimbursement. Not only do the rates vary, but there is

concern that the rates themselves do not reflect accurate costs for performing the procedures.

Failure to remove certain procedure codes from the ASC list of covered procedures resulted in an estimated $8 to $14 million in additional program payments

Currently, CMS regulations require that the ASC list of covered procedures not include procedures that are commonly performed or that may be safely performed in physicians' offices. Contrary to regulations, CMS has failed to remove certain procedure codes from the list of ASC-covered procedures. Using CMS's established criteria, 72 procedure codes should have been removed from the ASC-covered services list. As a result of not removing these procedure codes, Medicare spent approximately $8 to $14 million more for services performed in ASCs as opposed to OPDs or physician offices, respectively.

RECOMMENDATIONS

We believe that Congress intended Medicare to be a prudent purchaser of services and only to pay for those costs that are necessary for the efficient delivery of needed health services. Our analysis of payment systems shows that reimbursement disparities result in an estimated $1.1 billion in additional Medicare program payments. Furthermore, failure to remove certain procedure codes from the list of ASC-approved procedures resulted in an estimated $8 to $14 million in additional Medicare program payments.

We reiterate previous OIG recommendations, with which CMS concurred, that there should be greater parity of payments for services performed in an outpatient setting and those performed in ASCs. These recommendations are consistent with the Medicare Payment Advisory Commission's position that all else being equal, Medicare payment should be based on the service, and not the setting. To safeguard the Medicare program from excessive payments, we recommend that CMS:

- seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services,
- conduct and use timely ASC-survey data to reevaluate ASC-payment rates, and
- remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.

AGENCY COMMENTS

We received comments from the Centers for Medicare & Medicaid Services. The CMS neither concurred nor non-concurred with our recommendations. The complete text of CMS's comments can be found in Appendix E.

The CMS commented that it would be valuable if we included an explicit acknowledgment that the three payment systems (outpatient prospective payment system, ASC fee schedule, and physician fee schedule) arise from different sections of the statute. We recognize that different statutory authorities mandate how CMS reimburses OPDs, ASCs, and physicians. Our recommendation recognizes that CMS needs additional authority because the payment systems have evolved over time from different laws enacted by Congress. We continue to urge CMS to seek the authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services.

The CMS stated that they have not conducted ASC surveys in some time due to competing priorities. They also note that the endeavor is quite difficult and poses a significant burden on ASCs. The CMS stated that it is now considering how best to proceed. We recognize the difficulty in developing and conducting a survey of costs in ASCs. However, we also recognize that operating a program where 2001 Medicare reimbursement was $1.6 billion, based on data that is more than 15 years old, does little to manage appropriately the ASC-payment system. We urge CMS to conduct and use timely ASC-survey data to reevaluate ASC-payment rates.

In addition, CMS agrees that some procedures should be removed from the ASC-approved procedures list. The CMS states that they expect to complete the final rule regarding addition and deletions to the list of ASC-covered procedures. We understand that CMS is currently planning to issue parts of the June 1998 proposed regulations dealing with additions and deletions to the list of covered services. Our review of the draft final regulation circulating within the Department reveals that only 6 of the 72 procedure codes that we recommended are scheduled for deletion. Consequently, procedure codes meeting CMS's criteria for removal from the ASC-covered procedure list will continue to be reimbursed as ASC-covered procedures resulting in higher program payments.

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I N T R O D U C T I O N

OBJECTIVE

To determine to what extent Medicare payments for the same procedure codes continue to vary between hospital outpatient departments and ambulatory surgical centers and to assess the effect of this variance on the Medicare program.

BACKGROUND

The Medicare program covers hospital outpatient department (OPD) services, ambulatory surgical center (ASC) services and physician office services under the Medicare Supplementary Medical Insurance Program. How Medicare reimburses for services in these settings varies and has evolved over time.

Office of Inspector General Work

In the early 1990s, the Office of Inspector General (OIG) began examining how Medicare payments for services in ASCs and OPDs compared. In February and June 1991, OIG released two reports, which documented that Medicare paid more for services in OPDs than for the same services provided in ASCs.

In the February 1991 report, OIG examined payment for surgical services performed in OPDs as compared with payment for similar services paid in ASCs. The services examined were furnished in calendar year (CY) 1988. The study found that if Medicare had limited its reimbursement for these services to the ASC rates, OPD payments could have been reduced by $89 million.[1]

In the June 1991 report, OIG examined three high-volume procedures. They examined services provided in the first quarter of CY 1988 from the 10 states with the highest number of ASCs. The analysis included surgeons' fees, facility fees, preoperative and postoperative office visits and intraocular lens fees, when appropriate. The study found that Medicare payments to OPDs exceeded payments to ASCs by 26 to 74 percent, depending on the procedure.[2]

[1] A-14-89-00221, *Medicare Reimbursement for Hospital Outpatient Department Services*, February 1991

[2] OEI-09-88-01003, *Reimbursement for Outpatient Facility Services*, June 1991

Both reports made similar recommendations that directed the Centers for Medicare & Medicaid Services (CMS) to seek parity in the rates paid to OPDs and ASCs. For the fiscal year 1992 budget, the President's budget request proposed that prospective rates for OPDs and ASCs be set at the lower of the OPD rate or the ASC rate. More recently, CMS stated that "establishing uniform rates will guarantee that payment rates reflect only the costs necessary to efficiently deliver a Medicare service regardless of service setting."[3] To achieve this result, CMS planned to examine the differences across sites to develop recommendations for legislative change. The CMS has contracted with an outside organization to perform this analysis.

Medicare Reimbursement Policy

The Medicare program most frequently pays for services provided to beneficiaries in the following ambulatory settings: hospital OPDs, ASCs and physician offices. In 2001, Medicare reimbursement for outpatient services and ASC services was $17.7 billion and $1.6 billion, respectively. A number of factors have the potential to influence where a patient receives their care, including the patient's medical diagnosis, the availability of different settings, ownership interests, a physician's admitting privileges, and payment.

Except the physician's office, two claims are submitted when a service is provided in an ambulatory setting. One claim represents the physician's service in providing the procedure, and the other claim represents the services provided by the facility for the provision of the procedure. When a procedure is provided in a physician's office, the physician submits a single claim that includes both professional and facility services.

Hospital Outpatient Departments. Medicare historically reimbursed hospital OPDs for services using a facility fee, based on the lesser of costs or charges. For ASC-covered procedures, Medicare reimbursed hospitals using either the lesser of costs or charges, or a blend of the hospital's costs or charges and the ASC payment rate. The intent of the blended rate was to bring OPD rates more in line with ASC rates. In 1991, Congress set the blended rate to 58 percent of the lower of the hospital's costs or charges and 42 percent of the ASC rate.

Hospitals were required to file annual cost reports, which included all overhead and operating costs associated with operating the hospital. The CMS used these reports to reconcile the hospitals' actual service costs with the interim payments CMS made to hospitals throughout the year.

In the Balanced Budget Act of 1997, Congress required that CMS implement an outpatient prospective payment system (PPS). Congress required that CMS use 1996

[3] *Review of the Health Care Financing Administration's Development of Medicare's Prospective Payment System for Hospital ~~Outpatient D~~epartment Services* (A-14-98-00400)

claims data along with the most recent available cost report to determine the outpatient PPS.

In August 2000, CMS implemented a PPS for hospital outpatient services. The new PPS for outpatient procedures classifies services into a number of payment groups based on time, type of service, organ system involved, and the cost of performing the service. For each group, CMS assigned a payment weight based on the median cost (operating and capital) of the services included in that group. To determine the median cost, CMS used settled but not audited cost reports.

The payment that a hospital receives for a service is the product of this payment weight, a dollar-based conversion factor, and a geographic adjustment factor to account for area labor cost differences. Currently, CMS bases the payment weight on outpatient claims that hospitals filed under the previous cost-based system. In 2003, the payment weight will be based on the first year of outpatient PPS claims history.

Ambulatory Surgical Centers. In 1980, recognizing that some surgical procedures provided on an inpatient basis could be safely performed in less intensive and less costly settings, the Medicare program began covering services provided in ASCs. The ASCs operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization. A facility must have an agreement with CMS to participate as an ASC in Medicare.

There are approximately 2,500 Medicare-approved procedures that Medicare can reimburse when performed in an ASC. This list includes those procedures that can be performed safely and less costly in an ASC than in an inpatient setting. In addition, CMS regulations require that the ASC list of covered procedures not include procedures that are commonly performed or that may be safely performed in physicians' offices. This prohibition was intended to discourage the shift of services from physician offices to ASCs.

Congress required that the fee paid to ASCs equal 80 percent of the standard overhead amount established by the Secretary based on an estimate of a fair fee. The fair fee takes into account costs incurred by ASCs in providing services as determined by a survey of the actual audited costs. Congress required that CMS conduct these surveys every five years.

The CMS assigns each procedure to one of eight payment groups. Currently, reimbursement for each group is calculated from cost and charge data obtained from 295 ASCs in 1986. The same adjusted amount applies to all procedures designated within a single payment group.

In June 1998, CMS issued a proposed notice in the *Federal Register*, which would have implemented a PPS for ASCs. To date, CMS has not issued the proposed notice in final.

The Benefits Improvement and Protection Act (BIPA) of 2000 delayed implementation of an ASC prospective payment system before January 1, 2002. The BIPA also required that CMS use 1999 or later cost survey data in the ASC prospective payment system. The CMS is continuing to work with the ASC industry to develop payment groupings that address the needs of both industry and the Medicare program.

Physician Office. Beginning in 1992, reimbursement for physician office procedures uses a fee schedule based on three factors: the physician's work in providing services, their malpractice expense, and a practice expense. A relative value unit (RVU) was assigned to each factor depending upon the service being provided. The sum of these RVUs is then multiplied by a geographic factor and a conversion factor to maintain budget neutrality (changes resulting in increases in one RVU were balanced by decreases in another RVU).

METHODOLOGY

Identification of Procedure Codes for Analysis

For our analysis, we selected 453 procedure codes that CMS listed as ASC-approved procedures in 1999. These procedure codes were used a minimum of 1,000 times in any one of the following three settings: physician office, hospital OPDs, and ASCs. These procedure codes represent 95 percent of the volume of all ASC-approved services in all settings in 1999. Because of the deletion of procedure codes, the number of procedure codes examined in 2001 was 424. (See Appendix A for the list of procedure codes along with OPD and ASC rates.)

Practice or Facility Expense Comparison

Medicare payments for ambulatory care generally consist of two separate parts: a payment to the facility for furnished services and supplies, and a payment to the practitioner for related professional services. Payments to hospital OPDs and ASCs cover only facility costs. Physician and other professional costs are paid separately. Meanwhile, the "facility" payment under the physician fee schedule is considered to be the practice expense component of the fee schedule, which represents the costs of operating an office-based practice.

To determine whether variation exists between ASCs and OPDs, we compared the reimbursement for the facility expense for these settings for 2001. For OPDs, we used the Hospital Outpatient Prospective Payment rates for 2001. For ASCs, we used the facility payment published in the *Federal Register* for the ASC group in which the procedure code fell for 2001. We used only the base amounts without geographic adjustments for all comparisons.

To determine whether certain procedure codes should have been removed from the ASC list of covered services, we used CMS's criteria for removing procedure codes from the ASC-covered list. The CMS's criteria for removing ASC-approved procedures uses site-of-service volume. For a procedure code to be deleted, the inpatient, outpatient, and ASC site of service volumes need to be less than 46 percent of the procedure's total volume, and the procedure needs to be performed more than 50 percent of the time in a physician's office. We used site-of-service volume data from CY 1999.

After determining which procedure codes met CMS's criteria, we determined what the potential effect would be on Medicare reimbursement for 2001. To accomplish this, we developed two scenarios. The first scenario assumed that all the services related to the procedure codes identified for removal from the ASC list were performed in an OPD instead of an ASC. In this case, we compared the Hospital Outpatient Prospective Payment rates for 2001 to the ASC rates for 2001 to determine the effect.

In the second scenario, we assumed that all the services related to the procedure codes identified for removal from the ASC list were performed in a physician's office instead of an ASC. In this case, we compared the full 2001 physician's fee schedule amount to the 2001 ASC rates.

We did not evaluate the quality of care provided in these settings nor any concerns about access to care. Because of previous OIG work examining difference in rates between ASCs and OPDs, we limited our comparison to these two settings and did not compare these rates to the physician office fee schedule.

We reviewed previous OIG reports as well as reports issued by the Medicare Payment Advisory Commission. In addition, we reviewed all applicable statutes, regulations, and *Federal Register* notices.

We conducted this inspection in accordance with the *Quality Standards for Inspections*, issued by the President's Council on Integrity and Efficiency.

FINDINGS

We compared the payment rates between ASCs and OPDs for 424 different procedure codes for 2001. Volume for these procedure codes represented approximately 95 percent of all ASC-approved services. We found that variation between ASC and OPD rates continues, resulting in an estimated $1.1 billion in additional Medicare program payments. Furthermore, failure to remove certain procedure codes from the list of ASC-approved procedures resulted in an estimated $8 to $14 million in additional payments.

Variation between ASC and OPD rates continues and results in higher program payments

Despite attempts by the Congress and CMS to bring OPD and ASC payments more in line, variation between these rates continues. Congress attempted to bring payments to hospitals more in line by changing how Medicare reimbursed hospitals for outpatient services. In addition to congressional action, CMS concurred with a number of OIG recommendations to achieve parity between ASC and OPD rates.

OPD rates exceed ASC rates two-thirds of the time

For 66 percent (279) of the procedure codes that we examined, CMS reimbursed an OPD more than if the same service is provided in an ASC. For these procedure codes, the median difference was $282.33. The range of difference was $4.07 to $1,383.18. Four procedure codes differed by more than 200 percent.

For the remaining 34 percent (145) of the procedure codes, CMS reimbursed an ASC more than an OPD. The median difference between ASC and OPD rates was $135.78 with a range of $3.18 to $410.39. For 12 procedure codes, the difference between ASC and OPD rates was 200 percent or more. (See Appendix B for more information on the percent differences between OPD and ASC rates.)

Medicare paid an estimated $1.1 billion more for services provided in settings with the higher reimbursement

For those procedure codes where CMS reimbursed OPDs at a higher rate than ASCs, the Medicare program could have saved an estimated $1 billion if the lower ASC rate had been used. Almost 32 percent of the estimated savings comes from just one procedure code (66984 - cataract surgery with intraocular lens insertion). Under the hospital outpatient prospective payment system, CMS reimbursed hospitals $1,333.89 for procedure code 66984, while CMS reimbursement for the same procedure code is $949 in ASCs. The volume of services is almost evenly split, with hospital outpatient

departments providing approximately 844,000 services and ASCs providing 802,000 services.

For the 34 percent of procedure codes where Medicare paid ASCs more, an additional $100 million in estimated savings could have been realized, if CMS had used the lower outpatient prospective rates instead of the higher ASC rates. Forty-five percent of this estimated savings comes from one procedure code (66821 - after cataract laser surgery). An ASC received $433 for this service, while a hospital outpatient department received $245.67. For this procedure code, nearly twice as many services (235,085) occurred in ASCs than in hospital outpatient departments (122,072).

To facilitate analysis of the data, we classified the 424 procedure codes using the Berenson-Eggers Type of Service (BETOS) classification. The CMS developed the BETOS system to analyze the growth in Medicare expenditures. An examination of the potential savings by BETOS groupings revealed that nearly half the savings was in the eye procedure group. This grouping of procedure codes contained approximately $466 million in additional payments, of which cataract procedures represent $330 million. Another $233 million can be found in the BETOS group for endoscopies. (See Table 1 and Appendix C for additional information on savings by BETOS groupings.)

Table 1 **Savings by BETOS Categories**

# of Procedure Codes	BETOS Category	BETOS Description	OPD > ASC	ASC > OPD	Potential Savings
1	M5	Specialist	1	0	$1,101,131
32	P1	Major Procedure-Other	20	12	$77,317,382
12	P2	Major Procedure - Cardiovascular	10	2	$81,124,618
18	P3	Major Procedure - Orthopedic	15	3	$48,464,759
49	P4	Eye Procedures	41	8	$465,907,275
165	P5	Ambulatory Procedures	120	45	$205,138,190
54	P6	Minor Procedures	11	43	$14,897,995
93	P8	Endoscopy	59	34	$232,511,646
		Total	**279**	**145**	**$1,126,462,996**

Source: OIG analysis

In addition, CMS could have reduced payments without necessarily creating equal rates. For example, 144 procedure codes varied by more than $300. If CMS limited the amount of difference to $300, they could have reduced payments by $352 million. If CMS chose $400, they could have realized approximately $188 million in savings.

Accuracy of OPD and ASC rates are questionable

Not only do payment rates between OPDs and ASCs vary, but there is concern that the rates themselves do not reflect accurate costs for performing the procedure. A series of OIG audits of hospital cost reports found significant unallowable and questionable costs. Based on these audits, OIG raised concerns about the methodology used to determine hospital outpatient PPS rates, which used settled, but not audited, cost reports. The OIG believed that the original rate setting methodology included unallowable costs and improper payments, thereby inflating the rates.[4]

[4] *Review of the Health Care Financing Administration's Development of Medicare's Prospective Payment System for Hospital ~~Outpatient D~~epartment Services* (A-14-98-00400)

In addition, CMS has not rebased the ASC payment amounts using recent survey data, which raises questions about the accuracy of the payment rates. The law requires CMS to survey ASCs to determine the actual audited costs they incur. Currently, ASC payment rates are based on 1986 ASC survey data, which may not represent their operating costs today.

Since 1992, the type of procedures that ASCs provide has changed. In 1992, two eye procedure codes represented 57 percent of the ASC services. By 1999, this dropped to 42 percent. Over the same time period, the number of procedure codes with 1,000 or more services in an ASC increased from 72 procedure codes to 125 procedure codes. Resource intense procedures performed in ASCs in 1986 may be less resource intensive now, due to changes in technology, and therefore, may be less expensive to perform. A more recent ASC survey may provide more accurate information for procedures that are now commonly performed in ASCs.

Failure to remove certain procedure codes from the ASC list of covered procedures resulted in higher program payments

Contrary to regulations, CMS has failed to remove procedure codes from the list of ASC-covered procedures. Currently, CMS regulations require that the ASC list of covered procedures not include procedures that are commonly performed or that may be safely performed in physicians' offices. To determine which procedure codes should be removed, CMS established a standard using utilization data. Based on our analysis of calender year 1999 data, 72 procedure codes met CMS's criteria for removal.

As a result, Medicare potentially paid an additional $8 to $14 million for services

If CMS removed the 72 procedure codes that met its criteria for removal from the ASC-covered list, CMS could have spent approximately $8 to $14 million less for services in 2001. If all the services related to these 72 procedure codes provided in ASCs were instead provided in hospital OPDs, CMS could have saved nearly $8 million. If these same services were provided in physician offices, CMS could have saved almost $14 million. (See Appendix D for more information on procedure codes and savings.)

CONCLUSION AND RECOMMENDATION

We believe that Congress intended Medicare to be a prudent purchaser of services and only to pay for those costs that are necessary for the efficient delivery of needed health services. Our analysis of payment systems shows that reimbursement disparities result in an estimated $1.1 billion in additional Medicare program payments. Furthermore, failure to remove certain procedure codes from the list of ASC-approved procedures resulted in an estimated $8 to 14 million in additional Medicare program payments.

We reiterate previous OIG recommendations, with which CMS concurred, that there should be greater parity of payments for services performed in an outpatient setting and those performed in ASCs. These recommendations are consistent with the Medicare Payment Advisory Commission's position that, "all else being equal, Medicare should pay for ambulatory care based on the service, not the setting."[5] To safeguard the Medicare program from excessive payments, we recommend that CMS:

- seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services,
- conduct and use timely ASC-survey data to reevaluate ASC-payment rates, and
- remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.

[5] *Report to the Congress, Context for a Changing Medicare Program,* Medicare Payment Advisory Commission, June 1998, pg. 72

AGENCY COMMENTS

We received comments from the Centers for Medicare & Medicaid Services. The CMS neither concurred nor non-concurred with our recommendations. The complete text of CMS's comments can be found in Appendix E.

The CMS commented that it would be valuable if we included an explicit acknowledgment that the three payment systems (outpatient prospective payment system, ASC fee schedule, and physician fee schedule) arise from different sections of the statute. We recognize that different statutory authorities mandate how CMS reimburses OPDs, ASCs, and physicians. Our recommendation recognizes that CMS needs additional authority because the payment systems have evolved over time from different laws enacted by Congress. We continue to urge CMS to seek the authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services.

The CMS stated that they have not conducted ASC surveys in some time due to competing priorities. They also note that the endeavor is quite difficult and poses a significant burden on ASCs. The CMS stated that it is now considering how best to proceed. We recognize the difficulty in developing and conducting a survey of costs in ASCs. However, we also recognize that operating a program where 2001 Medicare reimbursement was $1.6 billion, based on data that is more than 15 years old, does little to manage appropriately the ASC-payment system. We urge CMS to conduct and use timely ASC-survey data to reevaluate ASC-payment rates.

In addition, CMS agrees that some procedures should be removed from the ASC-approved procedures list. The CMS states that they expect to complete the final rule regarding addition and deletions to the list of ASC-covered procedures. We understand that CMS is currently planning to issue parts of the June 1998 proposed regulations dealing with additions and deletions to the list of covered services. Our review of the draft final regulation circulating within the Department reveals that only 6 of the 72 procedure codes that we recommended are scheduled for deletion. Consequently, procedure codes meeting CMS's criteria for removal from the ASC-covered procedure list will continue to be reimbursed as ASC-covered procedures resulting in higher program payments.

APPENDIX A

Procedure Codes Examined with ASC and OPD Rates

HCPCS	OPD Rate	ASC Rate	Differences	HCPCS	OPD Rate	ASC Rate	Differences
10180	$184.88	$433.00	($248.12)	19101	$621.50	$433.00	$188.50
11042	$177.35	$433.00	($255.65)	19120	$621.50	$495.00	$126.50
11043	$177.35	$433.00	($255.65)	19125	$621.50	$495.00	$126.50
11044	$625.50	$433.00	$192.50	19126	$621.50	$495.00	$126.50
11404	$327.07	$323.00	$4.07	19140	$621.50	$612.00	$9.50
11406	$327.07	$433.00	($105.93)	19160	$621.50	$495.00	$126.50
11424	$327.07	$433.00	($105.93)	19162	$1,577.29	$966.00	$611.29
11426	$627.50	$433.00	$194.50	19180	$1,577.29	$612.00	$965.29
11444	$327.07	$323.00	$4.07	19290	$921.50	$323.00	$598.50
11446	$627.50	$433.00	$194.50	19291	$921.50	$323.00	$598.50
11604	$327.07	$433.00	($105.93)	19318	$1,577.29	$612.00	$965.29
11606	$527.02	$433.00	$94.02	20205	$527.02	$495.00	$32.02
11624	$327.07	$433.00	($105.93)	20206	$271.81	$323.00	($51.19)
11626	$627.50	$433.00	$194.50	20220	$200.97	$323.00	($122.03)
11644	$327.07	$433.00	($105.93)	20225	$327.07	$433.00	($105.93)
11646	$627.50	$433.00	$194.50	20650	$755.63	$495.00	$260.63
12020	$122.08	$323.00	($200.92)	20670	$527.02	$323.00	$204.02
12021	$122.08	$323.00	($200.92)	20680	$627.50	$495.00	$132.50
12034	$122.08	$433.00	($310.92)	20690	$1,061.58	$433.00	$628.58
13100	$187.90	$433.00	($245.10)	20694	$755.63	$323.00	$432.63
13101	$187.90	$495.00	($307.10)	21550	$200.97	$323.00	($122.03)
13120	$187.90	$433.00	($245.10)	21555	$627.50	$433.00	$194.50
13121	$187.90	$495.00	($307.10)	21556	$627.50	$433.00	$194.50
13131	$187.90	$433.00	($245.10)	21800	$82.40	$323.00	($240.60)
13132	$187.90	$495.00	($307.10)	21920	$327.07	$323.00	$4.07
13150	$608.42	$495.00	$113.42	21930	$627.50	$433.00	$194.50
13151	$187.90	$495.00	($307.10)	22305	$82.40	$323.00	($240.60)
13152	$187.90	$495.00	($307.10)	22310	$82.40	$323.00	($240.60)
13160	$608.42	$433.00	$175.42	23120	$1,394.69	$696.00	$698.69
14000	$608.42	$433.00	$175.42	23130	$1,394.69	$696.00	$698.69
14001	$608.42	$495.00	$113.42	23410	$1,816.70	$696.00	$1,120.70
14020	$608.42	$495.00	$113.42	23412	$1,816.70	$966.00	$850.70
14021	$608.42	$495.00	$113.42	23420	$1,816.70	$966.00	$850.70
14040	$608.42	$433.00	$175.42	23500	$82.40	$323.00	($240.60)
14041	$608.42	$495.00	$113.42	23600	$109.03	$323.00	($213.97)
14060	$608.42	$495.00	$113.42	23620	$109.03	$323.00	($213.97)
14061	$608.42	$495.00	$113.42	23700	$553.66	$323.00	$230.66
14300	$608.42	$612.00	($3.58)	24075	$527.02	$433.00	$94.02
15000	$608.42	$433.00	$175.42	24076	$627.50	$433.00	$194.50
15100	$608.42	$433.00	$175.42	24105	$755.63	$495.00	$260.63
15101	$608.42	$495.00	$113.42	24500	$109.03	$323.00	($213.97)
15120	$608.42	$433.00	$175.42	24670	$109.03	$323.00	($213.97)
15220	$608.42	$433.00	$175.42	24685	$1,119.87	$495.00	$624.87
15240	$608.42	$495.00	$113.42	25000	$755.63	$495.00	$260.63
15260	$608.42	$433.00	$175.42	25075	$327.07	$433.00	($105.93)
15350	$608.42	$433.00	$175.42	25111	$568.72	$495.00	$73.72
15576	$608.42	$495.00	$113.42	25115	$755.63	$612.00	$143.63

HCPCS	OPD Rate	ASC Rate	Differences	HCPCS	OPD Rate	ASC Rate	Differences
15732	$793.81	$495.00	$298.81	25310	$1,394.69	$495.00	$899.69
15734	$793.81	$495.00	$298.81	25447	$1,109.82	$696.00	$413.82
15740	$793.81	$433.00	$360.81	25605	$109.03	$495.00	($385.97)
19100	$271.81	$323.00	($51.19)	25611	$1,119.87	$495.00	$624.87
25620	$1,119.87	$696.00	$423.87	29822	$1,234.42	$495.00	$739.42
26055	$568.72	$433.00	$135.72	29823	$1,234.42	$495.00	$739.42
26115	$627.50	$433.00	$194.50	29826	$1,234.42	$495.00	$739.42
26116	$627.50	$433.00	$194.50	29874	$1,234.42	$495.00	$739.42
26121	$987.74	$612.00	$375.74	29875	$1,234.42	$612.00	$622.42
26123	$987.74	$612.00	$375.74	29876	$1,234.42	$612.00	$622.42
26125	$987.74	$612.00	$375.74	29877	$1,234.42	$612.00	$622.42
26145	$568.72	$495.00	$73.72	29879	$1,234.42	$495.00	$739.42
26160	$568.72	$495.00	$73.72	29880	$1,234.42	$612.00	$622.42
26418	$568.72	$612.00	($43.28)	29881	$1,234.42	$612.00	$622.42
26531	$1,460.00	$966.00	$494.00	30115	$603.89	$433.00	$170.89
26605	$109.03	$433.00	($323.97)	30130	$603.89	$495.00	$108.89
26860	$987.74	$495.00	$492.74	30140	$603.89	$433.00	$170.89
26951	$568.72	$433.00	$135.72	30520	$1,276.12	$612.00	$664.12
27193	$109.03	$323.00	($213.97)	30801	$260.24	$323.00	($62.76)
27266	$1,109.82	$433.00	$676.82	30802	$603.89	$323.00	$280.89
27425	$1,061.58	$966.00	$95.58	30903	$111.03	$323.00	($211.97)
27520	$109.03	$323.00	($213.97)	30905	$111.03	$323.00	($211.97)
27530	$109.03	$323.00	($213.97)	31233	$63.30	$433.00	($369.70)
27570	$553.66	$323.00	$230.66	31235	$683.78	$323.00	$360.78
27750	$109.03	$323.00	($213.97)	31237	$683.78	$433.00	$250.78
27760	$109.03	$323.00	($213.97)	31238	$683.78	$323.00	$360.78
27780	$109.03	$323.00	($213.97)	31240	$683.78	$433.00	$250.78
27786	$109.03	$323.00	($213.97)	31254	$920.01	$495.00	$425.01
27792	$1,119.87	$495.00	$624.87	31255	$920.01	$696.00	$224.01
27808	$109.03	$323.00	($213.97)	31256	$920.01	$495.00	$425.01
27814	$1,119.87	$495.00	$624.87	31267	$920.01	$495.00	$425.01
28002	$755.63	$495.00	$260.63	31276	$920.01	$495.00	$425.01
28043	$527.02	$433.00	$94.02	31287	$920.01	$495.00	$425.01
28045	$777.23	$495.00	$282.23	31288	$920.01	$495.00	$425.01
28080	$777.23	$495.00	$282.23	31525	$683.78	$323.00	$360.78
28090	$777.23	$495.00	$282.23	31535	$920.01	$433.00	$487.01
28110	$1,055.06	$495.00	$560.06	31536	$920.01	$495.00	$425.01
28112	$777.23	$495.00	$282.23	31541	$920.01	$612.00	$308.01
28113	$777.23	$495.00	$282.23	31570	$920.01	$433.00	$487.01
28119	$777.23	$612.00	$165.23	31600	$625.50	$433.00	$192.50
28122	$777.23	$495.00	$282.23	31615	$404.95	$323.00	$81.95
28285	$777.23	$495.00	$282.23	31622	$404.95	$323.00	$81.95
28288	$869.17	$495.00	$374.17	31625	$404.95	$433.00	($28.05)
28290	$1,055.06	$433.00	$622.06	31628	$404.95	$433.00	($28.05)
28292	$1,055.06	$433.00	$622.06	31629	$404.95	$433.00	($28.05)
28293	$1,055.06	$495.00	$560.06	31641	$404.95	$433.00	($28.05)

HCPCS	OPD Rate	ASC Rate	Differences	HCPCS	OPD Rate	ASC Rate	Differences
28296	$1,055.06	$495.00	$560.06	31645	$404.95	$323.00	$81.95
28308	$869.17	$433.00	$436.17	32000	$182.88	$323.00	($140.12)
28310	$777.23	$495.00	$282.23	32002	$182.88	$433.00	($250.12)
28315	$777.23	$612.00	$165.23	32020	$182.88	$433.00	($250.12)
28400	$109.03	$323.00	($213.97)	32400	$271.81	$323.00	($51.19)
28750	$777.23	$612.00	$165.23	32405	$271.81	$323.00	($51.19)
28810	$777.23	$433.00	$344.23	36489	$271.30	$323.00	($51.70)
28820	$777.23	$433.00	$344.23	36491	$271.30	$323.00	($51.70)
28825	$777.23	$433.00	$344.23	36533	$971.66	$495.00	$476.66
36534	$657.65	$433.00	$224.65	43450	$238.15	$323.00	($84.85)
36535	$328.07	$323.00	$5.07	43453	$238.15	$323.00	($84.85)
36800	$971.66	$495.00	$476.66	43456	$238.15	$433.00	($194.85)
36821	$1,330.88	$495.00	$835.88	43458	$238.15	$433.00	($194.85)
36825	$1,330.88	$612.00	$718.88	43750	$359.22	$433.00	($73.78)
36830	$1,330.88	$612.00	$718.88	43760	$118.57	$323.00	($204.43)
36832	$1,330.88	$612.00	$718.88	44360	$374.29	$433.00	($58.71)
36860	$971.66	$433.00	$538.66	44361	$374.29	$433.00	($58.71)
36861	$971.66	$495.00	$476.66	44388	$400.93	$323.00	$77.93
37609	$327.07	$433.00	($105.93)	45170	$888.26	$433.00	$455.26
37720	$1,015.37	$495.00	$520.37	45305	$142.18	$323.00	($180.82)
37785	$743.06	$495.00	$248.06	45331	$142.18	$323.00	($180.82)
38500	$697.85	$433.00	$264.85	45333	$314.51	$323.00	($8.49)
38505	$271.81	$323.00	($51.19)	45334	$314.51	$323.00	($8.49)
38510	$697.85	$433.00	$264.85	45338	$314.51	$323.00	($8.49)
38525	$697.85	$433.00	$264.85	45339	$314.51	$323.00	($8.49)
38740	$982.71	$433.00	$549.71	45378	$400.93	$433.00	($32.07)
38745	$982.71	$612.00	$370.71	45380	$400.93	$433.00	($32.07)
40814	$603.89	$433.00	$170.89	45382	$400.93	$433.00	($32.07)
41112	$603.89	$433.00	$170.89	45383	$400.93	$433.00	($32.07)
42104	$603.89	$433.00	$170.89	45384	$400.93	$433.00	($32.07)
42145	$625.50	$696.00	($70.50)	45385	$400.93	$433.00	($32.07)
42440	$1,276.12	$495.00	$781.12	46040	$117.57	$495.00	($377.43)
42826	$935.49	$612.00	$323.49	46050	$117.57	$323.00	($205.43)
43200	$359.22	$323.00	$36.22	46080	$646.09	$495.00	$151.09
43202	$359.22	$323.00	$36.22	46200	$888.26	$433.00	$455.26
43215	$359.22	$323.00	$36.22	46255	$888.26	$495.00	$393.26
43220	$359.22	$323.00	$36.22	46260	$888.26	$495.00	$393.26
43226	$359.22	$323.00	$36.22	46270	$888.26	$495.00	$393.26
43234	$359.22	$323.00	$36.22	47000	$271.81	$323.00	($51.19)
43235	$359.22	$323.00	$36.22	47525	$253.21	$323.00	($69.79)
43239	$359.22	$433.00	($73.78)	48102	$271.81	$323.00	($51.19)
43241	$359.22	$433.00	($73.78)	49080	$182.88	$433.00	($250.12)
43243	$359.22	$433.00	($73.78)	49081	$182.88	$433.00	($250.12)
43245	$359.22	$433.00	($73.78)	49180	$271.81	$323.00	($51.19)
43246	$359.22	$433.00	($73.78)	49420	$985.73	$323.00	$662.73
43247	$359.22	$433.00	($73.78)	49421	$985.73	$323.00	$662.73

HCPCS	OPD Rate	ASC Rate	Differences	HCPCS	OPD Rate	ASC Rate	Differences
43248	$359.22	$433.00	($73.78)	49505	$1,126.91	$612.00	$514.91
43249	$359.22	$433.00	($73.78)	49520	$1,126.91	$966.00	$160.91
43250	$359.22	$433.00	($73.78)	49525	$1,126.91	$612.00	$514.91
43251	$359.22	$433.00	($73.78)	49550	$1,126.91	$696.00	$430.91
43255	$359.22	$433.00	($73.78)	49560	$1,126.91	$612.00	$514.91
43258	$359.22	$495.00	($135.78)	49565	$1,126.91	$612.00	$514.91
43259	$359.22	$495.00	($135.78)	49585	$1,126.91	$612.00	$514.91
43260	$529.04	$433.00	$96.04	50200	$271.81	$323.00	($51.19)
43261	$529.04	$433.00	$96.04	50390	$271.81	$323.00	($51.19)
43262	$529.04	$433.00	$96.04	50392	$272.80	$323.00	($50.20)
43264	$529.04	$433.00	$96.04	50393	$272.80	$323.00	($50.20)
43268	$529.04	$433.00	$96.04	50398	$253.21	$323.00	($69.79)
43269	$529.04	$433.00	$96.04	51010	$195.43	$323.00	($127.57)
43271	$529.04	$433.00	$96.04	51040	$878.72	$612.00	$266.72
51710	$118.57	$323.00	($204.43)	64420	$166.80	$323.00	($156.20)
51725	$195.43	$323.00	($127.57)	64421	$166.80	$323.00	($156.20)
51726	$195.43	$323.00	($127.57)	64510	$166.80	$323.00	($156.20)
51772	$195.43	$323.00	($127.57)	64520	$166.80	$323.00	($156.20)
51785	$109.04	$323.00	($213.96)	64620	$166.80	$323.00	($156.20)
52000	$272.80	$323.00	($50.20)	64622	$166.80	$323.00	($156.20)
52005	$549.63	$433.00	$116.63	64623	$166.80	$323.00	($156.20)
52204	$549.63	$433.00	$116.63	64714	$701.36	$433.00	$268.36
52214	$549.63	$433.00	$116.63	64718	$701.36	$433.00	$268.36
52224	$549.63	$433.00	$116.63	64719	$701.36	$433.00	$268.36
52234	$878.72	$433.00	$445.72	64721	$701.36	$433.00	$268.36
52235	$878.72	$495.00	$383.72	64722	$701.36	$323.00	$378.36
52240	$1,455.98	$495.00	$960.98	64727	$701.36	$323.00	$378.36
52260	$549.63	$433.00	$116.63	65400	$303.45	$323.00	($19.55)
52275	$549.63	$433.00	$116.63	65420	$692.82	$433.00	$259.82
52276	$549.63	$495.00	$54.63	65426	$692.82	$696.00	($3.18)
52281	$549.63	$433.00	$116.63	65730	$1,651.92	$966.00	$685.92
52285	$549.63	$433.00	$116.63	65755	$1,651.92	$966.00	$685.92
52310	$549.63	$433.00	$116.63	65805	$692.82	$323.00	$369.82
52315	$549.63	$433.00	$116.63	65865	$692.82	$323.00	$369.82
52317	$878.72	$323.00	$555.72	65875	$692.82	$612.00	$80.82
52318	$878.72	$433.00	$445.72	66170	$1,036.97	$612.00	$424.97
52332	$878.72	$433.00	$445.72	66172	$1,036.97	$612.00	$424.97
52450	$878.72	$495.00	$383.72	66180	$1,036.97	$696.00	$340.97
52500	$878.72	$495.00	$383.72	66250	$692.82	$433.00	$259.82
52601	$1,455.98	$612.00	$843.98	66710	$303.45	$433.00	($129.55)
52640	$878.72	$433.00	$445.72	66821	$245.67	$433.00	($187.33)
54161	$684.27	$433.00	$251.27	66850	$1,333.89	$966.00	$367.89
54520	$917.39	$495.00	$422.39	66852	$1,333.89	$612.00	$721.89
54840	$917.39	$612.00	$305.39	66984	$1,333.89	$949.00	$384.89
55040	$1,126.91	$495.00	$631.91	66985	$1,333.89	$806.00	$527.89
55700	$248.20	$433.00	($184.80)	66986	$1,333.89	$806.00	$527.89

HCPCS	OPD Rate	ASC Rate	Differences	HCPCS	OPD Rate	ASC Rate	Differences
56405	$119.57	$433.00	($313.43)	67005	$1,706.18	$612.00	$1,094.18
56605	$200.97	$323.00	($122.03)	67010	$1,706.18	$612.00	$1,094.18
57240	$938.50	$696.00	$242.50	67015	$1,706.18	$323.00	$1,383.18
57410	$814.41	$433.00	$381.41	67031	$245.67	$433.00	($187.33)
57520	$814.41	$433.00	$381.41	67036	$1,706.18	$612.00	$1,094.18
57522	$938.50	$433.00	$505.50	67038	$1,706.18	$696.00	$1,010.18
58120	$726.99	$433.00	$293.99	67039	$1,706.18	$966.00	$740.18
60220	$982.71	$433.00	$549.71	67040	$1,706.18	$966.00	$740.18
61055	$182.88	$323.00	($140.12)	67107	$1,706.18	$696.00	$1,010.18
61070	$182.88	$323.00	($140.12)	67108	$1,706.18	$966.00	$740.18
62270	$150.72	$323.00	($172.28)	67141	$147.71	$433.00	($285.29)
62273	$182.88	$323.00	($140.12)	67255	$1,706.18	$495.00	$1,211.18
62282	$182.88	$323.00	($140.12)	67311	$903.83	$495.00	$408.83
62350	$354.20	$433.00	($78.80)	67312	$903.83	$612.00	$291.83
62362	$561.19	$433.00	$128.19	67314	$903.83	$612.00	$291.83
62367	$22.61	$433.00	($410.39)	67880	$303.45	$495.00	($191.55)
62368	$22.61	$433.00	($410.39)	67903	$676.74	$612.00	$64.74
63650	$898.80	$433.00	$465.80	67904	$676.74	$612.00	$64.74
64415	$166.80	$323.00	($156.20)	67908	$676.74	$612.00	$64.74
67911	$676.74	$495.00	$181.74				
67916	$676.74	$612.00	$64.74				
67917	$676.74	$612.00	$64.74				
67921	$676.74	$495.00	$181.74				
67923	$676.74	$612.00	$64.74				
67924	$676.74	$612.00	$64.74				
67950	$676.74	$433.00	$243.74				
67961	$676.74	$495.00	$181.74				
67966	$676.74	$495.00	$181.74				
68320	$676.74	$612.00	$64.74				
68720	$1,190.70	$612.00	$578.70				
68810	$132.64	$323.00	($190.36)				
69110	$327.07	$323.00	$4.07				
69145	$327.07	$433.00	($105.93)				
69436	$603.89	$495.00	$108.89				
69631	$1,276.12	$696.00	$580.12				

Source: OIG Analysis

Number of Codes by Percent Differences

OPD rates greater than ASC rates

Number of Codes	Percent Difference
4	>200%
69	100-199%
88	50-99%
118	1-49%

Source: OIG Analysis

ASC rates greater than OPD rates

Number of Codes	Percent Difference
12	>200%
41	100-199%
26	50-99%
66	1-49%

Source: OIG Analysis

Analysis by BETOS Classification

# of Procedure Codes	BETOS Category	BETOS Description	# OPD > ASC	#ASC > OPD	Potential Savings
1	M5D	Specialist	1	0	$1,101,131
		Subtotal	**1**	**0**	**$1,101,131**
3	P1A	Major Procedure - Breast	3	0	$10,657,129
2	P1D	Major Procedure - TURP	2	0	$13,050,648
27	P1G	Major Procedure - Other	15	12	$53,609,605
		Subtotal	**20**	**12**	**$77,317,382**
12	P2F	Major Procedure - Cardiovascular	10	2	$81,124,618
		Subtotal	**10**	**2**	**$81,124,618**
18	P3D	Major Procedure - Orthopedic	15	3	$48,464,759
		Subtotal	**15**	**3**	**$48,464,759**
2	P4A	Eye Procedure	2	0	$5,865,302
5	P4B	Eye Procedure - Cataract	5	0	$330,368,672
3	P4C	Eye Procedure - Retinal Detachment	2	1	$12,610,047
39	P4E	Eye Procedure - Other	32	7	$117,063,254
		Subtotal	**41**	**8**	**$465,907,275**
37	P5A	Ambulatory Procedures - Skin	25	12	$18,888,083
51	P5B	Ambulatory Procedures - Musculoskeletal	47	4	$56,844,714
4	P5C	Ambulatory Procedures - Inguinal Hernia Repair	4	0	$39,355,713
73	P5E	Ambulatory Procedures - Other	44	29	$90,049,680
		Subtotal	**120**	**45**	**$205,138,190**
12	P6A	Minor Procedures - Skin	4	8	$4,318,404
22	P6B	Minor Procedures - Musculoskeletal	4	18	$2,061,819

# of Procedure Codes	BETOS Category	BETOS Description	# OPD > ASC	#ASC > OPD	Potential Savings
20	P6C	Minor Procedures - Other	3	17	$8,517,772
		Subtotal	**11**	**43**	**$14,897,995**
10	P8A	Endoscopy - Arthroscopy	10	0	$96,335,979
26	P8B	Endoscopy - Upper Gastrointestinal	13	13	$28,370,205
6	P8C	Endoscopy - Sigmoidscopy	0	6	$928,643
7	P8D	Endoscopy - Colonoscopy	1	6	$15,502,443
18	P8E	Endoscopy - Cystoscopy	17	1	$64,500,588
7	P8F	Endoscopy - Brochoscopy	3	4	$1,977,433
5	P8H	Endoscopy - Laryngoscopy	5	0	$8,060,606
14	P8I	Endoscopy - Other	10	4	$16,835,749
		Subtotal	**59**	**34**	**$232,511,646**
		Total	**279**	**145**	**$1,126,462,945**

Source: OIG Analysis

APPENDIX D

Procedure Codes Identified for Removal from ASC List

APPENDIX D

HCPCS	OPD Rate	ASC Rate	Fee Schedule	Est. ASC Reimbusement	Est. OPD Reimbursement	Phys. Office Reimbursement
23620	$109.03	$323.00	$280.81	$0.00	$0.00	$0.00
24670	$109.03	$323.00	$255.95	$0.00	$0.00	$0.00
27786	$109.03	$323.00	$299.94	$0.00	$0.00	$0.00
28400	$109.03	$323.00	$281.20	$0.00	$0.00	$0.00
62367	$22.61	$433.00	$31.37	$155,880.00	$8,139.60	$11,293.79
22305	$82.40	$323.00	$199.71	$323.00	$82.40	$199.71
27780	$109.03	$323.00	$284.64	$323.00	$109.03	$284.64
27760	$109.03	$323.00	$308.74	$323.00	$109.03	$308.74
27520	$109.03	$323.00	$309.13	$323.00	$109.03	$309.13
27808	$109.03	$323.00	$330.55	$646.00	$218.06	$661.10
23600	$109.03	$323.00	$312.57	$969.00	$327.09	$937.71
56405	$119.57	$433.00	$133.90	$4,763.00	$1,315.27	$1,472.94
31235	$683.78	$323.00	$213.10	$3,553.00	$7,521.58	$2,344.07
12021	$122.08	$323.00	$144.23	$6,783.00	$2,563.68	$3,028.89
46050	$117.57	$323.00	$153.03	$6,783.00	$2,468.97	$3,213.68
45305	$142.18	$323.00	$71.93	$17,442.00	$7,677.72	$3,883.96
31233	$63.30	$433.00	$191.29	$9,959.00	$1,455.90	$4,399.68
21920	$327.07	$323.00	$159.15	$11,628.00	$11,774.52	$5,729.53
31570	$920.01	$433.00	$318.31	$9,959.00	$21,160.23	$7,321.07
38505	$271.81	$323.00	$144.23	$17,119.00	$14,405.93	$7,644.35
42104	$603.89	$433.00	$153.80	$28,578.00	$39,856.74	$10,150.64
30801	$260.24	$323.00	$120.13	$33,269.00	$26,804.72	$12,373.43
65805	$692.82	$323.00	$158.39	$31,977.00	$68,589.18	$15,680.46
51710	$118.57	$323.00	$198.56	$27,778.00	$10,197.02	$17,076.12
56605	$200.97	$323.00	$102.91	$55,556.00	$34,566.84	$17,701.26
31238	$683.78	$323.00	$273.55	$33,915.00	$71,796.90	$28,722.27
40814	$603.89	$433.00	$290.38	$43,300.00	$60,389.00	$29,037.90
19100	$271.81	$323.00	$154.56	$74,613.00	$62,788.11	$35,703.99
69145	$327.07	$433.00	$226.87	$71,012.00	$53,639.48	$37,206.77
30802	$603.89	$323.00	$179.43	$72,675.00	$135,875.25	$40,371.86
41112	$603.89	$433.00	$236.82	$82,703.00	$115,342.99	$45,232.17
68810	$132.64	$323.00	$313.72	$53,941.00	$22,150.88	$52,390.64
13100	$187.90	$433.00	$237.20	$99,590.00	$43,217.00	$54,556.05
64420	$166.80	$323.00	$125.10	$143,089.00	$73,892.40	$55,421.07
31525	$683.78	$323.00	$210.80	$85,918.00	$181,885.48	$56,073.37
11446	$627.50	$433.00	$323.28	$93,961.00	$136,167.50	$70,151.97
13120	$187.90	$433.00	$250.21	$127,302.00	$55,242.60	$73,561.14
13150	$608.42	$495.00	$325.58	$133,650.00	$164,273.40	$87,905.64
11624	$327.07	$433.00	$265.51	$182,726.00	$138,023.54	$112,045.73
31237	$683.78	$433.00	$244.09	$202,644.00	$320,009.04	$114,232.57
67141	$147.71	$433.00	$484.73	$104,786.00	$35,745.82	$117,304.69
51725	$195.43	$323.00	$226.11	$178,296.00	$107,877.36	$124,810.16
11424	$327.07	$433.00	$211.57	$285,347.00	$215,539.13	$139,422.85
20670	$527.02	$323.00	$241.03	$190,570.00	$310,941.80	$142,205.36
11604	$327.07	$433.00	$221.13	$290,543.00	$219,463.97	$148,379.45
11444	$327.07	$323.00	$263.98	$197,353.00	$199,839.77	$161,292.32
67031	$245.67	$433.00	$299.56	$287,945.00	$163,370.55	$199,208.01
62368	$22.61	$433.00	$42.08	$2,105,246.00	$109,929.82	$204,611.97
15740	$793.81	$433.00	$781.61	$115,611.00	$211,947.27	$208,690.67
11404	$327.07	$323.00	$189.00	$366,282.00	$370,897.38	$214,320.35
13101	$187.90	$495.00	$285.02	$456,885.00	$173,431.70	$263,076.09
51772	$195.43	$323.00	$200.86	$446,709.00	$270,279.69	$277,782.50

APPENDIX D

HCPCS	OPD Rate	ASC Rate	Fee Schedule	Est. ASC Reimbusement	Est. OPD Reimbursement	Phys. Office Reimbursement
13131	$187.90	$433.00	$283.11	$574,591.00	$249,343.30	$375,686.89
13121	$187.90	$495.00	$314.10	$595,980.00	$226,231.60	$378,175.20
13151	$187.90	$495.00	$355.42	$550,440.00	$208,944.80	$395,224.54
14000	$608.42	$433.00	$493.15	$355,060.00	$498,904.40	$404,380.47
11644	$327.07	$433.00	$336.29	$547,745.00	$413,743.55	$425,405.20
14021	$608.42	$495.00	$746.80	$297,495.00	$365,660.42	$448,825.67
13152	$187.90	$495.00	$479.76	$546,975.00	$207,629.50	$530,131.01
67921	$676.74	$495.00	$444.18	$643,995.00	$880,438.74	$577,873.68
14020	$608.42	$495.00	$554.74	$820,215.00	$1,008,151.94	$919,208.24
14061	$608.42	$495.00	$925.85	$508,860.00	$625,455.76	$951,769.71
14041	$608.42	$495.00	$840.15	$654,390.00	$804,331.24	$1,110,675.49
13132	$187.90	$495.00	$419.69	$1,848,825.00	$701,806.50	$1,567,547.22
51726	$195.43	$323.00	$205.45	$2,660,874.00	$1,609,952.34	$1,692,464.12
52281	$549.63	$433.00	$239.88	$3,458,371.00	$4,389,894.81	$1,915,907.88
55700	$248.20	$433.00	$184.40	$7,684,884.00	$4,405,053.60	$3,272,802.94
14040	$608.42	$433.00	$632.02	$3,126,260.00	$4,392,792.40	$4,563,211.92
14060	$608.42	$495.00	$682.52	$4,511,925.00	$5,545,748.30	$6,221,210.85
52000	$272.80	$323.00	$185.55	$14,508,191.00	$12,253,357.60	$8,334,429.53
26605	$109.03	$433.00	$313.72	$4,763.00	$1,199.33	$3,450.88
52285	$549.63	$433.00	$361.16	$238,583.00	$302,846.13	$198,997.21
			Total Expenditures	**$51,088,968.00**	**$43,374,896.63**	**$37,507,111.11**
			Total Savings		**$7,714,071.37**	**$13,581,856.90**

Source: OIG Analysis

APPENDIX E

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC - 4 2002

TO: Janet Rehnquist
Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers" (OEI-05-00-00340)

Thank you for the opportunity to review and comment on the above-referenced draft report, which assesses the effect of payment variations between ambulatory surgical centers (ASCs) and hospital outpatient departments on the Medicare program. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort that went into this report.

We believe that the report would be more valuable to readers if it included an explicit acknowledgement that the three payment systems at issue (outpatient prospective payment system, the ASC fee schedule, and the physician fee schedule) spring from different sections of statute. Each section specifies separately and in detail the payment formulas that Medicare is to use in determining payment for the relevant providers, and the statute does not include any explicit mandate or authority intended to insure comparability of payment across these three settings. Thus, a change in statute is needed to achieve the comparability recommended in this report.

While we believe that further comparability is desirable, how to achieve it without compromising the internal logic of each payment system is not obvious. One approach would be to use the lowest payment rate in all settings.

A second approach would be to attempt to pay an amount in each setting that would reflect in a comparable way the relative costs of using each site. This approach, analyzed by OIG, would be intended to remove any inappropriate financial incentives among clinicians for choosing one site over another, so the choice of site would presumably be guided primarily by other factors, including clinical reasons, convenience, and practitioner affiliations.

Determining which approach would be most appropriate for Medicare requires deliberation by policy makers. We understand that the Medicare Payment Advisory Commission is currently considering this matter, and we will be doing so as well. Our responses to the recommendations are outlined below.

OIG Recommendation
That CMS seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services.

CMS Response
This recommendation would require CMS to seek a change in statute from the Congress, and we will consider this recommendation as we develop our legislative program.

OIG Recommendation
That CMS conduct and use timely ASC survey data to reevaluate ASC payment rates.

CMS Response
We are required by the statute to conduct such surveys of ASCs and to rebase payments based on survey results. We have not conducted such a survey in some time, due to competing priorities such as the implementation of the outpatient prospective payment system. It is worth noting that this endeavor is quite difficult and poses a significant burden on ASCs. The ASCs do not file cost reports as other providers do, and their accounting systems vary significantly from one another. Consequently, surveying these entities regarding their costs would require a substantial amount of case-by-case interaction.

We also note that ASCs are the only provider type subject to a requirement that rates be rebased based on their costs. Of particular relevance to the current OIG report, no such rebasing requirement attaches to payment rates for either hospital outpatient departments or physicians' offices. Thus, whether rebasing ASC payments based on a survey would bring rates closer to comparability is not obvious. Similarly, the effects on total Medicare payments of updated survey-derived ASC rates are equally unclear. However, we are now considering how best to proceed with reference to this requirement.

OIG Recommendation
That CMS remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.

CMS Response
We agree that some services should be removed from the list; some should be added as well. We have previously issued a notice of proposed rule-making, partly to propose such changes. We expect to finalize this rule and implement changes to the list effective shortly.

ACKNOWLEDGMENTS

This report was prepared under the direction of William C. Moran, Regional Inspector General for Evaluation and Inspections in Chicago, Brian T. Pattison in Kansas City, and Natalie Coen, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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