



VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS -
NETWORK SERVICES ORGANIZATION

VERMONT
HEALTH SYSTEMS
PAYMENT VARIATION REPORT
Phase 1 Draft Report

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1. Executive Summary

The Green Mountain Care Board (GMCB) contracted with the Vermont Association of Hospitals and Health Systems – Network Services Organization (VAHHS-NSO) to provide analysis on health care payment variation in Vermont. The scope of the work includes analyzing payment variation specific to inpatient, outpatient and professional care services, as well as to provide analytics focused on the continuum of payments related to post-acute care services. The goal of the study, within the limitations of the data, is to provide an accurate picture of payer and provider payment variation. It is not the intent to justify whether the variation is appropriate or to provide a review of policy decisions that may also impact this variation. This report will support policy analysis to better understand the reasons for existing payment variation among Vermont providers.

VAHHS-NSO utilized the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) data for its analysis. In addition, data was also incorporated from the Vermont Uniform Hospital Discharge Data Set (VUHDDS). The data being analyzed is based on claims and discharges from the federal fiscal year 2012, starting on October 1, 2011 through September 30, 2012. The study utilizes only VHCURES payment data and does not incorporate payments or costs that occur outside VHCURES such as Medicare, Medicaid DSH payments or the Medicaid provider tax.

Key Findings

Data Quality

While the VHCURES database is both expansive and detailed, our research has identified issues with the data. For example, we found incomplete DRG and ICD-9 data, lack of data fields to identify provider location within professional claims and a data layout that is complex which could be replaced with a one record per discharge model. To address these issues we recommend that the State undertake a comprehensive data review.

Variation

Significant variation was found not only between payers and hospitals, but noticeably within the same hospital, same payer setting even when viewed at a DRG/procedure level. Variation in Medicaid payments was less than in commercial payments.

- **Hospital Inpatient** (case-mix adjusted at the aggregate level)
 - On average, variation within payer networks between the lowest paid hospital and the highest paid hospital ranged from 19% below the average to 34% over

the average. In other words, on average, the highest paid hospital received 1.65 times the lowest paid hospital. (See figure 4.1)

- On average, 78% of the hospitals were paid within +/- 25 percent of the average payment within the average payer network. (See figure 4.1)
- Commercial payers paid 55% more than Medicaid, on average.
- Of the major Vermont payers, Blue Cross Blue Shield paid 5% more than the commercial average, MVP 8% more. Cigna paid 12% less than the commercial average and TVHP 9% less.
- Figure 1.1 shows the hospitals, with payer, that received the lowest and highest average payments for the top three DRGs overall (percent shown is relative to state average):

Figure 1.1 Min and Max Average Payments (Relative to Statewide System Average) by Top 3 Inpatient DRGs (Minimum 5 discharges)

Top 3 DRGs		Min	Max
775 - Vaginal Delivery w/o Complicating Diagnoses	Payer: Hospital: Percent:	Blue Cross N. Country -28%	TVHP Gifford 108%
470 - Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	Payer: Hospital: Percent:	TVHP CVMC -39%	TVHP RRMC 70%
766 - Cesarean Section w/o CC/MCC	Payer: Hospital: Percent:	TVHP CVMC -29%	Blue Cross RRMC 79%

- **Hospital Outpatient (not case-mix adjusted)**
 - Variation exists between payers and hospitals, as well as within individual payer-hospital combinations (see figures 4.9 through 4.12)
 - Commercial payers paid 194% more than Medicaid, on average.
 - Of the major Vermont payers, Blue Cross Blue Shield paid 1% less than the commercial average, Cigna 11% less and TVHP 2% less. MVP paid 13% more than the commercial average.
 - Figure 1.2 shows the hospitals, with payer, that received the lowest and highest average payments for the top three ICD-9 procedure codes overall:

Figure 1.2 Min and Max Average Payments (Relative to Statewide System Average) by Top 3 Outpatient ICD-9 Procedures (Minimum 15 discharges)

Top 3 ICD-9s		Min	Max
9925 - Inj/Infus Cancer Chemo Substance	Payer: Hospital: Percent:	Medicaid Copley -63%	UHC FAHC 77%
4542 - Endo Polypectomy Large Intestine	Payer: Hospital: Percent:	Medicaid Copley -63%	Aetna FAHC 70%
4523 - Colonoscopy	Payer: Hospital: Percent:	Medicaid SVMC -58%	CBA N. Country 98%

- **Professional Claims**
 - Results by site of service show variation both between and within payers:
 - Hospital Inpatient: Commercial payers paid 184% more than Medicaid.
 - Hospital Outpatient: Commercial paid 189% more than Medicaid.
 - Office: Commercial paid 37% more than Medicaid.
 - Hospital ER: Commercial paid 128% more than Medicaid.
- **Post Acute Care (See Figure 1.3)**
 - Payments for post acute care (PAC) received within 30 days after an inpatient stay make up an average of 27% of the total amount spent for an entire episode of care.
 - The impact of any one post acute category is, on average, no more than 4% of total spending. Because the majority of payments come from the inpatient discharge, the impacts of variation arising from post acute care are minimal.

Figure 1.3 Post Acute Summary Shares

Hosp	n	Post-Acute			Home/Amb				All	Total
		Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other	PAC	
All	12,194	73%	14%	4%	4%	1%	2%	1%	27%	100%

2. Introduction

Background

Key features of Vermont's Health System:

- 14 not-for-profit community hospitals, including 8 critical access hospitals
- 1 in-state academic medical center
- 8 FQHCs serving more than 120,000 Vermonters
- Approximately 2,000 physicians
- 3 major insurance carriers
- 6.8% uninsured

Vermont's hard work on health care reform has not gone unnoticed. In February 2013 the Center for Medicare & Medicaid Innovation (CMMI) State Innovation Modeling (SIM) awarded a \$45 million grant to Vermont aimed at supporting movement towards three innovative provider payment models:¹

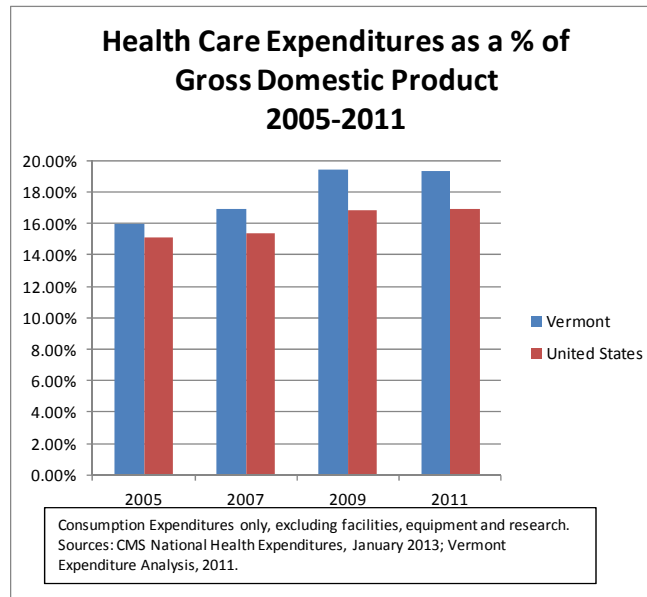
- Shared savings accountable care payments, under which a single network of providers takes responsibility for managing the costs and quality of care for a group of Vermonters
- Bundled payments, which provide a single payment to a group of providers for the care of a patient surrounding a hospitalization
- Pay-for-performance models

Health care reform efforts, both nationally and in Vermont, are a response to high rates of health care spending. In 2011, Vermont spent an estimated 19.3 percent of gross domestic product on health care, significantly more than the national average of 16.9 percent² (Figure 2.1). Health care reform and more specifically payment reform requires the State to have a baseline understanding of provider payment patterns and payment variation. This report is part of the State's effort to meet those requirements.

¹ <http://innovation.cms.gov/initiatives/state-innovations-model-testing/>

² CMS National Health Expenditures: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf> and the Vermont Expenditure Analysis 2011: <http://www.dfr.vermont.gov/sites/default/files/2009-EA-InForecast-Final.pdf>

Figure 2.1 Spending as a Percent of GDP



Scope of Report

The goal of this study is to examine and present the extent of payment variation within Vermont. It is not designed to make observations about payment policy or to draw conclusions on whether payment variation levels are acceptable or not. However, the data contained in this report will hopefully provide:

- a solid grounding upon which to guide those subsequent inquiries.
- a baseline for evaluating payment reform activities.

VAHHS-NSO has collected hospital discharge data for the state for many years and has recently acquired access to the all payer claims data as well (VHCURES). This report will draw on both data sources to provide the most complete picture possible of hospital inpatient and outpatient costs, charges and payments.

VAHHS-NSO engagement with the GMCB:

- Analysis of hospital inpatient and outpatient variation for hospital fiscal year 2012 – payments, charges and cost
 - Case-mix adjusted aggregate inpatient results
 - Inpatient results by top 20 DRGs
 - Outpatient results by top 20 ICD-9 principal procedure codes
- Analysis of professional claims variation by top 20 CPT – charges and payments
- Analysis of post-acute episodic care – charges and payments
- Discuss statistical risk adjustment methodologies with the GMCB

3. Data Sources and Methodology

Data Sources

This study utilizes VHCURES, the Vermont all payer claims database which includes commercial and Medicaid claims and payment data for Vermont residents insured under those plans. The dataset does not include Medicare information. To enhance data accuracy, VAHHS-NSO developed a comprehensive matching and validation tool between VHCURES and VUHDDS.³ This tool identified and allowed for an additional \$38 million of inpatient DRG related payments as well as \$130 million of outpatient ICD-9 payments to be incorporated into the study.⁴

Data Limitations

The findings of this report rely primarily on the accuracy of claims and payment data reported within VHCURES. The data provided in this report accurately reflect what is contained in the VHCURES dataset. The analysis went through a strict quality control process to ensure consistency and adherence to the primary data. In addition to this testing we held conversations with key stakeholders to validate our data model. Given the weight and scope of policy decisions that may arise from this analysis, VAHHS-NSO recommends that a more comprehensive testing and validation of the VHCURES data be pursued. Participants should include provider representation, insurers, key data users as well as Onpoint Health Data.

Methodology

Relative Payments:

This report examines provider payments relative to other providers at the aggregate level as well as at the procedure level. Relative payment is a calculated measure that compares individual provider payments to a common average payment, such as the payer network average payment. Actual payments from both commercial and Medicaid records are analyzed, by payer and by hospital, and converted to relative payments which establishes consistency and are more useful when comparing data points. The study does not incorporate any special payments (Medicaid DSH) or costs (provider taxes) outside of the data that is contained in VHCURES or VUHDDS.

³ Matching criteria includes admit date, discharge date, birth date, zip code, principle diagnosis, gender and hospital.

⁴ Refer to Appendix Section 2 for details

Cost Calculations:

Specific procedure costs are not captured in VHCURES or VUHDDS. To provide cost estimates, VAHHS-NSO has developed and incorporated a methodology based on Centers for Medicare and Medicaid Services (CMS) cost-to-charge ratios (RCCs).

The RCC ratios represent a way to convert charges to estimated costs for specific service area categories (such as MRI, Pharmacy, ICU, diagnostic radiology). For each patient, the estimated service specific cost is equal to the patient's charge times the hospital's ratio of cost-to-charges for each service area utilized. These itemized costs are summed up to calculate the total estimated cost of the claim.

Using the RCC approach is a well established methodology to estimate costs when groups of patients are compared (e.g. comparing DRG costs in one hospital versus another hospital, or comparing groups of patients in one hospital with other groups of patients in that hospital).⁵

Measuring Variation:

The relative payments calculated in this study take the form of the percent over or under the average payment within a given payer network or provider setting. Or put another way, it's the average payment to a single provider compared to the average payment across all providers. (How does provider X compare to the overall average?) Specifically, the percent over/under is calculated as:

- $$\frac{(\text{Avg Pmt from Payer X to Hospital Y}) - (\text{Avg Pmt from Payer X to all Hospitals})}{(\text{Avg Pmt from Payer X to all Hospitals})}$$
- **Example:** Blue Cross's average payment to Hospital A is \$12,000. Blue Cross's average payment to all of its providers in its payer network is \$10,000. The % over/under for Hospital A is 20%, within Blue Cross's payer network. (\$12,000 is 20% over \$10,000). Or if the average Blue Cross payment to Hospital A is \$7,500, then the % over/under becomes -25%. (\$7,500 is 25% less than \$10,000.)
- **Note:** The % over/under can be measured in different ways – it depends on what the individual provider's average payment is being measured against. The denominator could be the average payment within a *payer network* if one is trying to examine variation between providers within a single payer network. Or, if one is interested in comparing all providers at a procedure level to a system-wide average, then the denominator could be the *statewide average payment* for a given DRG, ICD-9 or CPT.

⁵ Michael Schwartz, David Young, & Richard Siegrist, The Ratio of Costs to Charges: How Good a Basis for Estimating Costs?, *Inquiry* 32: 476-481 (Winter 1005/1996). Blue Cross and Blue Shield Association, also: <http://www.ahrq.gov/legacy/gual/mortality/KrochRiskappa.htm>

Case Mix Adjusting:

Hospitals offer differing amounts of services at different levels of severity. This ‘case-mix’ accounts for considerable payment variation between hospitals. Any type of meaningful summary analysis of inpatient data must adjust for these case-mix differences. VAHHS-NSO incorporated CMS’s MS-DRG weights into the inpatient data to adjust for differences in aggregate case mix by provider.⁶ Case mix adjusting is not necessary at an individual DRG level as the weights are identical no matter where the procedure is performed.

As there are no industry standards to case-mix adjust aggregate outpatient data, this information is reported at an ICD-9 procedure code level, which provides a high degree of specificity between cases.

Professional claims are presented at the CPT level and do not need to be case mix adjusted, for the same reasons as inpatient DRGs and outpatient ICD-9s.

The results in this study indicate that even within the same hospital and under the same payer, there can be widespread variation in payments given the same DRG. This study did not quantify line item resource consumption per case per procedure per hospital per payer, but that could be a topic for further research.

Other Definitions:

- **Payer:** An insurer with more than \$1 million in payments in FY2012 (includes private payers as well as Medicaid), otherwise payers are together as ‘Other’.
- **Payer Network:** The set of health care providers (i.e. hospitals and physicians) that were under contract with a payer and that received payments in FY2012.
- **n:** A proxy for the number of discharges. In VHCURES, a single discharge may have multiple claims, and vice versa. It is not always possible to isolate or distinguish a single discharge with 100% confidence.
- **Cost vs. Payment vs. Price:** Payments are the allowed reimbursements paid to providers by insurers. Costs, as defined previously, represent the normal expenses a provider incurs in the business of providing health care services (salaries, overhead, etc.) The term ‘price’ is avoided in this study, though data on charges is presented in the Appendix.

⁶ CMS uses MS-DRG weights to build case-mix indexes (CMI) for individual Prospective Payment System (PPS) hospitals. NSO used these same weights and methodology to build CMIs for all Vermont hospitals, including Critical Access Hospitals (CAH). NSO validated this CMI against an established methodology using all-payer weights (gross charges) and found no statistical difference between the two.



- **Small Numbers:** Within individual graphs or tables, some data points may show wide variation due to low numbers of observations (discharges) and an undue influence from extreme values. Small numbers were excluded from some summary figures in the body of the report, but more detail is provided in the Appendix materials. Grace Cottage Hospital and Mount Ascutney Hospital were largely excluded from these results due to low numbers (see Figure 4.4b).

Data Filtering and Exclusions:

Data was excluded from parts of the report in order to reduce the effects of, and control for, identifiable variation. They include:

- Newborns excluded from the aggregate calculations.
- Claims with payments less than \$1 were excluded from the report.
- CPT analysis includes only CPTs where:
 - the code appeared once on the bill
 - the unit value is equal to 1 or blank
 - the CPT modifier field is blank

4. Results

Hospital Inpatient

To examine payment variation in hospital inpatient data, commercial and Medicaid payments were pulled from VHCURES. Each payment was individually case-mix adjusted, which allows payments to be compiled in any manner necessary for a particular report view. The graphs start at a high summary level and subsequently drill down to more detailed views. The goal in drilling down is to isolate and control for the major determinants of variation (i.e. different payers, different procedures). The first major 'cuts' on the data are to view results by payer and by hospital. This will be followed by examining individual DRG level data. (Two sample DRGs are shown in the body of the report. The remaining DRGs that meet the criteria for minimum record counts are shown in the Appendix.)

The sequence of the presentation for inpatient variation results is as follows:

1. Summary table of variation between hospitals, within payer networks (Fig. 4.1)
2. Summary chart of variation between payers, in aggregate (Fig. 4.2)
3. Summary chart of variation between hospitals (Fig. 4.3)
4. Bubble chart and table of variation between hospitals within payer networks (Fig. 4.4, 4.4b))
5. Bubble chart, by hospital, of hospital variation (Fig. 4.5)
6. Bubble chart summary of variation by major DRGs (Fig. 4.6)
7. Box-plot charts of variation within top DRGs, by payer, by hospital (Figs. 4.7, 4.8)

Figure 4.1 Inpatient Payment Variation Summary within Payer Networks

Payer	# Providers	n	Compared to Payer Average		Max/Min Spread	% of Providers w/in 25% of Avg
			Min	Max		
Medicaid	14	6,922	-13%	17%	0.30	93%
BCBS	14	2,558	-18%	48%	0.66	71%
Cigna	14	1,620	-23%	36%	0.59	79%
TVHP	14	999	-35%	91%	1.26	43%
MVP	14	1,040	-26%	60%	0.86	64%
CBA Blue	14	398	-37%	36%	0.73	71%
Apex	6	362	-34%	1%	0.35	33%
WellPoint	13	324	-30%	48%	0.78	62%
UHC	10	159	-25%	-4%	0.21	60%
Aetna	9	147	-32%	57%	0.89	22%
Other	12	99	-20%	15%	0.35	58%
Weighted Average Payer:			-19%	34%	53%	78%

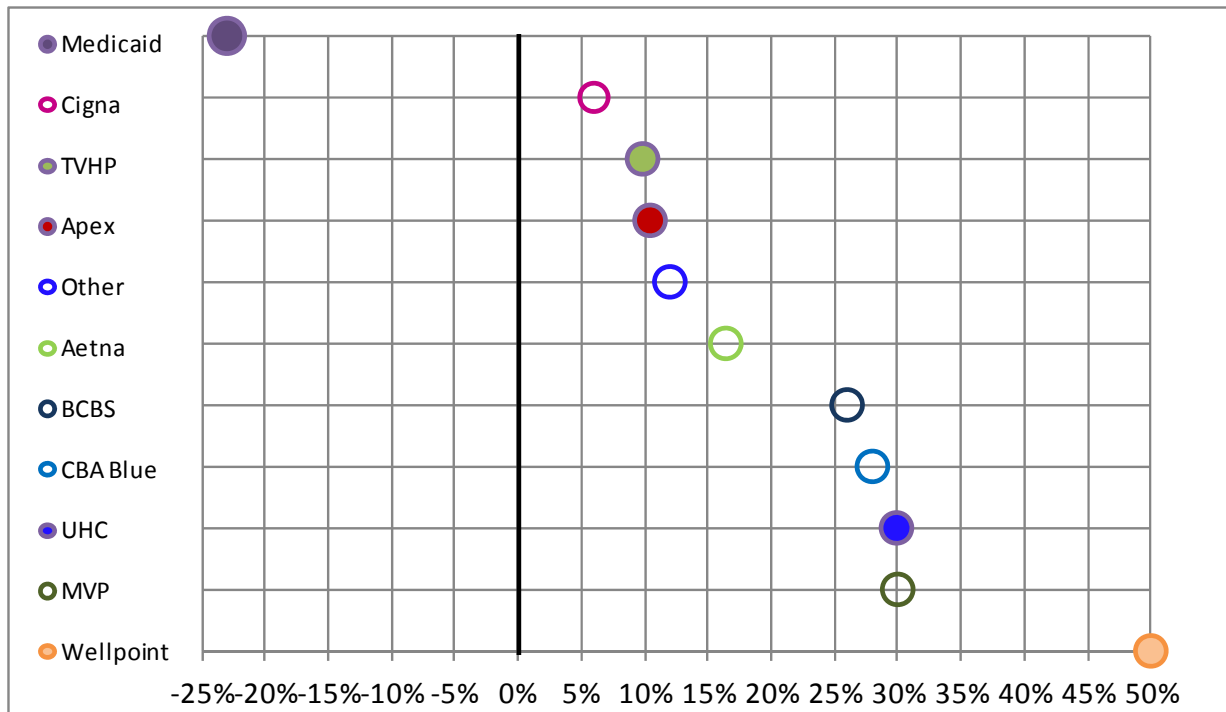
How to Read:

- Each row represents a payer network.
- Min and Max are the percent over/under the payer network average payment for the lowest and highest paid hospital within the payer network. Min and Max exclude hospitals with 5 or fewer discharges per payer.
- Spread is the range from Min to Max, and is a general measure of variability within the payer network.
- ‘% of Providers w/in 25% of Avg’ reflects the concentration of hospitals within a payer network.
- ‘Average Payer’ data in the bottom row reflect the weighted averages of data in the table.

Key Findings:

- Significant spread exists between the least paid hospitals and the highest paid hospitals within payer networks. Generally, the larger payers have less payment variation, with small numbers causing some of the variation in the smaller payers.
- The weighted average spread across all payers is 53%, which is equivalent to an average maximum 65% higher than the average minimum (a Max of 34% above the average compared to the Min of 19% below the average is equivalent to \$134/\$81).

Figure 4.2 Average Payer Payments Relative to Statewide System Average Payment



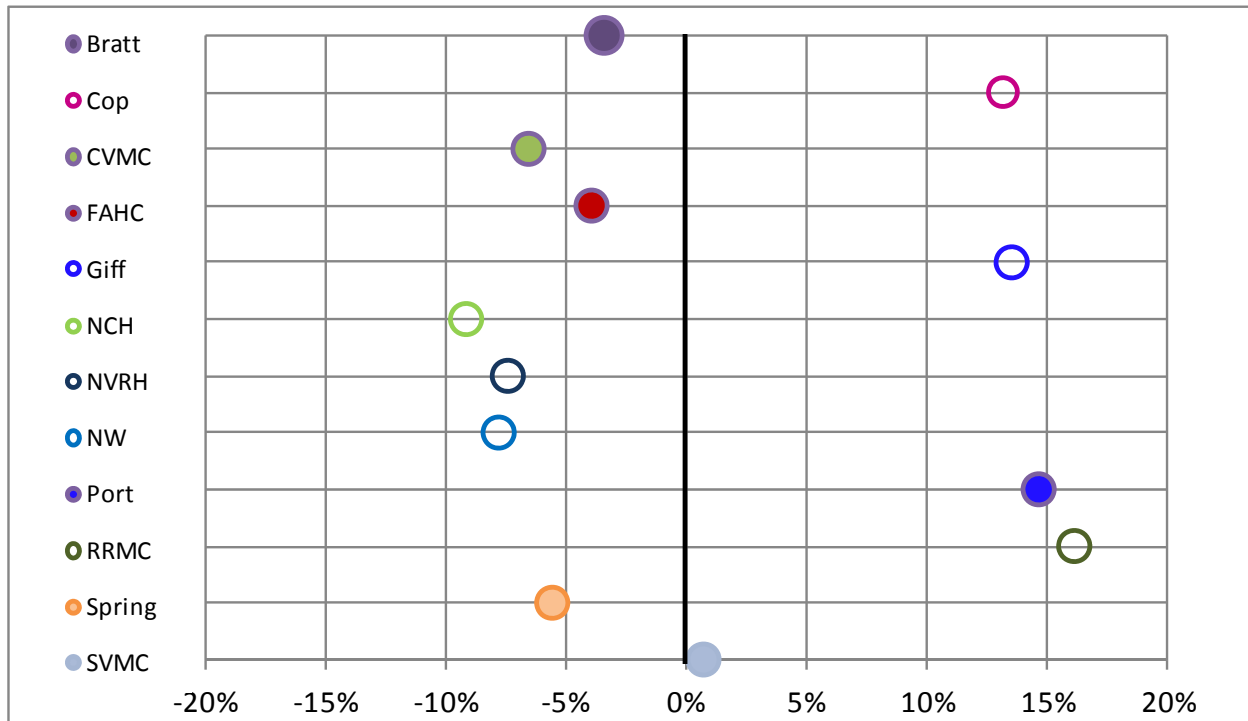
How to Read:

Data points represent the percent over/under the statewide inpatient system average payment, represented by the vertical line at 0% (system=commercial and Medicaid payments together).

Key Findings:

- Significant variation exists between the highest and lowest payers at the aggregate level, particularly between Medicaid and all other commercial payers. (Every payer listed has over 100 observations, so small numbers do not bias the statistical significance of these results.)
- Most commercial payers fall within five to fifteen points on either side of Blue Cross, which lies in the middle of the range.

Figure 4.3 Average Hospital Payments (commercial with Medicaid) Relative to Statewide System Average Payment



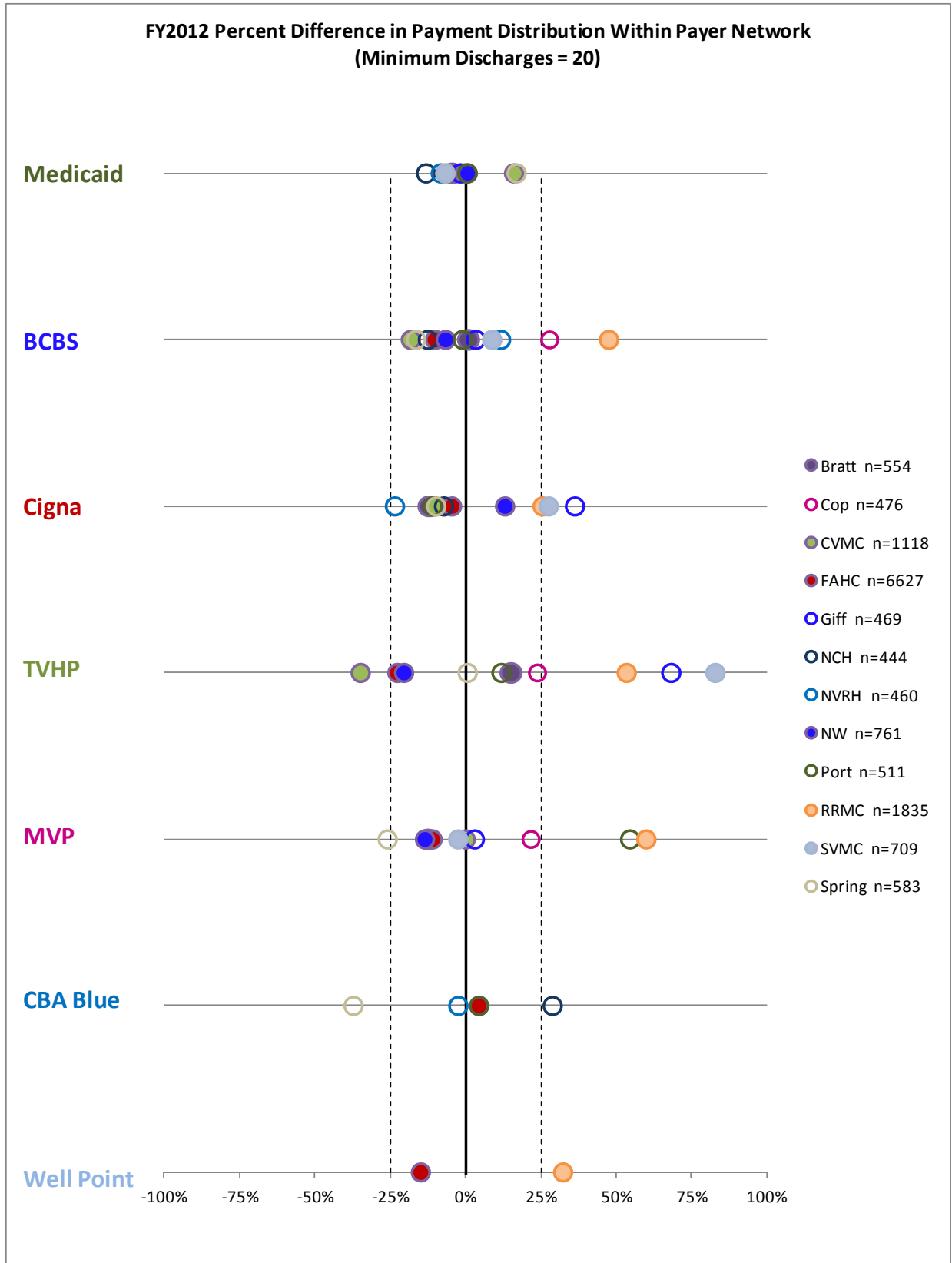
How to Read:

Data points represent the percent over/under the statewide inpatient system average payment, represented by the vertical line at 0% (system=commercial and Medicaid payments together).

Key Findings:

- Fletcher Allen, due to its large volume, drives the statewide average payment.
- A hospital’s ranking here is significantly influenced by its payer mix. Hospitals with a higher share of Medicaid payments will skew to the left, and hospitals with higher shares of commercial payers will skew to the right.
- Grace Cottage and Mount Ascutney hospitals are not shown due to small numbers.

Figure 4.4 Inpatient Payment Variations Between Hospitals within Payer Networks



How to Read Figure 4.4:

Each row represents a payer network. The payers are ranked according to statewide total payments. Each data point represents a hospital's percent over/under the payer network average payment. Supporting data is shown in Figures 4.4b below.

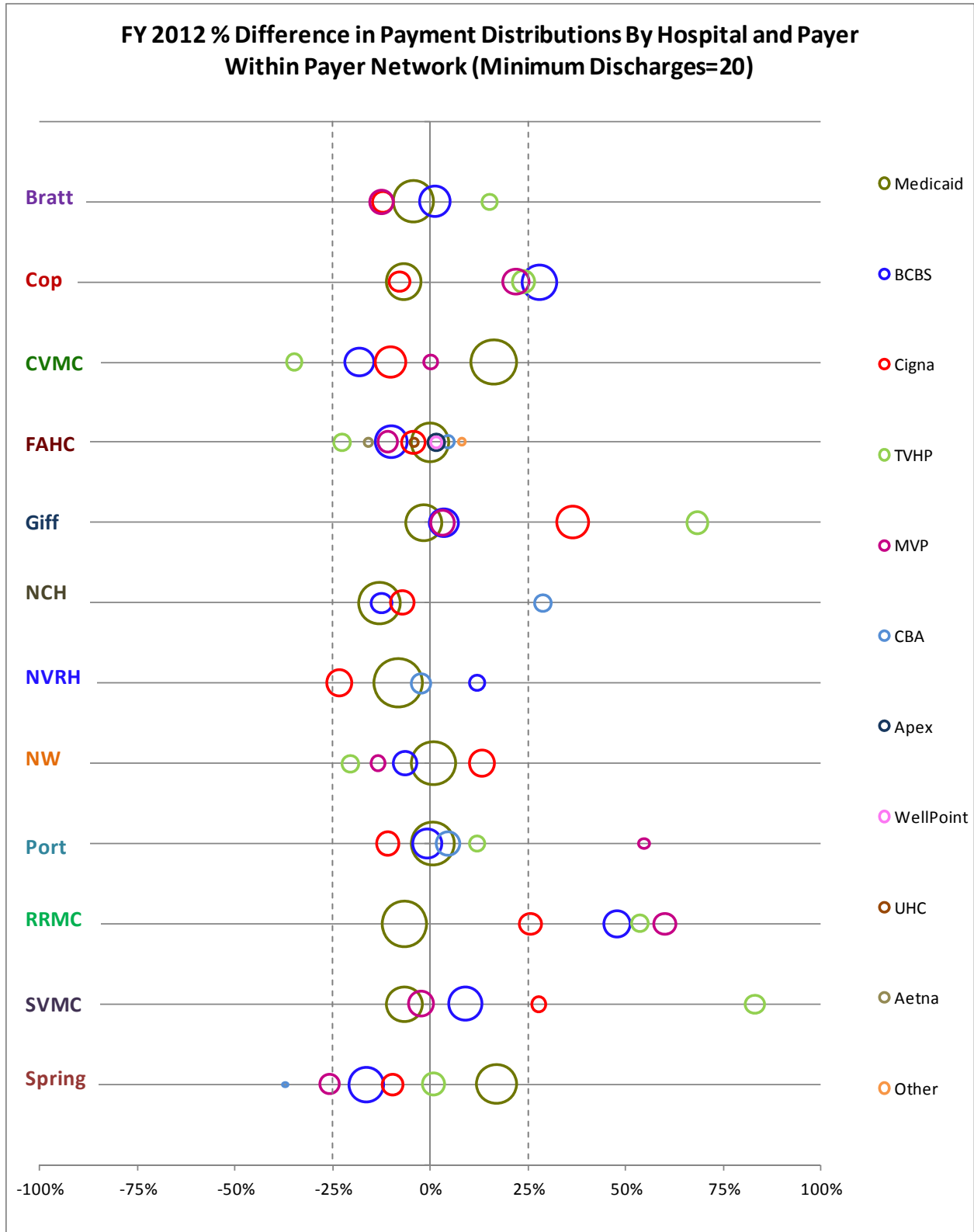
Key Findings:

- Significant variation exists between hospitals at the aggregate level, within payer networks. The majority of payers have average payments both above and below the 25% level.
- 81% (57/71 data points) of the data falls within 25% of the average.
- Greater variation above 25% than below -25%.
- A hospital 25% above the average compared to a hospital 25% below the average represents a 67% higher average payment. Again, the larger payers show less variation.
- There are 2 hospitals that appear on the WellPoint line. FAHC is at -15% and Brattleboro is at -13%.
- Variation is greatest within commercial payers.
- TVHP is paying two of the largest hospitals (FAHC and CVMC) -23% and -35% below the average, which pulls the average down. TVHP pays -9% below all other commercial payers. CAH are all paid above average.

Figure 4.4b Record Counts, for Figure 4.4

	FAHC	RRMC	CVMC	NW	SVMC	Spring	Bratt	Port	Cop	Giff	NVRH	NCH	Mt. A.	Grace	Total
Medicaid	2,680	1,035	547	419	399	380	278	213	209	214	255	261	22	10	6,922
BCBS	1,286	301	190	94	140	68	87	114	91	74	59	47	5	2	2,558
Cigna	745	153	218	63	57	26	56	30	52	83	62	60	13	2	1,620
MVP	526	83	39	64	63	26	61	40	51	53	10	16	2	6	1,040
TVHP	504	146	85	50	24	25	23	38	43	30	15	12	2	2	999
CBA Blue	164	9	15	14	2	35	14	49	9	3	44	32	7	1	398
Apex	343		1	13				2	2			1			362
WellPoint	138	72	10	12	7	10	21	13	9	8	7	12	5		324
UHC	91	19	5	15	11	3		5	5		3		2		159
Aetna	97	12	6	4	5	6	11	4	2						147
Other	53	5	2	13	1	4	3	3	3	4	5	3			99
Total	6,627	1,835	1,118	761	709	583	554	511	476	469	460	444	58	23	14,628

Figure 4.5 Inpatient Payment Variations Between Hospitals



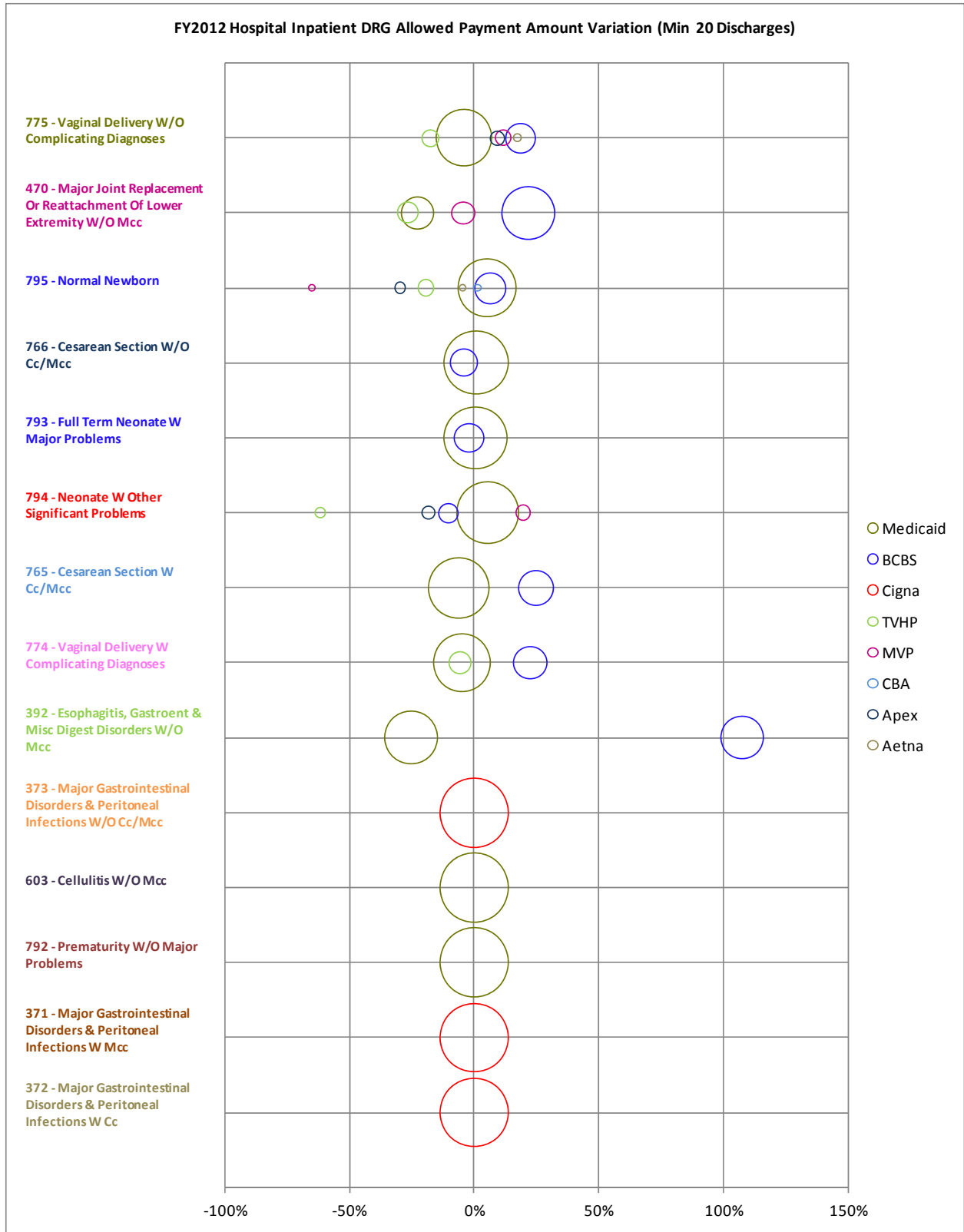
How to Read:

Each row contains a given hospital's network of payers. The bubbles for each payer are sized to reflect payer share for the given hospital. The data points represent the payer's average payment to that hospital, relative to its own payer network average. (Payer X pays Hospital Y percent Z over/under the average of what it pays to all other hospitals).

Key Findings:

- Fletcher Allen makes up roughly 45% of any given payer's network and thus drives the overall average payment for each payer network, which explains the concentration in Fletcher Allen's payments.
- 81% of the data falls within +/-25% of the average.
- The majority of the variation stems from Cigna, MVP and TVHP
- Variation is greatest at Rutland and Gifford
- Medicaid is the dominant payer for every hospital.
- Grace Cottage and Mt. Ascutney are not shown due to small numbers.

Figure 4.6 Inpatient Payment Variations by Payer, by DRG



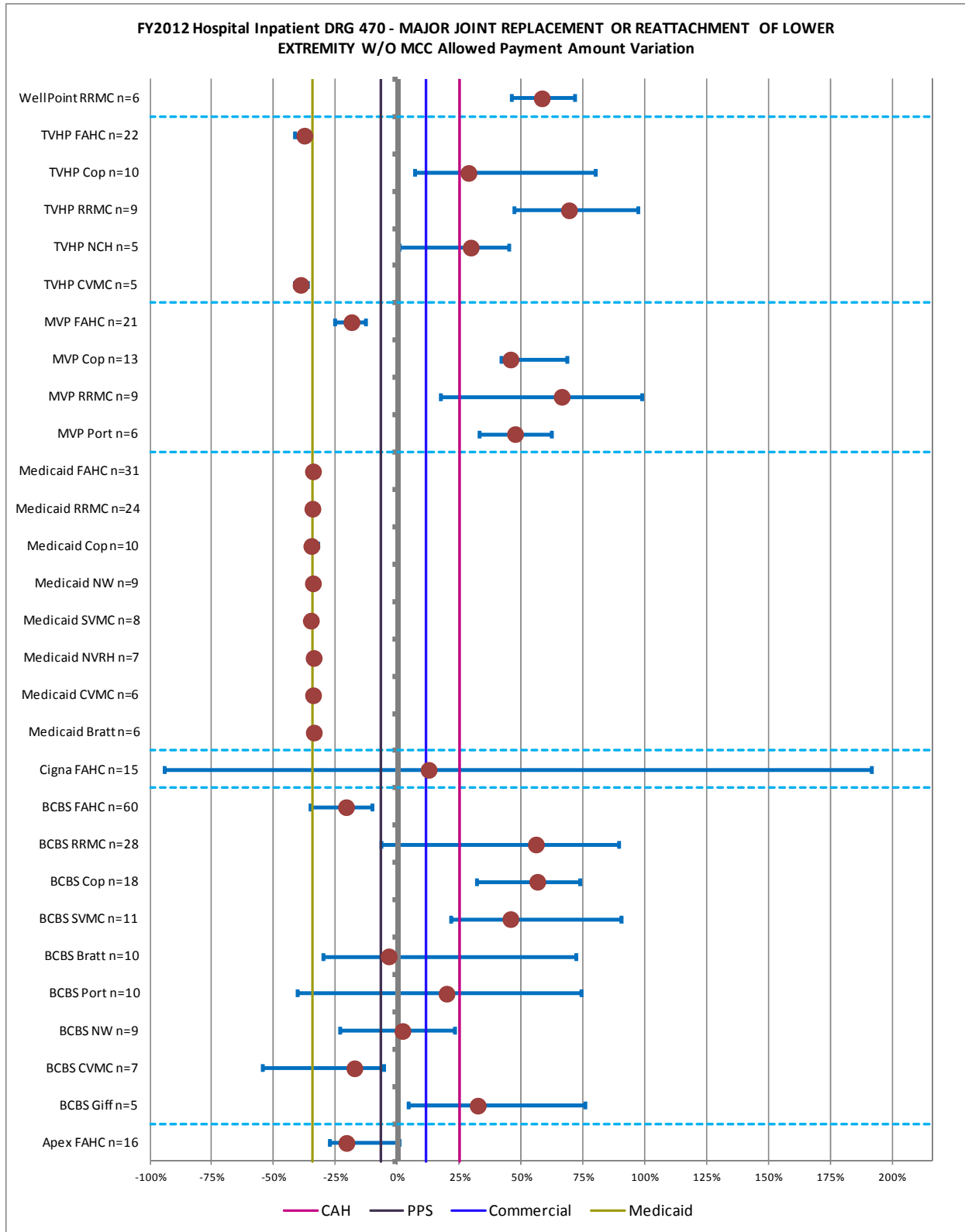
How to Read:

Figure 4.6 is a summary presentation of the top ranked DRGs, with variation by payer. Each row shows payment data for a given DRG with at least 20 discharges per bubble. The DRGs are ranked by payments from high to low. The data points represent a given payer's average payment for that DRG, relative to the system wide average payment for the same DRG (0% on the horizontal axis), effectively showing variation between payers for the same DRG. (System = commercial + Medicaid together). The bubbles for each DRG are sized to reflect payer share for that DRG. This same graph is shown the Appendix Section 3.a in more detail.

Key Findings:

- Medicaid is the largest payer for many of these top ranked DRGs (eg. Delivery and Newborn).
- Variation between Medicaid and commercial payers is less here than in Outpatient or Professional claims.
- The degree of variation between payers appears largely to be a function of the specific DRG. For example, vaginal or cesarean deliveries without complications show less variation than other DRGs.
- Variation within each DRG is shown by payer and by hospital in the Appendix. The top two examples are presented below (joint replacements and vaginal delivery). (In the following examples, data is shown for instances with 5 or more discharges.)

Figure 4.7 Inpatient Payment Variation by Payer, by Hospital, by DRG 470 – Major Joint Replacement



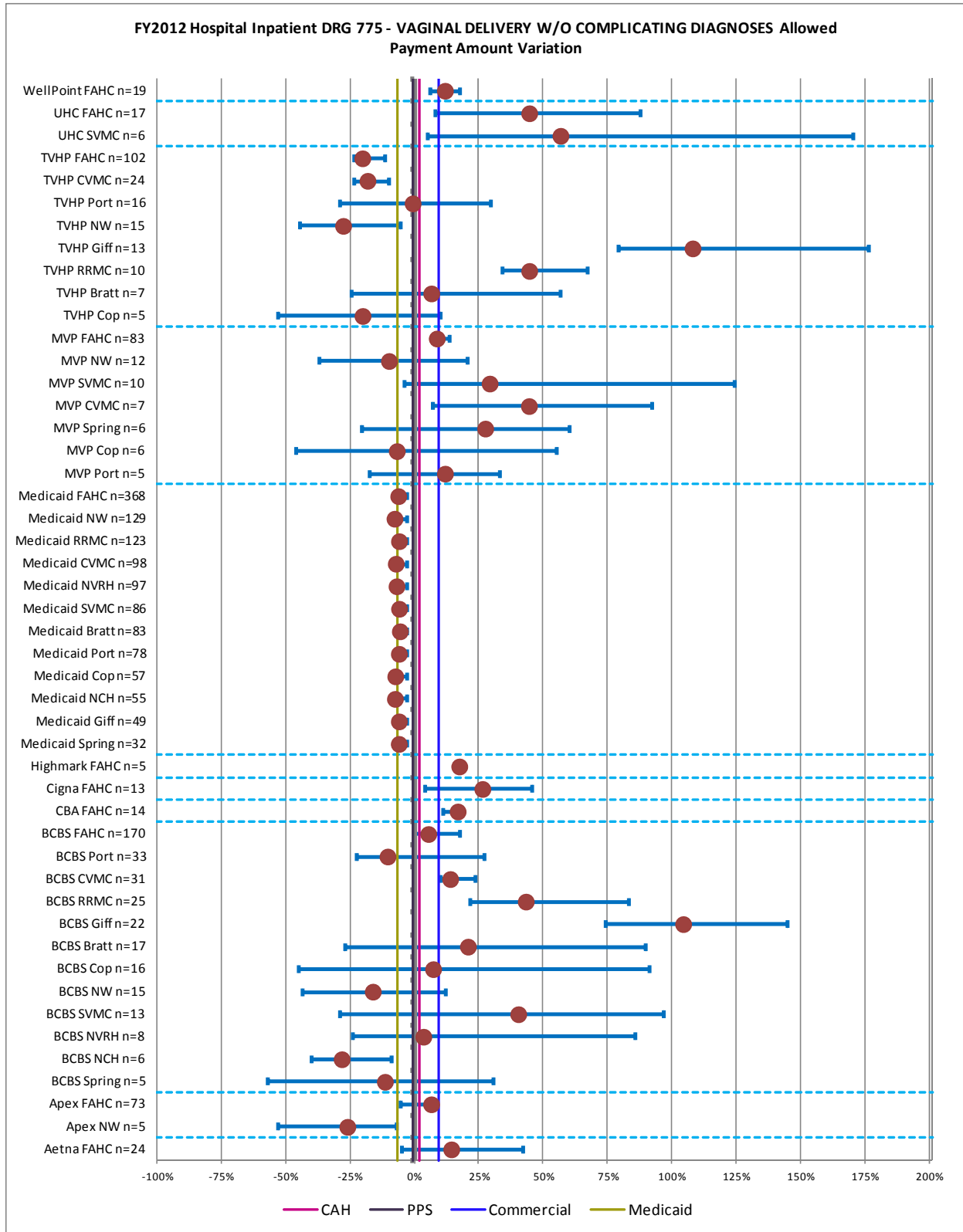
How to Read: Each row represents a unique payer-hospital combination. Rows are grouped by payer. All payer-hospital combinations with 5 or more observations are displayed.⁷ The red data point is the average payment relative to the statewide system average, for that payer to that hospital for that DRG. The whiskers show the 10th and 90th percentile payment levels, and 0% over/under represents the average payment, system wide, for the DRG. The average payment levels are also shown for Prospective Payment System (PPS) and Critical Access (CAH) hospitals, as well as the average payment for commercial payers vs. Medicaid (see key at bottom of graph).

Key Findings:

- Significant variation in payments exists between payer-hospital combinations. In addition, significant variation exists *within* any one payer-hospital. Small numbers explains some of this variability, but this highlights payment variation between individual cases. Analysis of the variability in resource consumption, patient needs and treatments, lengths of stay, etc. would shed more light on the roots of variation within DRGs.
- Additionally, differences in reimbursement rules may play a significant role in payment variation at this level. For example, Medicaid pays a flat rate for the DRG across all hospitals. However, some payers may pay some hospitals a flat rate while others pay a percent of charge, per diem or some other arrangement. For example note the relative absence of variation for TVHP's payments to CVMC and FAHC, but not for NCH, RRMC or Copley. Also, MVP may pay FAHC a flat rate, but not the other hospitals in its network. Further policy analysis may shed more light on why this variation exists.

⁷ Due to the sparseness of inpatient discharge counts by specific DRGs across hospitals, the limit is set to only 5 here to provide more data points for viewing purposes. Care should be taken in drawing conclusions from small numbers.

Figure 4.8 Inpatient Payment Variation by Payer, by Hospital, by DRG 775 – Vaginal Delivery



Hospital Outpatient

No practical or reasonable methodology currently exists to case-mix adjust aggregate outpatient data. Therefore, to explore variation on outpatient claims, payments must be isolated by ICD-9 procedure code. Outpatient records with principal procedure codes include those cases commonly referred to as Outpatient Ambulatory Surgery.⁸

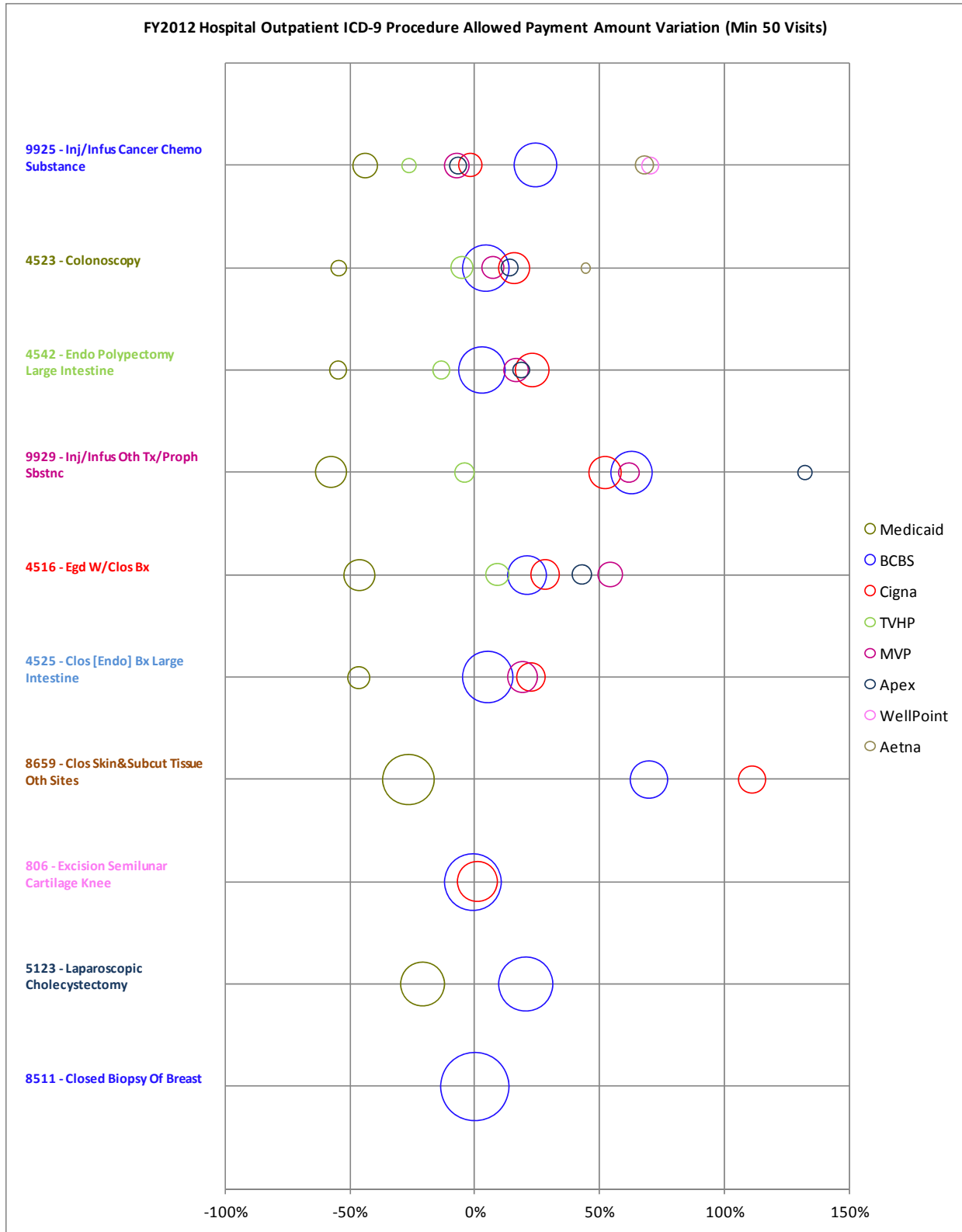
As with inpatient DRGs, outpatient claims with the same principal procedure will vary in their levels of resource consumption, patient needs, etc. and may therefore still show significant variation between individual cases, even within the same hospital under the same payer.

The sequence of the presentation for outpatient variation results is as follows:

1. Bubble chart summary of variation by top ranked principal procedures (Fig. 4.9)
2. Three examples of specific procedures: Box-plot charts of variation within ICD-9, by payer, by hospital (Figs. 4.10 - 4.12). The remaining procedures that meet the criteria for minimum record counts are shown in the Appendix.

⁸ Only about 10% of total outpatient records are coded with ICD-9 procedures. These records account for about 37% of payments in VHCURES.

Figure 4.9 Outpatient Variation by ICD-9 Principal Procedure Codes



How to Read:

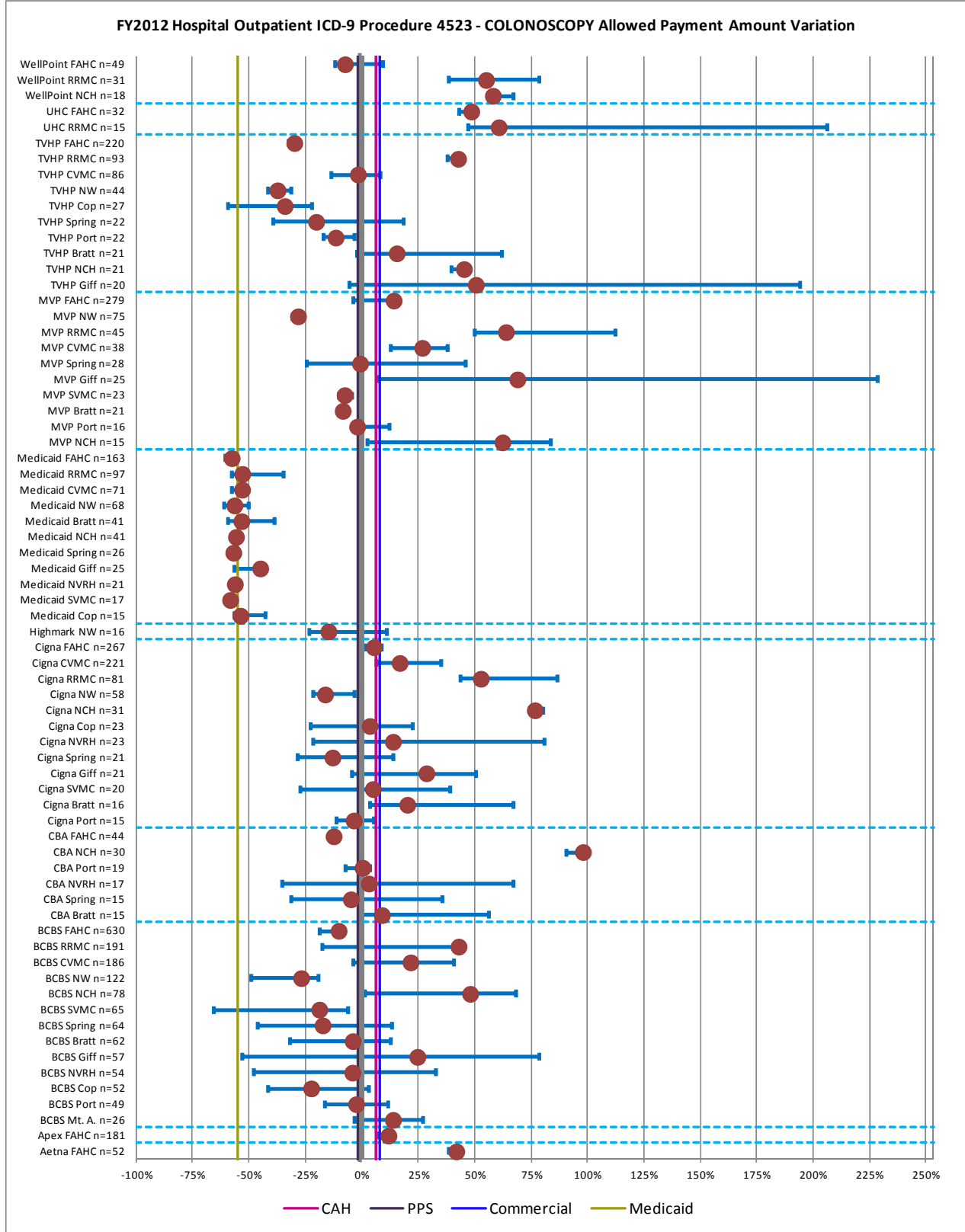
This is a summary presentation of the top ranked ICD-9 Principal Procedures, with variation by payer.

Each row shows payment data for a given principal procedure with at least 50 discharges per bubble. The procedures are ranked by payments from high to low. The data points represent a given payer's average payment for that procedure, relative to the system wide average payment for the same procedure, effectively showing variation between payers for the same procedure. The bubbles for each procedure are sized to reflect payer share.

Key Findings:

- Most of the observed variation is between Medicaid and the commercial payers.
- Significant variation with no discernible pattern by payer.
- Variation is procedure based to some degree. For example there could be larger variation for procedures that include high drug costs where different drugs have extreme price differentials and lower variation for more routine procedures such as a colonoscopy.

Figure 4.10 Outpatient Variation by ICD-9 Principal Procedure Code 4523 – Colonoscopy



How to Read:

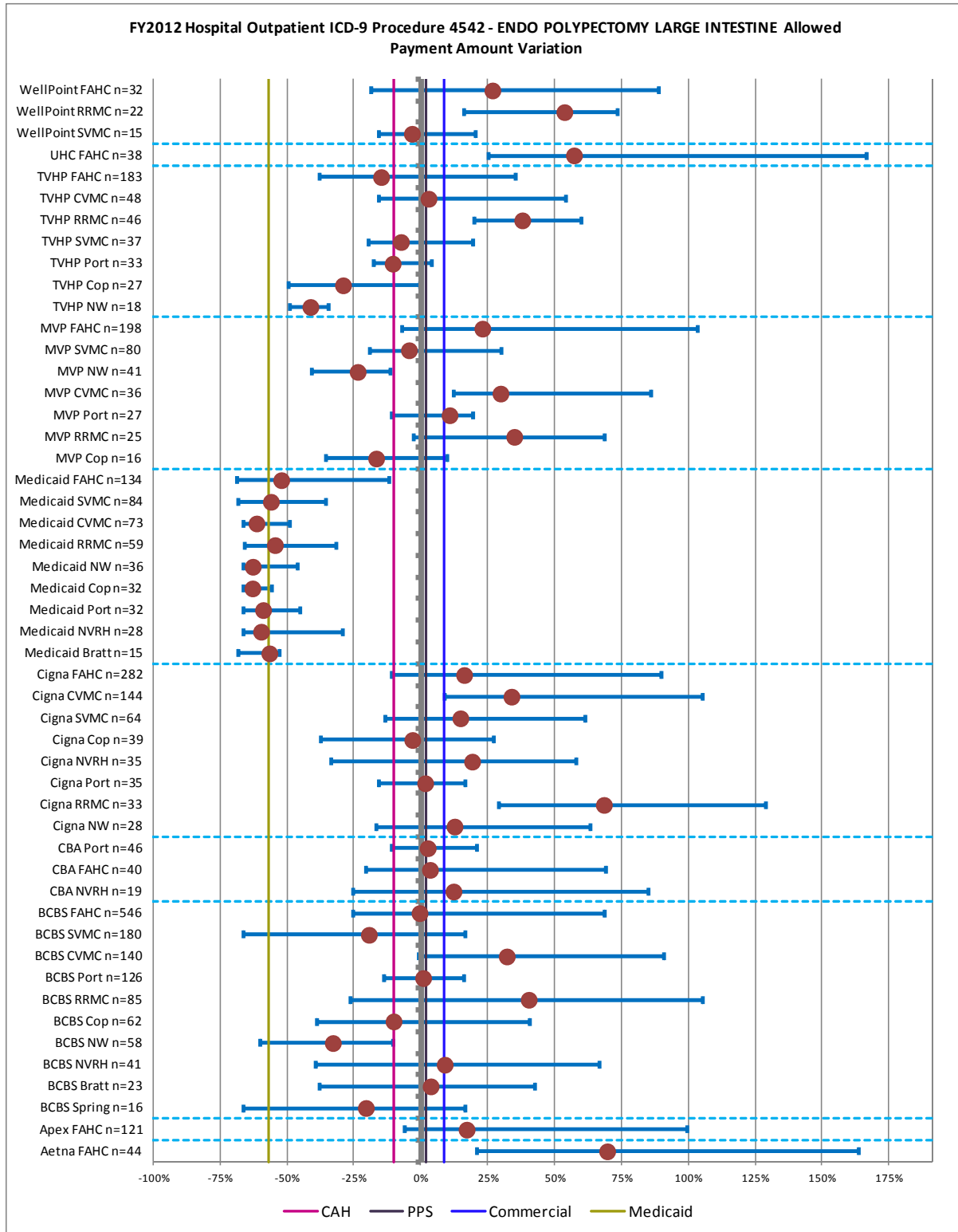
Each row represents a unique payer-hospital combination. Rows are grouped by payer. All payer-hospital combinations with 15 or more observations are displayed.⁹ The red data point is the average relative payment (relative to the statewide system average) for that payer to that hospital for that principal procedure. The whiskers show the 10th and 90th percentile payment levels.

Key Findings:

- Different levels of variation exist between different hospitals within payer groups and across same hospitals between payer groups.
- The whiskers show high levels of payment variation within individual hospitals even under single payers, again highlighting the variability of individual cases.
- As with DRGs, some hospitals are paid close to a flat rate for the procedure (Medicaid, MVP-NW, TVHP-FAHC, etc.) where others have much more variability (MVP-Giff or Spring, TVHP-Giff, Cigna-SVMC, etc.) perhaps suggesting a percent of charge contract.

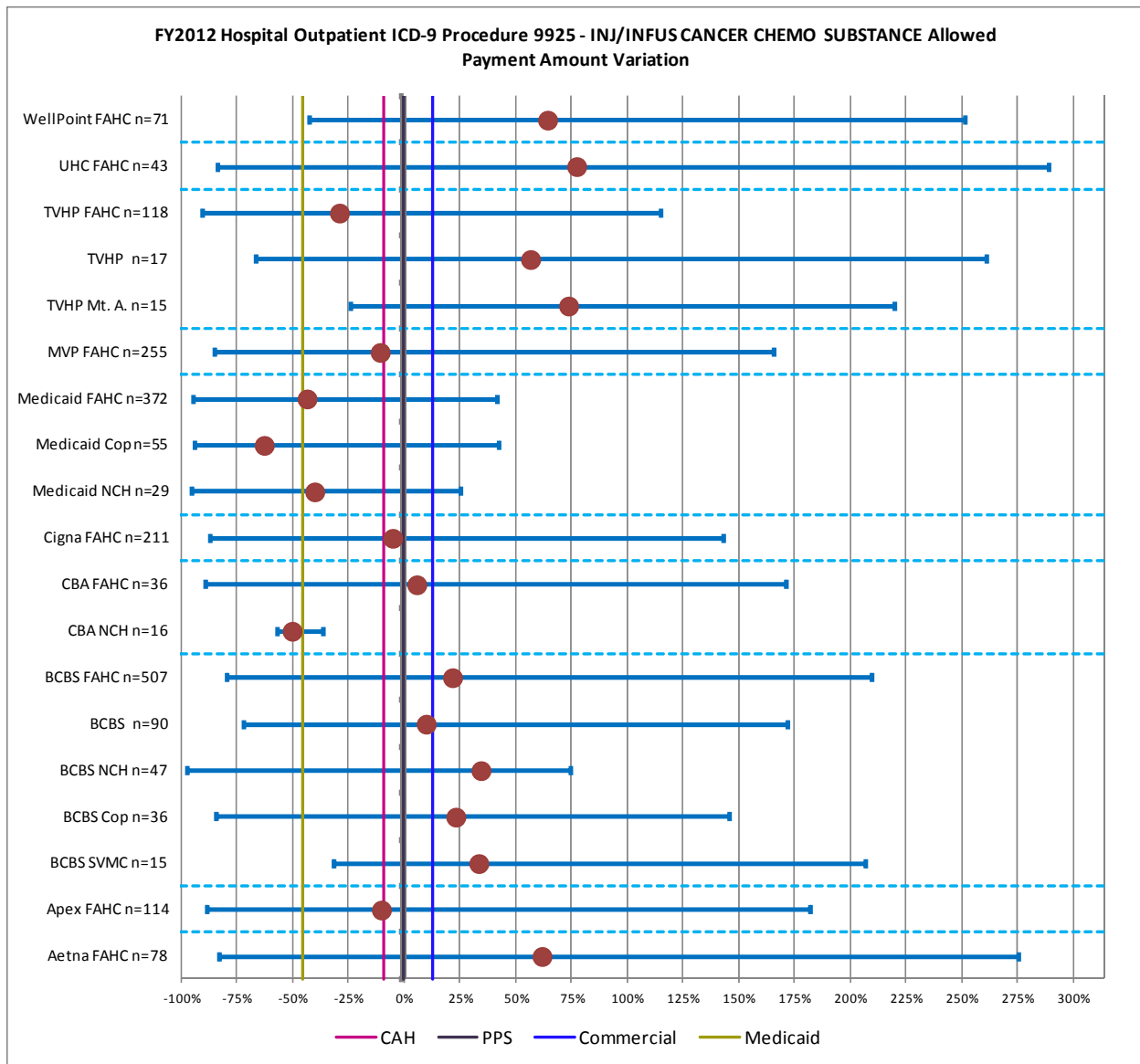
⁹ There are far more outpatient visits than inpatient visits to most hospitals. With this abundance of data, the limit here is set to 15 to provide more robust statistical significance (as well as allowing the data to fit on one page).

Figure 4.11 Outpatient Variation by ICD-9 Principal Procedure Code 4542 – Endo Polypectomy



Key Findings: There are high levels of variation within most payer-hospital combinations, including Medicaid, compared to other procedures.

Figure 4.12 Outpatient Variation by ICD-9 Principal Procedure Code 9925 – INJ/INFUS Cancer Chemo



Key Findings: Much of this variation may come from large differences in the types, quantities and costs of drugs used.

Professional Claims

Due to the large number of providers billing professional claims in VHCURES, variation is presented by site of service and HCPC/CPT rather than by individual provider. VHCURES does not currently identify the specific institution with which a given provider is associated. The data do, however, identify the 'service site' for each claim (e.g. hospital inpatient, hospital outpatient, hospital Emergency Room [ER], office, etc). Therefore, data results show the top ranked CPTs for inpatient, outpatient, ER and office service sites.

The sequence of the presentation for professional variation results is as follows:

1. Hospital Inpatient
 - a. Bubble chart summary of variation by top ranked CPT's (Fig. 4.13)
 - b. Box-plot charts of variation within CPT's, by payer, by hospital (Fig. 4.14, 4.15)
2. Hospital Outpatient
 - a. Bubble chart summary of variation by top ranked CPT's (Fig. 4.16)
 - b. Box-plot charts of variation within CPT's, by payer, by hospital (Fig. 4.17, 4.18)
3. Hospital ER
 - a. Bubble chart summary of variation by top ranked CPT's (Fig. 4.19)
 - b. Box-plot charts of variation within CPT's, by payer, by hospital (Fig. 4.20, 4.21)
4. Office
 - a. Bubble chart summary of variation by top ranked CPT's (Fig. 4.22)
 - b. Box-plot charts of variation within CPT's, by payer, by hospital (Fig. 4.23, 4.24)

How to Read Figures:

The graph formats are identical to those presented for inpatient and outpatient.

Key Findings for all Professional Categories:

- As with the outpatient claims, there is a high degree of variation between Medicaid and other payers.
- There are high levels of variation within any one payer-hospital combination.
- Variation may be a function of provider specialty.

Figure 4.13 Professional Variation Summary by CPT – Hospital Inpatient

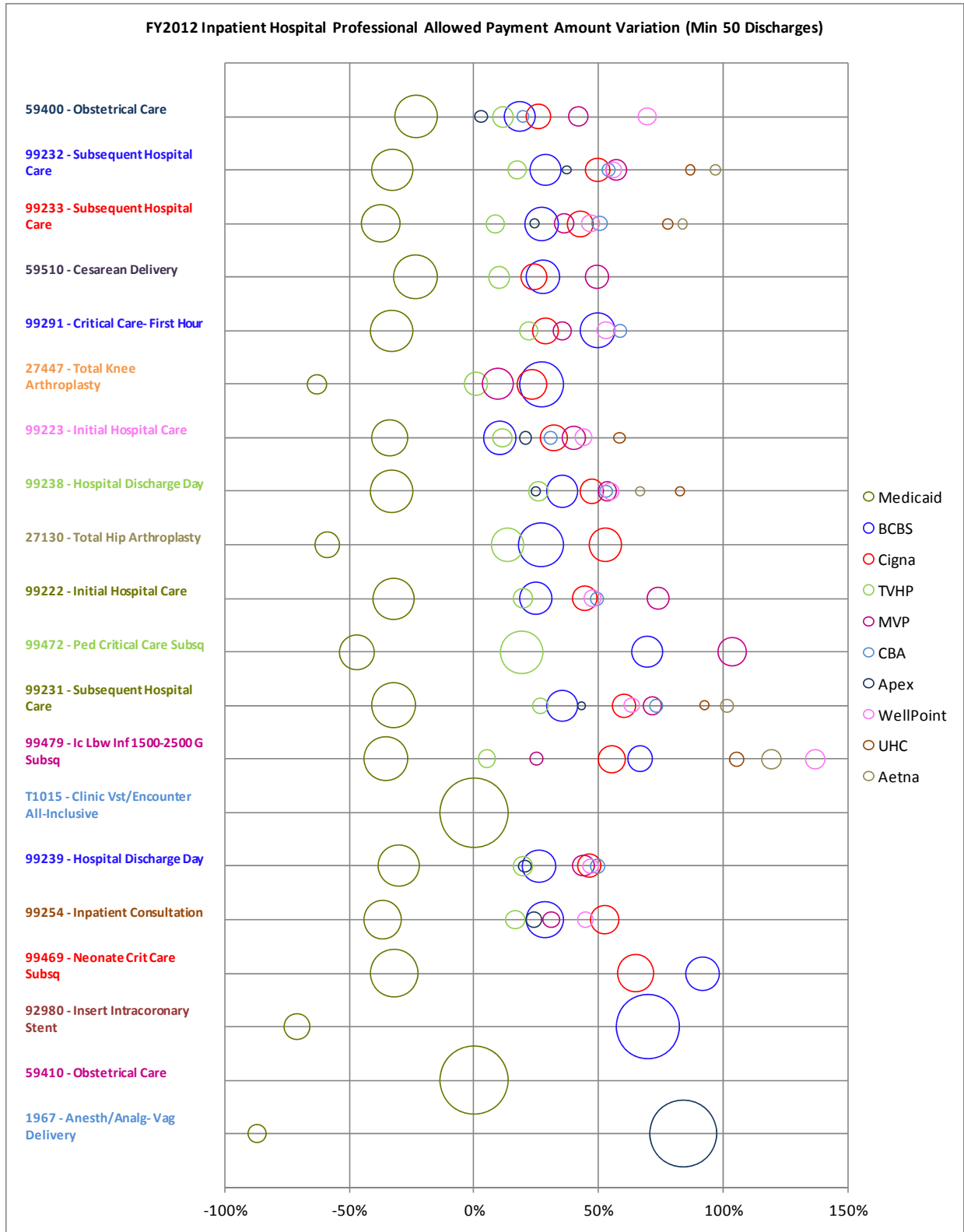


Figure 4.14 Professional Variation by CPT 59510 – Cesarean Delivery, Hospital Inpatient

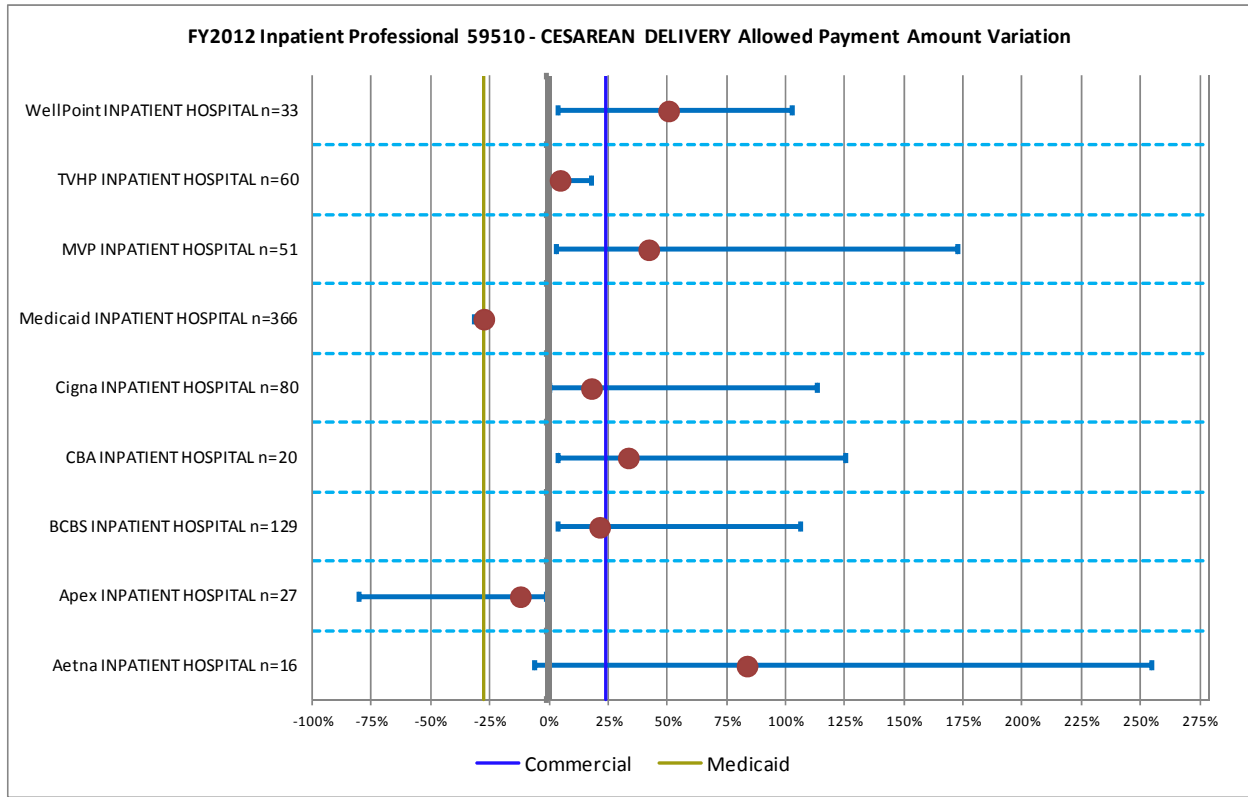


Figure 4.15 Professional Variation by CPT 27447 – Total Knee Arthroplasty, Hospital Inpatient

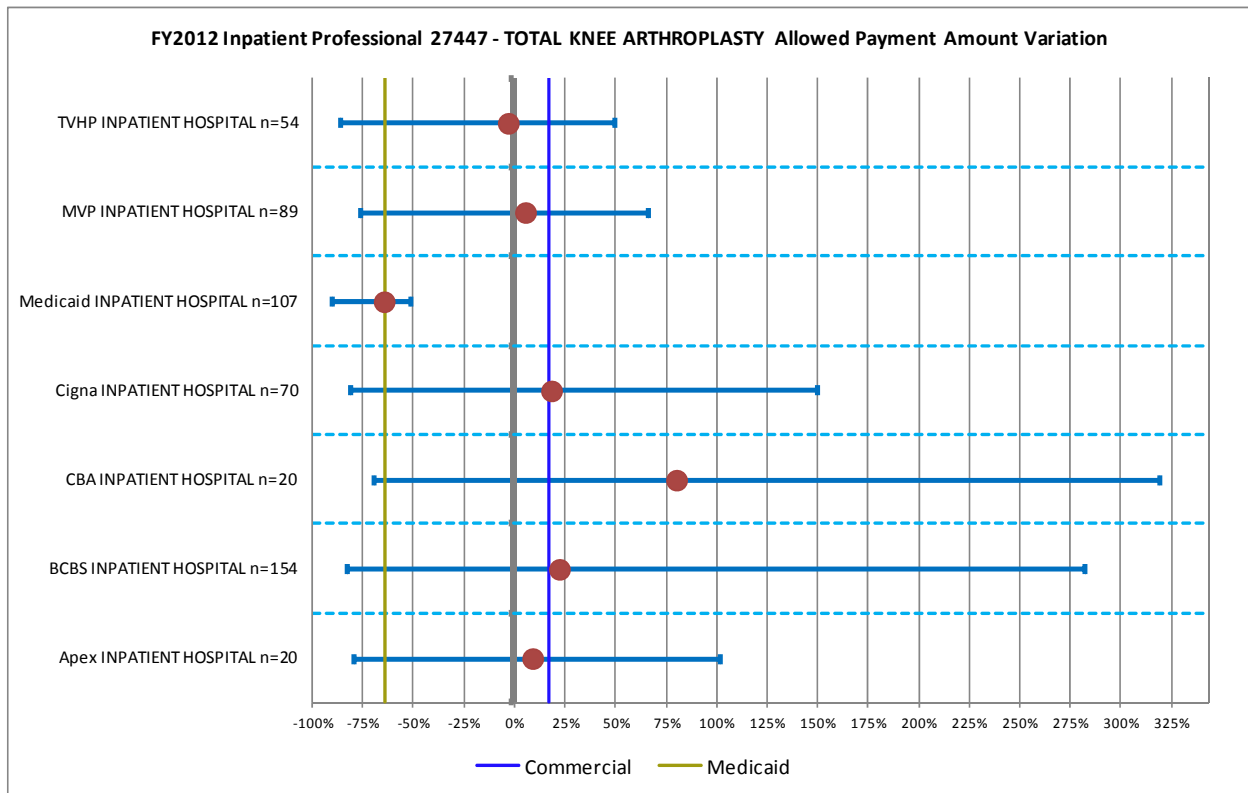
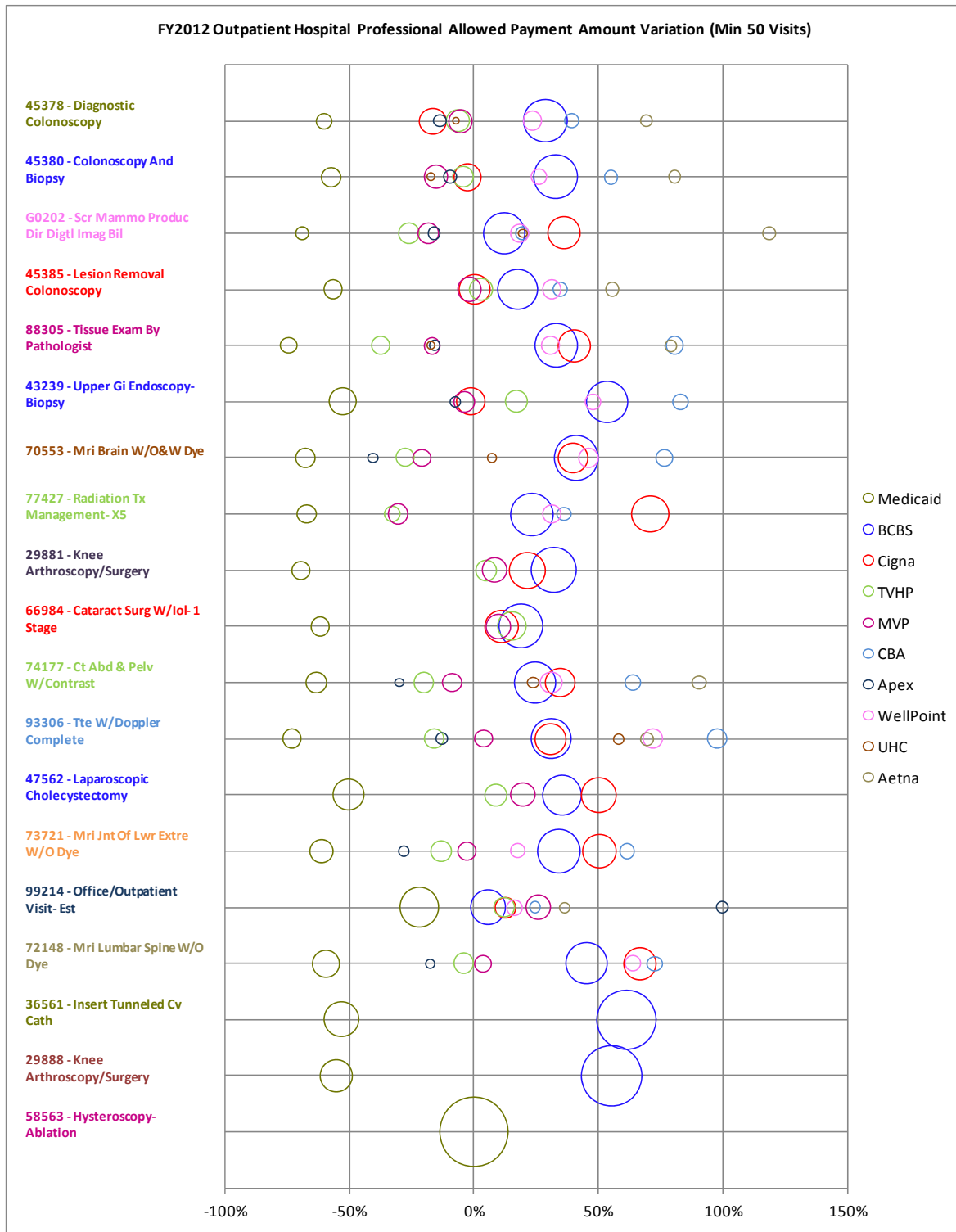


Figure 4.16 Professional Variation Summary by CPT – Hospital Outpatient



Key Findings: There is a higher degree of variation here than seen in professional inpatient claims. There appears to be some consistency in payer patterns.

Figure 4.17 Professional Variation by CPT 45378 – Dx Colonoscopy, Hospital Outpatient

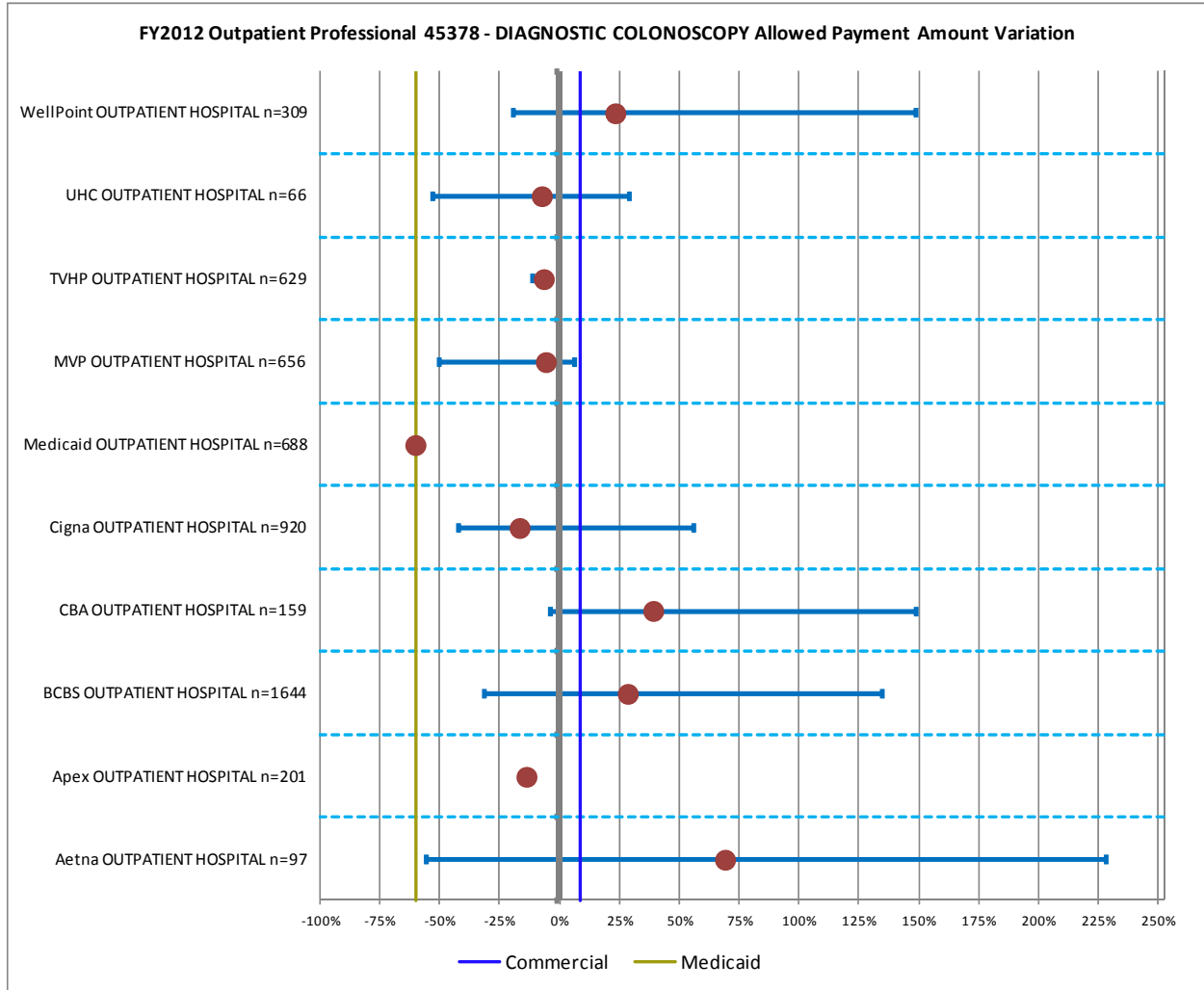


Figure 4.18 Professional Variation by CPT G0202 – Screening Mammogram, Hospital Outpatient

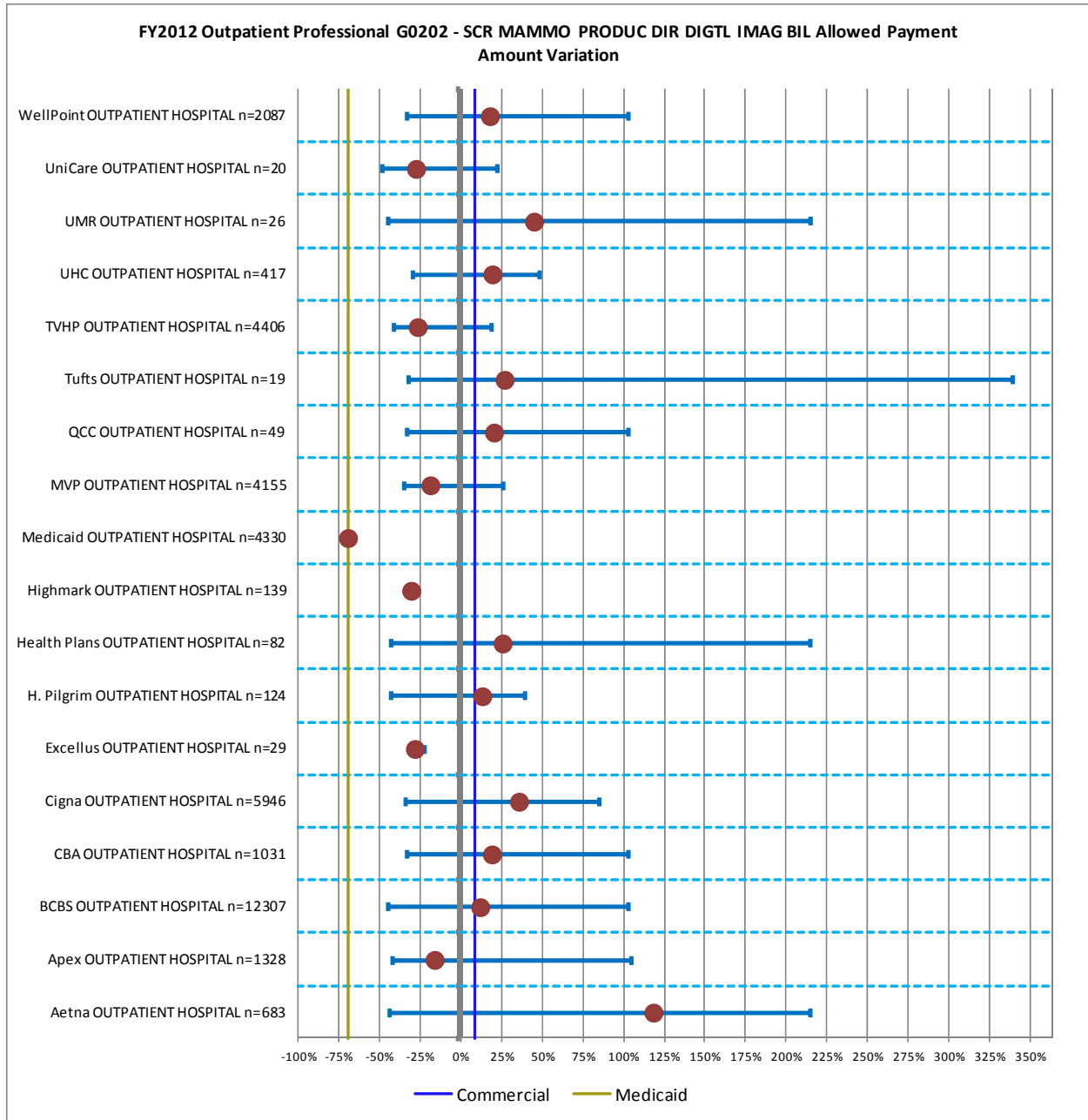
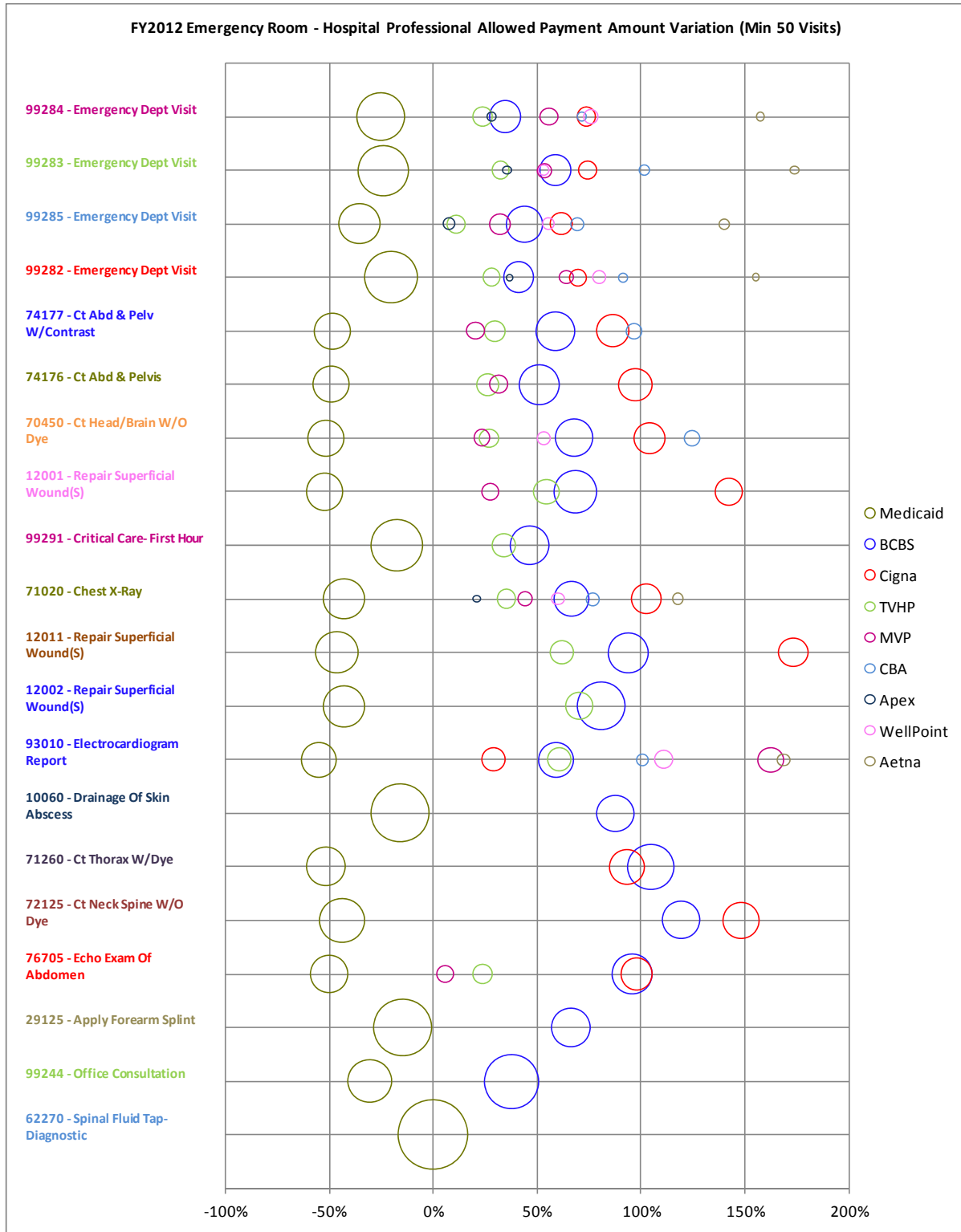


Figure 4.19 Professional Variation Summary by CPT – Hospital ER



Key Findings: There is a clearly visible pattern in payer rankings.

Figure 4.20 Professional Variation by CPT 99284 ED Visit Level 4, Hospital ER

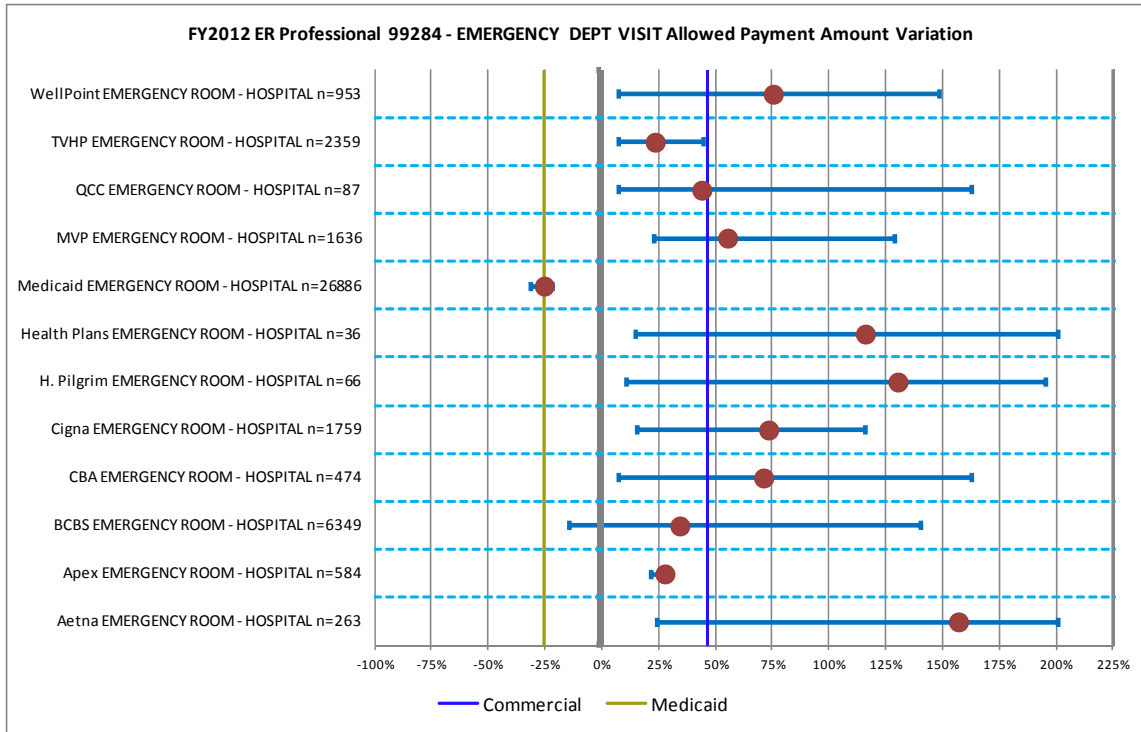


Figure 4.21 Professional Variation by CPT 71020 Chest X-Ray, Hospital ER

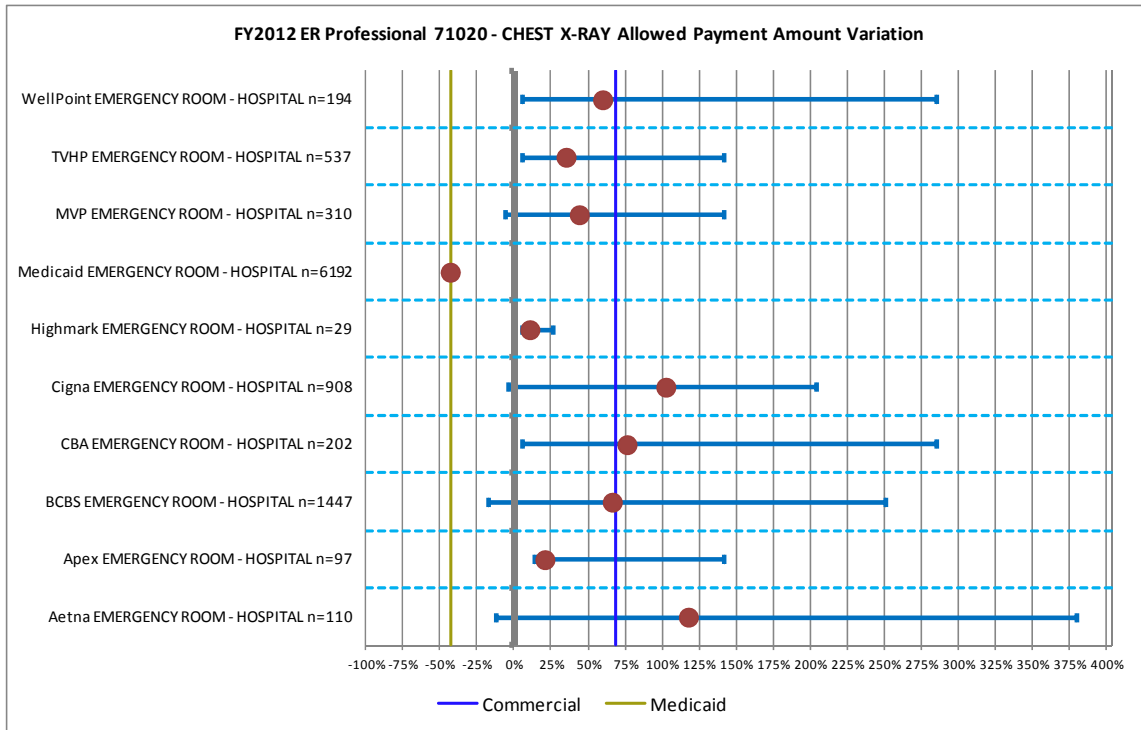
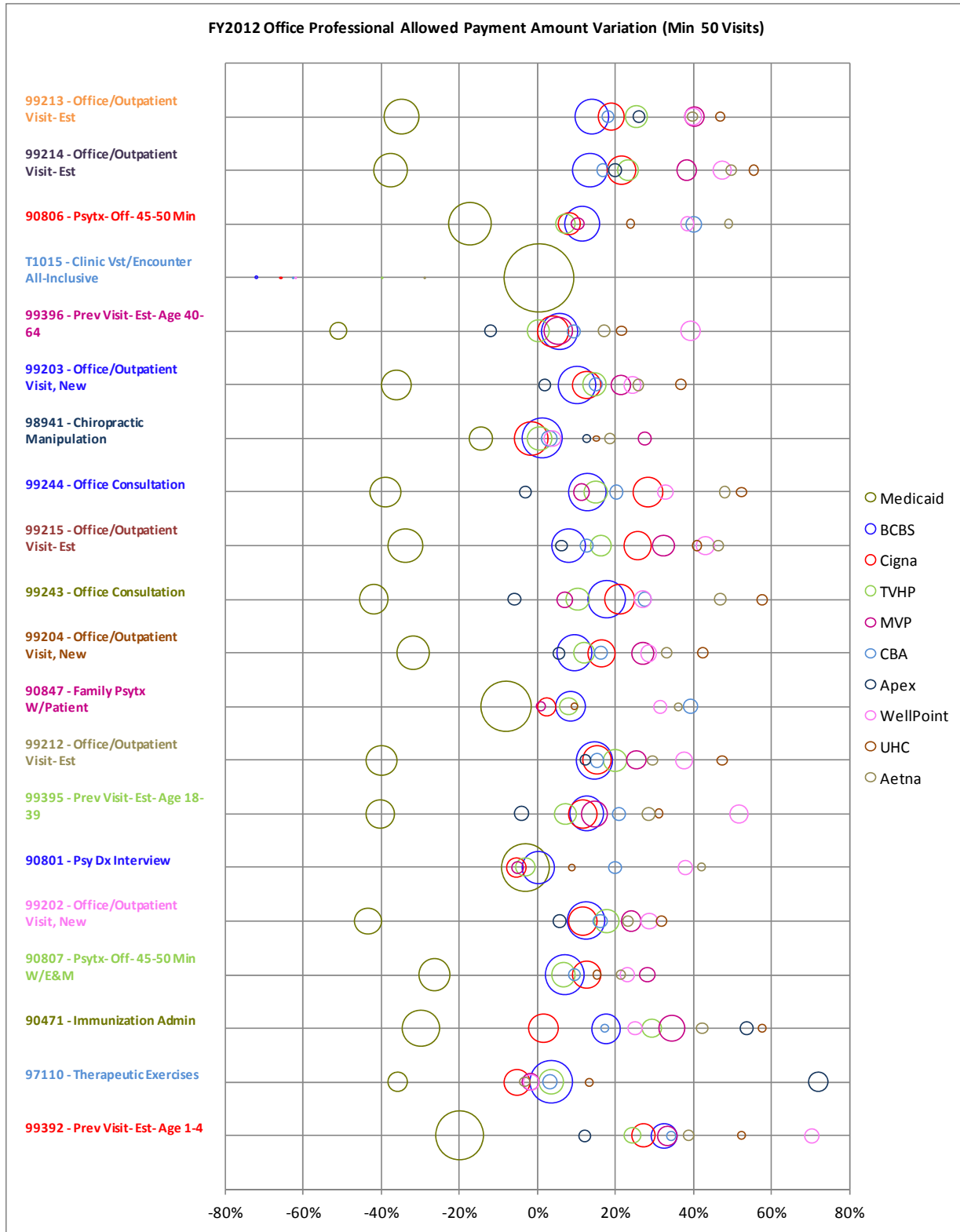


Figure 4.22 Professional Variation Summary by CPT – Office



Key Findings: One source of variation here may come from differing provider specialties.

Figure 4.23 Professional Variation by CPT 99213 –Office/OP Visit-Est, Office

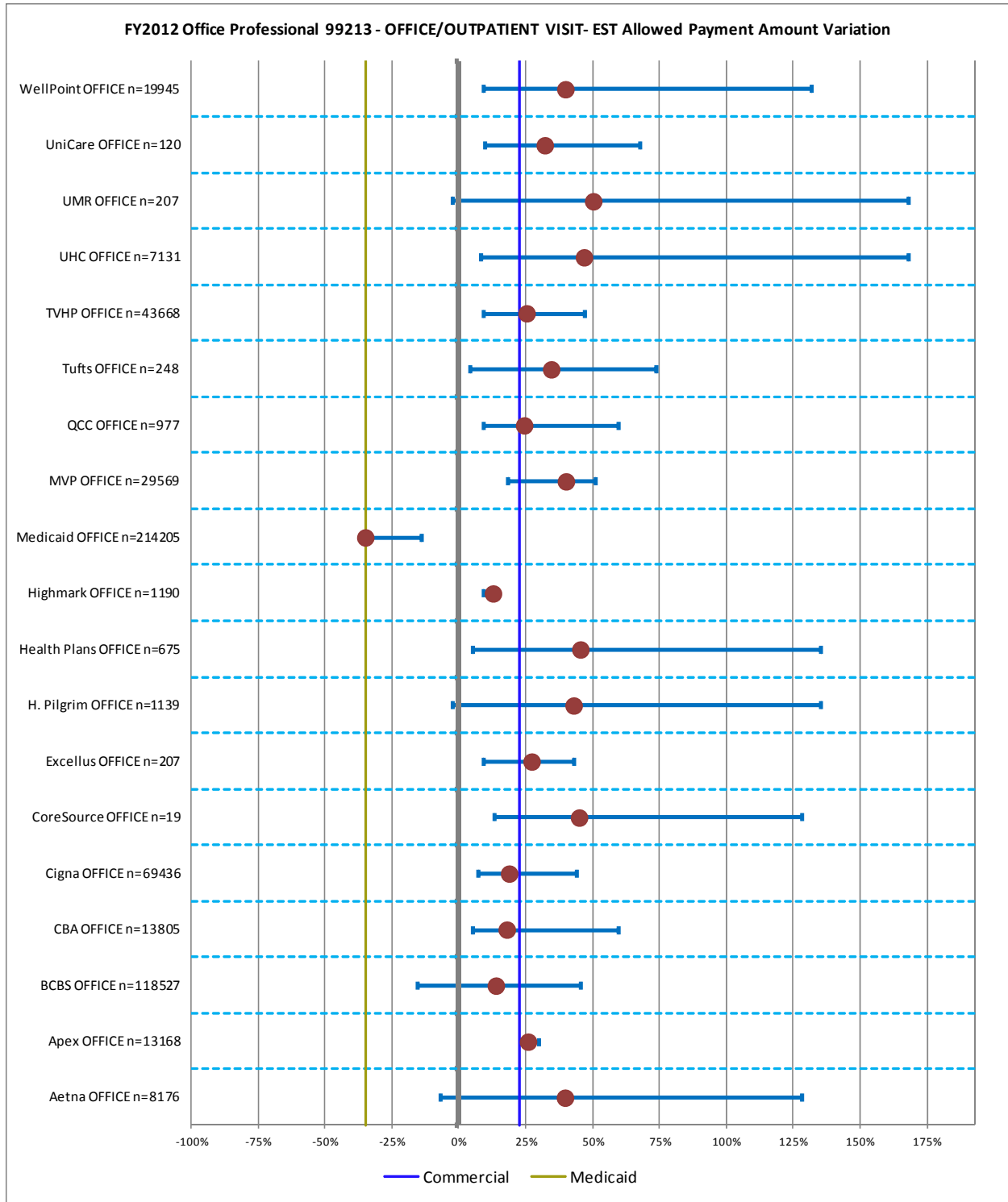
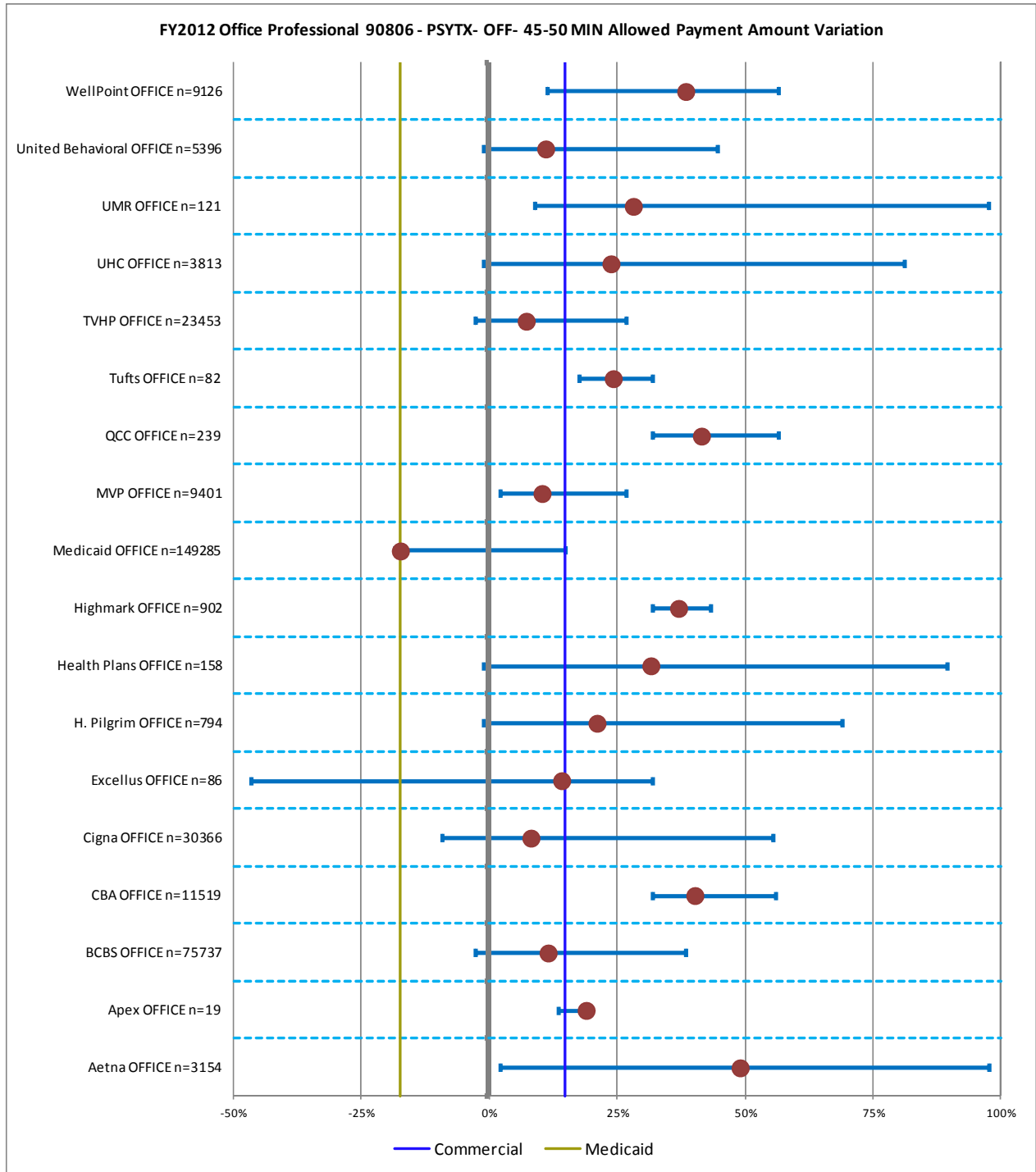


Figure 4.24 Professional Variation by CPT 90806 – Psychotherapy Office Visit, Office



Post Acute Care

The post-acute care analysis is presented in a similar fashion to the bundled payment analytical approach. The anchoring event is an inpatient stay. The lookback period is defined as a period of time prior to the inpatient admission where there was no observed inpatient utilization. In this summary analysis, the lookback period is 30 days. The post-acute period in which system-wide health care utilization is observed is presented for 30, 60 and 90 days. Post-acute utilization is observed at the following facilities or resource types:

1. Inpatient readmissions (all-cause)
2. Outpatient visits
3. Professional visits
4. Home or Ambulatory Durable Medical Equipment (DME)
5. Pharmacy
6. Other

Key Findings:

- Post acute care payments are 27% of total episode payments.
- Due to the majority of post acute care payments resulting from the inpatient discharge, the variation arising from differences in post acute care are minimal compared to variation in inpatient payments.

Figures 4.25 and 4.26 show a 30 day post-acute period.

Figures 4.27 and 4.28 show 30, 60 and 90 day post-acute periods all within the same data table.

Figures 4.29 and 4.30 show Post-Acute data by Payer.

Figure 4.25 Post-Acute Care Detail (\$ are averages) (30 Days Post Acute)

Hosp	n	Post-Acute			Home/Amb				Total
		Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other	
Bratt	504	\$ 8,878	\$ 1,673	\$ 698	\$ 583	\$ 137	\$ 293	\$ 149	\$12,412
Cop	423	\$ 11,381	\$ 1,691	\$ 519	\$ 450	\$ 259	\$ 239	\$ 219	\$14,759
CVMC	935	\$ 8,988	\$ 1,690	\$ 544	\$ 571	\$ 114	\$ 299	\$ 206	\$12,412
FAHC	5452	\$ 12,874	\$ 2,336	\$ 806	\$ 767	\$ 240	\$ 411	\$ 180	\$17,614
Giff	395	\$ 9,234	\$ 1,140	\$ 524	\$ 418	\$ 189	\$ 199	\$ 179	\$11,882
Grace	14	\$ 7,242	\$ 7,721	\$1,021	\$2,127	\$ 410	\$ 1,669	\$ 846	\$21,035
Mt. A.	23	\$ 9,603	\$10,820	\$3,404	\$3,569	\$ 2,476	\$ 2,737	\$1,823	\$34,430
NCH	376	\$ 9,699	\$ 2,286	\$ 550	\$ 635	\$ 133	\$ 275	\$ 131	\$13,709
NVRH	376	\$ 8,273	\$ 898	\$ 557	\$ 367	\$ 62	\$ 187	\$ 163	\$10,507
NW	694	\$ 9,511	\$ 1,276	\$ 554	\$ 431	\$ 227	\$ 184	\$ 103	\$12,287
Port	463	\$ 9,882	\$ 1,847	\$ 344	\$ 558	\$ 284	\$ 267	\$ 145	\$13,327
RRMC	1454	\$ 13,193	\$ 3,096	\$ 723	\$ 633	\$ 203	\$ 312	\$ 154	\$18,313
SVMC	613	\$ 10,699	\$ 2,050	\$ 717	\$ 437	\$ 97	\$ 303	\$ 179	\$14,482
Spring	472	\$ 7,984	\$ 2,741	\$ 609	\$ 725	\$ 92	\$ 287	\$ 222	\$12,659
Total	12,194	\$ 11,423	\$ 2,187	\$ 698	\$ 651	\$ 204	\$ 339	\$ 177	\$15,679

Figure 4.26 Post-Acute Care Detail – Percent Distribution

Hosp	n	Post-Acute			Home/Amb				Total
		Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other	
Bratt	504	72%	13%	6%	5%	1%	2%	1%	28%
Cop	423	77%	11%	4%	3%	2%	2%	1%	23%
CVMC	935	72%	14%	4%	5%	1%	2%	2%	28%
FAHC	5452	73%	13%	5%	4%	1%	2%	1%	27%
Giff	395	78%	10%	4%	4%	2%	2%	2%	22%
Grace	14	34%	37%	5%	10%	2%	8%	4%	66%
Mt. A.	23	28%	31%	10%	10%	7%	8%	5%	72%
NCH	376	71%	17%	4%	5%	1%	2%	1%	29%
NVRH	376	79%	9%	5%	3%	1%	2%	2%	21%
NW	694	77%	10%	5%	4%	2%	1%	1%	23%
Port	463	74%	14%	3%	4%	2%	2%	1%	26%
RRMC	1454	72%	17%	4%	3%	1%	2%	1%	28%
SVMC	613	74%	14%	5%	3%	1%	2%	1%	26%
Spring	472	63%	22%	5%	6%	1%	2%	2%	37%
Total	12,194	73%	14%	4%	4%	1%	2%	1%	27%



Figure 4.27 Average Allowed Payment Amounts, By Hospital (30,60,90 Days Post-Acute)

Hosp	n	Days	Claim Type Post-Acute			Home/Amb				Total
			Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other	
Bratt	504	30	\$8,878	\$1,673	\$698	\$583	\$137	\$293	\$149	\$12,412
	504	60	\$8,878	\$2,857	\$1,278	\$1,009	\$232	\$549	\$211	\$15,012
	504	90	\$8,878	\$3,216	\$1,629	\$1,285	\$298	\$845	\$269	\$16,420
Cop	423	30	\$11,381	\$1,691	\$519	\$450	\$259	\$239	\$219	\$14,759
	423	60	\$11,381	\$2,091	\$969	\$752	\$329	\$471	\$313	\$16,307
	423	90	\$11,381	\$2,245	\$1,242	\$966	\$387	\$663	\$357	\$17,242
CVMC	935	30	\$8,988	\$1,690	\$544	\$571	\$114	\$299	\$206	\$12,412
	935	60	\$8,988	\$2,111	\$995	\$872	\$153	\$557	\$306	\$13,981
	935	90	\$8,988	\$2,620	\$1,360	\$1,132	\$195	\$776	\$392	\$15,464
FAHC	5,452	30	\$12,874	\$2,336	\$806	\$767	\$240	\$411	\$180	\$17,614
	5,452	60	\$12,874	\$3,006	\$1,436	\$1,285	\$321	\$764	\$280	\$19,966
	5,452	90	\$12,874	\$3,614	\$1,887	\$1,679	\$375	\$1,128	\$369	\$21,926
Giff	395	30	\$9,234	\$1,140	\$524	\$418	\$189	\$199	\$179	\$11,882
	395	60	\$9,234	\$2,099	\$803	\$685	\$215	\$361	\$280	\$13,676
	395	90	\$9,234	\$2,485	\$985	\$865	\$230	\$531	\$381	\$14,711
Grace	14	30	\$7,242	\$7,721	\$1,021	\$2,127	\$410	\$1,669	\$846	\$21,035
	14	60	\$7,242	\$8,843	\$1,761	\$2,973	\$592	\$2,822	\$955	\$25,187
	14	90	\$7,242	\$9,985	\$2,270	\$3,438	\$697	\$4,080	\$1,108	\$28,820
Mt. A.	23	30	\$9,603	\$10,820	\$3,404	\$3,569	\$2,476	\$2,737	\$1,823	\$34,430
	23	60	\$9,603	\$25,318	\$5,976	\$6,533	\$3,862	\$4,830	\$2,110	\$58,232
	23	90	\$9,603	\$32,504	\$9,058	\$8,790	\$4,306	\$6,634	\$2,205	\$73,100
NCH	376	30	\$9,699	\$2,286	\$550	\$635	\$133	\$275	\$131	\$13,709
	376	60	\$9,699	\$2,697	\$1,100	\$967	\$171	\$655	\$208	\$15,497
	376	90	\$9,699	\$2,921	\$1,503	\$1,206	\$200	\$842	\$285	\$16,655
NVRH	376	30	\$8,273	\$898	\$557	\$367	\$62	\$187	\$163	\$10,507
	376	60	\$8,273	\$1,357	\$1,076	\$662	\$101	\$345	\$259	\$12,073
	376	90	\$8,273	\$1,773	\$1,553	\$888	\$120	\$478	\$333	\$13,419
NW	694	30	\$9,511	\$1,276	\$554	\$431	\$227	\$184	\$103	\$12,287
	694	60	\$9,511	\$1,478	\$948	\$727	\$275	\$435	\$152	\$13,527
	694	90	\$9,511	\$1,627	\$1,259	\$985	\$325	\$625	\$195	\$14,527
Port	463	30	\$9,882	\$1,847	\$344	\$558	\$284	\$267	\$145	\$13,327
	463	60	\$9,882	\$2,465	\$683	\$929	\$356	\$471	\$204	\$14,992
	463	90	\$9,882	\$2,830	\$846	\$1,233	\$371	\$645	\$253	\$16,060
RRMC	1,454	30	\$13,193	\$3,096	\$723	\$633	\$203	\$312	\$154	\$18,313
	1,454	60	\$13,193	\$3,890	\$1,317	\$1,007	\$261	\$592	\$229	\$20,488
	1,454	90	\$13,193	\$4,524	\$1,763	\$1,314	\$315	\$852	\$289	\$22,250
SVMC	613	30	\$10,699	\$2,050	\$717	\$437	\$97	\$303	\$179	\$14,482
	613	60	\$10,699	\$3,068	\$1,367	\$730	\$143	\$589	\$268	\$16,864
	613	90	\$10,699	\$3,578	\$1,759	\$949	\$174	\$851	\$295	\$18,305
Spring	472	30	\$7,984	\$2,741	\$609	\$725	\$92	\$287	\$222	\$12,659
	472	60	\$7,984	\$3,473	\$1,063	\$1,111	\$131	\$612	\$339	\$14,713
	472	90	\$7,984	\$3,914	\$1,346	\$1,417	\$147	\$909	\$439	\$16,156
Total	12,194	30	\$11,423	\$2,187	\$698	\$651	\$204	\$339	\$177	\$15,679
	12,194	60	\$11,423	\$2,878	\$1,258	\$1,074	\$272	\$645	\$267	\$17,816
	12,194	90	\$11,423	\$3,396	\$1,659	\$1,399	\$319	\$936	\$342	\$19,476



Figure 4.28 Average Allowed Payment Percents, By Hospital (30,60,90 Days Post-Acute)

Hosp	n	Days	Claim Type Post-Acute			Home/Amb				All	Total
			Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other	PAC	
Bratt	504	30	72%	13%	6%	5%	1%	2%	1%	28%	100%
	504	60	59%	19%	9%	7%	2%	4%	1%	41%	100%
	504	90	54%	20%	10%	8%	2%	5%	2%	46%	100%
Cop	423	30	77%	11%	4%	3%	2%	2%	1%	23%	100%
	423	60	70%	13%	6%	5%	2%	3%	2%	30%	100%
	423	90	66%	13%	7%	6%	2%	4%	2%	34%	100%
CVMC	935	30	72%	14%	4%	5%	1%	2%	2%	28%	100%
	935	60	64%	15%	7%	6%	1%	4%	2%	36%	100%
	935	90	58%	17%	9%	7%	1%	5%	3%	42%	100%
FAHC	5,452	30	73%	13%	5%	4%	1%	2%	1%	27%	100%
	5,452	60	64%	15%	7%	6%	2%	4%	1%	36%	100%
	5,452	90	59%	16%	9%	8%	2%	5%	2%	41%	100%
Giff	395	30	78%	10%	4%	4%	2%	2%	2%	22%	100%
	395	60	68%	15%	6%	5%	2%	3%	2%	32%	100%
	395	90	63%	17%	7%	6%	2%	4%	3%	37%	100%
Grace	14	30	34%	37%	5%	10%	2%	8%	4%	66%	100%
	14	60	29%	35%	7%	12%	2%	11%	4%	71%	100%
	14	90	25%	35%	8%	12%	2%	14%	4%	75%	100%
Mt. A.	23	30	28%	31%	10%	10%	7%	8%	5%	72%	100%
	23	60	16%	43%	10%	11%	7%	8%	4%	84%	100%
	23	90	13%	44%	12%	12%	6%	9%	3%	87%	100%
NCH	376	30	71%	17%	4%	5%	1%	2%	1%	29%	100%
	376	60	63%	17%	7%	6%	1%	4%	1%	37%	100%
	376	90	58%	18%	9%	7%	1%	5%	2%	42%	100%
NVRH	376	30	79%	9%	5%	3%	1%	2%	2%	21%	100%
	376	60	69%	11%	9%	5%	1%	3%	2%	31%	100%
	376	90	62%	13%	12%	7%	1%	4%	2%	38%	100%
NW	694	30	77%	10%	5%	4%	2%	1%	1%	23%	100%
	694	60	70%	11%	7%	5%	2%	3%	1%	30%	100%
	694	90	65%	11%	9%	7%	2%	4%	1%	35%	100%
Port	463	30	74%	14%	3%	4%	2%	2%	1%	26%	100%
	463	60	66%	16%	5%	6%	2%	3%	1%	34%	100%
	463	90	62%	18%	5%	8%	2%	4%	2%	38%	100%
RRMC	1,454	30	72%	17%	4%	3%	1%	2%	1%	28%	100%
	1,454	60	64%	19%	6%	5%	1%	3%	1%	36%	100%
	1,454	90	59%	20%	8%	6%	1%	4%	1%	41%	100%
SVMC	613	30	74%	14%	5%	3%	1%	2%	1%	26%	100%
	613	60	63%	18%	8%	4%	1%	3%	2%	37%	100%
	613	90	58%	20%	10%	5%	1%	5%	2%	42%	100%
Spring	472	30	63%	22%	5%	6%	1%	2%	2%	37%	100%
	472	60	54%	24%	7%	8%	1%	4%	2%	46%	100%
	472	90	49%	24%	8%	9%	1%	6%	3%	51%	100%
Total	12,194	30	73%	14%	4%	4%	1%	2%	1%	27%	100%
	12,194	60	64%	16%	7%	6%	2%	4%	1%	36%	100%
	12,194	90	59%	17%	9%	7%	2%	5%	2%	41%	100%

Figure 4.29 Average Allowed Payment Amounts, By Payer (30,60,90 Days Post-Acute)

Hosp	n	Days	Claim Type	Post-Acute			Home/Amb				Total
			Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other		
Medicaid	5,820	30	\$8,400	\$1,845	\$358	\$512	\$96	\$381	\$313	\$11,905	
	5,820	60	\$8,400	\$2,483	\$690	\$888	\$146	\$741	\$785	\$14,133	
	5,820	90	\$8,400	\$2,971	\$912	\$1,196	\$181	\$1,051	\$1,390	\$16,101	
BCBS	2,119	30	\$14,722	\$3,039	\$1,370	\$807	\$397	\$344	\$150	\$20,829	
	2,119	60	\$14,722	\$4,142	\$2,344	\$1,311	\$471	\$662	\$361	\$24,013	
	2,119	90	\$14,722	\$4,870	\$3,083	\$1,731	\$525	\$1,035	\$625	\$26,592	
Cigna	1,318	30	\$13,006	\$1,209	\$797	\$624	\$244	\$249	\$35	\$16,164	
	1,318	60	\$13,006	\$1,638	\$1,499	\$1,035	\$358	\$413	\$76	\$18,026	
	1,318	90	\$13,006	\$1,832	\$2,014	\$1,329	\$441	\$595	\$120	\$19,337	
TVHP	832	30	\$12,400	\$2,352	\$902	\$672	\$285	\$320	\$65	\$16,996	
	832	60	\$12,400	\$2,995	\$1,588	\$1,100	\$358	\$620	\$149	\$19,210	
	832	90	\$12,400	\$3,255	\$2,131	\$1,410	\$394	\$881	\$261	\$20,733	
MVP	862	30	\$15,466	\$2,507	\$1,149	\$828	\$296	\$323	\$14	\$20,582	
	862	60	\$15,466	\$3,246	\$1,938	\$1,288	\$367	\$614	\$47	\$22,965	
	862	90	\$15,466	\$3,917	\$2,575	\$1,636	\$405	\$904	\$87	\$24,989	
CBA	312	30	\$14,298	\$4,698	\$1,039	\$1,274	\$217	\$303	\$29	\$21,857	
	312	60	\$14,298	\$5,369	\$1,783	\$1,810	\$319	\$548	\$80	\$24,207	
	312	90	\$14,298	\$6,655	\$2,480	\$2,306	\$380	\$805	\$131	\$27,056	
Apex	311	30	\$13,935	\$3,391	\$886	\$730	\$289	\$511	\$15	\$19,757	
	311	60	\$13,935	\$4,034	\$1,651	\$1,231	\$383	\$859	\$37	\$22,129	
	311	90	\$13,935	\$5,376	\$2,120	\$1,529	\$470	\$1,193	\$59	\$24,681	
Well Point	277	30	\$16,089	\$4,595	\$1,206	\$1,041	\$389	\$325	\$285	\$23,930	
	277	60	\$16,089	\$5,348	\$2,080	\$1,546	\$501	\$633	\$804	\$27,001	
	277	90	\$16,089	\$5,798	\$2,718	\$1,854	\$616	\$926	\$1,407	\$29,408	
UHC	134	30	\$16,729	\$4,875	\$1,338	\$1,267	\$88	\$190	\$12	\$24,499	
	134	60	\$16,729	\$5,287	\$2,684	\$1,878	\$121	\$405	\$24	\$27,127	
	134	90	\$16,729	\$5,467	\$2,955	\$2,120	\$183	\$753	\$37	\$28,244	
Aetna	127	30	\$13,899	\$3,006	\$647	\$1,391	\$211	\$310	\$52	\$19,516	
	127	60	\$13,899	\$5,648	\$1,474	\$2,616	\$375	\$557	\$134	\$24,703	
	127	90	\$13,899	\$5,936	\$2,220	\$3,005	\$426	\$783	\$262	\$26,532	
Other	83	30	\$14,114	\$1,895	\$1,438	\$428	\$129	\$306	\$118	\$18,428	
	83	60	\$14,114	\$3,025	\$2,643	\$651	\$176	\$534	\$456	\$21,599	
	83	90	\$14,114	\$3,285	\$3,301	\$845	\$262	\$837	\$875	\$23,518	
Total	12,195	30	\$11,423	\$2,286	\$746	\$663	\$207	\$349	\$193	\$15,866	
	12,195	60	\$11,423	\$3,015	\$1,342	\$1,094	\$276	\$663	\$485	\$18,299	
	12,195	90	\$11,423	\$3,544	\$1,773	\$1,427	\$325	\$964	\$855	\$20,312	



Figure 4.30 Average Allowed Payment Percents, By Payer (30,60,90 Days Post-Acute)

Hosp	n	Days	Claim Type Post-Acute			Home/Amb				All PAC	Total
			Orig IP	IP Admit	OP	Pro	DME	Pharm/Rx	Other		
Medicaid	5,820	30	71%	16%	3%	4%	1%	3%	3%	29%	100%
	5,820	60	59%	18%	5%	6%	1%	5%	6%	41%	100%
	5,820	90	52%	18%	6%	7%	1%	7%	9%	48%	100%
BCBS	2,119	30	71%	15%	7%	4%	2%	2%	1%	29%	100%
	2,119	60	61%	17%	10%	5%	2%	3%	2%	39%	100%
	2,119	90	55%	18%	12%	7%	2%	4%	2%	45%	100%
Cigna	1,318	30	80%	7%	5%	4%	2%	2%	0%	20%	100%
	1,318	60	72%	9%	8%	6%	2%	2%	0%	28%	100%
	1,318	90	67%	9%	10%	7%	2%	3%	1%	33%	100%
TVHP	832	30	73%	14%	5%	4%	2%	2%	0%	27%	100%
	832	60	65%	16%	8%	6%	2%	3%	1%	35%	100%
	832	90	60%	16%	10%	7%	2%	4%	1%	40%	100%
MVP	862	30	75%	12%	6%	4%	1%	2%	0%	25%	100%
	862	60	67%	14%	8%	6%	2%	3%	0%	33%	100%
	862	90	62%	16%	10%	7%	2%	4%	0%	38%	100%
CBA	312	30	65%	21%	5%	6%	1%	1%	0%	35%	100%
	312	60	59%	22%	7%	7%	1%	2%	0%	41%	100%
	312	90	53%	25%	9%	9%	1%	3%	0%	47%	100%
Apex	311	30	71%	17%	4%	4%	1%	3%	0%	29%	100%
	311	60	63%	18%	7%	6%	2%	4%	0%	37%	100%
	311	90	56%	22%	9%	6%	2%	5%	0%	44%	100%
Well Point	277	30	67%	19%	5%	4%	2%	1%	1%	33%	100%
	277	60	60%	20%	8%	6%	2%	2%	3%	40%	100%
	277	90	55%	20%	9%	6%	2%	3%	5%	45%	100%
UHC	134	30	68%	20%	5%	5%	0%	1%	0%	32%	100%
	134	60	62%	19%	10%	7%	0%	1%	0%	38%	100%
	134	90	59%	19%	10%	8%	1%	3%	0%	41%	100%
Aetna	127	30	71%	15%	3%	7%	1%	2%	0%	29%	100%
	127	60	56%	23%	6%	11%	2%	2%	1%	44%	100%
	127	90	52%	22%	8%	11%	2%	3%	1%	48%	100%
Other	83	30	77%	10%	8%	2%	1%	2%	1%	23%	100%
	83	60	65%	14%	12%	3%	1%	2%	2%	35%	100%
	83	90	60%	14%	14%	4%	1%	4%	4%	40%	100%
Total	12,195	30	72%	14%	5%	4%	1%	2%	1%	28%	100%
	12,195	60	62%	16%	7%	6%	2%	4%	3%	38%	100%
	12,195	90	56%	17%	9%	7%	2%	5%	4%	44%	100%



5. Appendix

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1. Abbreviations

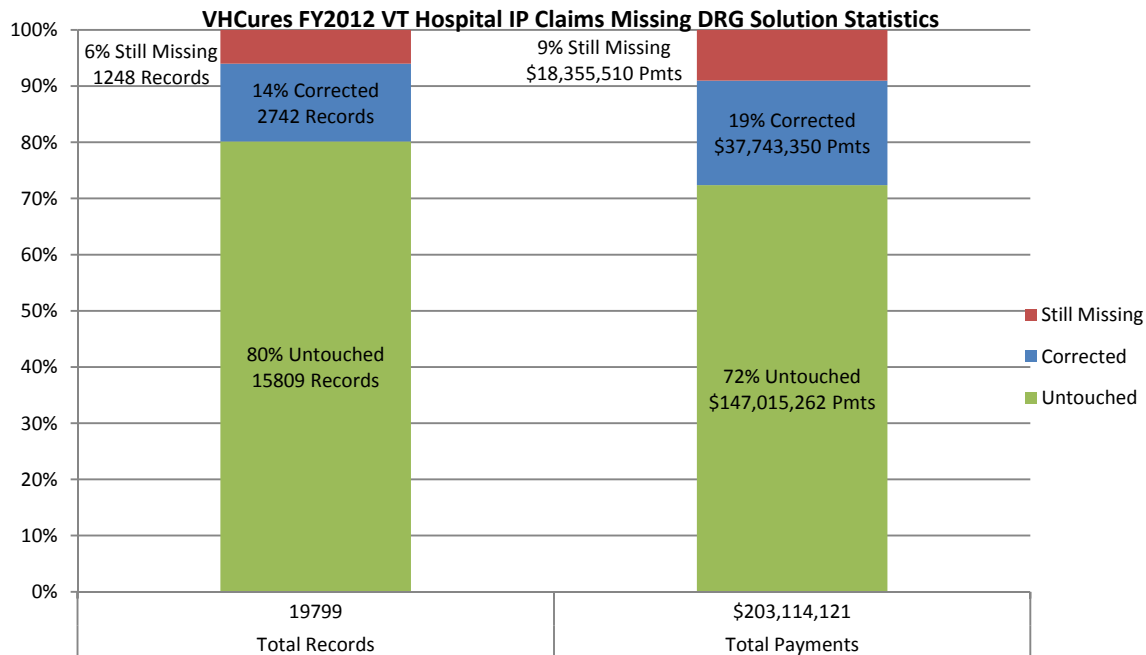
1. **GMCB** – Green Mountain Care Board
2. **VAHHS-NSO** – Vermont Association of Hospitals and Healthcare Systems – Network Services Organization
3. **VHCURES** – Vermont Healthcare Claims Uniform Reporting and Evaluation System
4. **VUHDDS** - Vermont Uniform Hospital Discharge Data Set
5. **CMS** – Centers for Medicare and Medicaid Services
6. **DRG** – Diagnostic Related Groups
7. **MS-DRG** – Medicare DRG
8. **ICD-9** – International Classification of Diseases
9. **CPT** – Current Procedure Terminology
10. **DSH** – Disproportionate Share Hospital
11. **PAC** – Post Acute Care
12. **FQHC** – Federally Qualified Health Center
13. **CMMI** – Center for Medicare and Medicaid Innovation
14. **RCC** – Ratio of Cost to Charge
15. **MRI** – Magnetic Resonance Imaging
16. **ICU** – Intensive Care Unit
17. **Hospital Abbreviations:**
 - **Bratt** – Brattleboro Memorial Hospital
 - **Cop** – Copley Hospital
 - **CVMC** – Central Vermont Medical Center
 - **FAHC** – Fletcher Allen Health Care
 - **Giff** – Gifford Medical Center
 - **Grace** – Grace Cottage Hospital
 - **Mt. A.** – Mount Ascutney Hospital
 - **NCH** – North Country Hospital
 - **NVRH** – Northeastern Vermont Regional Hospital
 - **NW** – Northwestern Medical Center
 - **Port** – Porter Medical Center
 - **RRMC** – Rutland Regional Medical Center
 - **SVMC** – Southwestern Vermont Medical Center
 - **Spring** – Springfield Hospital
18. **Payer Abbreviations:**
 - **BCBS** – Blue Cross Blue Shield
 - **CIGNA** – CIGNA Healthcare
 - **TVHP** – The Vermont Health Plan
 - **MVP** – MVP Healthcare
 - **CBA** – CBA Blue, a subsidiary of BCBS
 - **Apex** – Apex Benefits Services
 - **UHC** – United HealthCare

2. VHCURES-VUHDDS Data Matching Tool

Inpatient claims missing DRG:

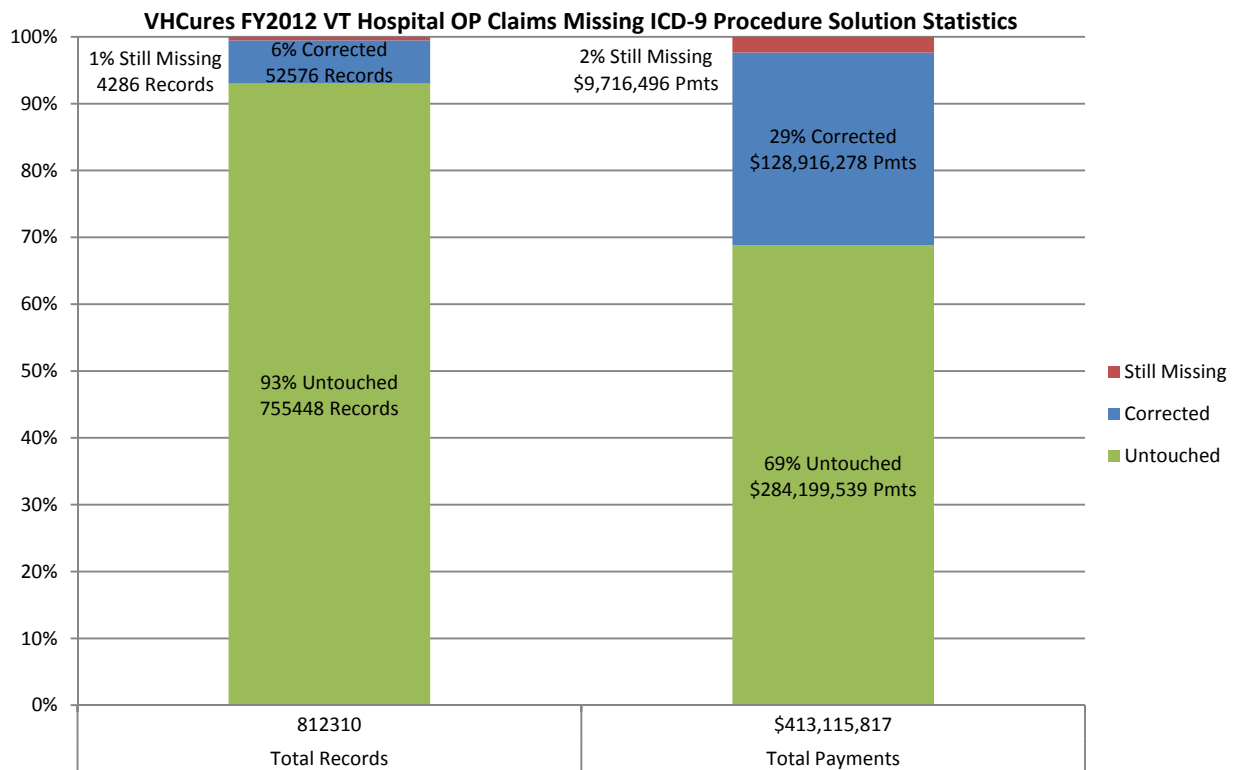
By matching the VUHDDS dataset to the VHCURES dataset using the criteria listed below, it was found that approximately 20% of the VHCURES inpatient records or 28% of VHCURES inpatient payments were missing DRGs.

- Admit date
- Discharge date
- Birth date
- Zip code
- Principle diagnosis
- Gender
- Hospital



Outpatient claims missing ICD-9:

By matching the VUHDDS dataset to the VHCURES dataset using the same criteria, it was found that approximately 7% of the VHCURES outpatient records or 29% of VHCURES outpatient payments were missing ICD-9 procedure codes.



VHCURES Database Issues/Recommendations:

- 1) Limited data validation on DRG, ICD-9, Revenue Code and CPT/HCPC Fields
- 2) Unreliable unique provider identification, NPI and taxonomy
- 3) Non-existent provider organization identifier
- 4) Inconsistent Patient Account number field (refining this data element in VHCURES would lead to the least complex, least difficult manner in which to link VHCURES to VUHDDS)
- 5) VHCURES would be exponentially more user-friendly if Onpoint Health adopted a one record per discharge data layout or provided some means of linking multiple records to a single visit.
- 6) Better online documentation that could include SQL examples and explanation.

3. Variation Detail

Purpose:

The purpose of this appendix is to provide a comprehensive presentation of variation at the procedure level. Data is shown for inpatient data at the DRG level, for outpatient at the ICD-9 procedure code level and at the CPT level for professional claims. The scope of the study called for presenting the top 20 DRGs, ICD-9s and CPTs where statistically valid data exists.

- For inpatient data, DRGs are shown where there exists a minimum of 5 discharges for each payer-hospital combination.
- For outpatient and professional, that filter was set to 15 discharges.

INPATIENT DETAIL

1. Relative Measures tables (Tables 1-6)
 - a. By Payer
 - b. By Hospital Type (PPS/CAH)
2. DRG Detail
 - a. Payments
 - b. Costs
 - c. Charges

Inpatient Relative Measures:

Table 1 shows inpatient relative measures for each hospital for payments, costs and charges (the three major groupings from left to right) for Commercial claims. For each of the groupings, the table shows 3 relative measures:

1. Relative to the commercial average (payment, cost or charge)
2. Relative to the Medicaid average (payment, cost or charge)
3. Relative to the system average, where system is Commercial plus Medicaid

Table 1 Inpatient Commercial Relative Measures, by Hospital

Hosp	n	Commercial								
		Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
Bratt	276	-1%	54%	19%	-4%	-1%	-2%	-16%	-9%	-13%
Cop	267	21%	87%	45%	10%	13%	11%	16%	26%	21%
CVMC	571	-19%	25%	-3%	-24%	-22%	-23%	-20%	-13%	-17%
FAHC	3,947	-9%	40%	9%	2%	5%	4%	-1%	8%	3%
Giff	255	21%	87%	45%	-3%	0%	-1%	12%	23%	17%
Grace	13	-26%	14%	-11%	2%	5%	3%	-41%	-35%	-38%
Mt. A.	36	-13%	35%	5%	9%	13%	11%	-26%	-19%	-23%
NCH	183	4%	61%	24%	-17%	-14%	-16%	-15%	-8%	-12%
NVRH	205	-1%	54%	19%	-37%	-35%	-36%	-7%	1%	-3%
NW	342	-9%	41%	10%	-2%	0%	-1%	-12%	-4%	-8%
Port	298	17%	82%	41%	29%	33%	31%	29%	41%	34%
RRMC	800	44%	123%	73%	18%	22%	20%	25%	37%	31%
SVMC	310	14%	77%	37%	-12%	-9%	-11%	-6%	3%	-2%
Spring	203	-15%	31%	2%	-19%	-17%	-18%	-19%	-11%	-15%
Commercial	7,706	0%	55%	20%	0%	3%	1%	0%	9%	4%
Medicaid	6,922	-36%	0%	-23%	-3%	0%	-2%	-8%	0%	-5%
System	14,628	-17%	29%	0%	-1%	2%	0%	-4%	5%	0%

Table 2 shows inpatient relative measures for each hospital for payments, costs and charges (the three major groupings from left to right) for Medicaid claims. For each of the groupings, the table shows the same 3 relative measures:

1. Relative to the average commercial measure
2. Relative to the average Medicaid measure
3. Relative to the average system measure, where system is Commercial plus Medicaid



Table 2 Inpatient Medicaid Relative Measures, by Hospital

Medicaid										
Hosp	n	Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
Bratt	278	-38%	-4%	-26%	-10%	-7%	-8%	-27%	-21%	-24%
Cop	209	-40%	-7%	-28%	-14%	-12%	-13%	-28%	-21%	-25%
CVMC	547	-25%	16%	-10%	-3%	0%	-1%	-7%	2%	-3%
FAHC	2,680	-36%	0%	-23%	6%	9%	8%	-1%	8%	3%
Giff	214	-37%	-2%	-24%	-5%	-2%	-4%	9%	19%	14%
Grace	10	-37%	-2%	-24%	12%	15%	13%	-38%	-33%	-36%
Mt. A.	22	55%	140%	86%	178%	187%	182%	64%	79%	71%
NCH	261	-44%	-13%	-33%	-25%	-22%	-24%	-25%	-18%	-22%
NVRH	255	-41%	-8%	-29%	-31%	-29%	-30%	2%	12%	6%
NW	419	-35%	1%	-22%	-15%	-13%	-14%	-25%	-18%	-22%
Port	213	-35%	1%	-22%	-4%	-1%	-3%	-15%	-7%	-11%
RRMC	1,035	-40%	-7%	-28%	1%	4%	3%	-7%	2%	-3%
SVMC	399	-40%	-7%	-28%	-25%	-22%	-24%	-18%	-10%	-14%
Spring	380	-25%	17%	-9%	-7%	-5%	-6%	-21%	-14%	-18%
Commercial	7,706	0%	55%	20%	0%	3%	1%	0%	9%	4%
Medicaid	6,922	-36%	0%	-23%	-3%	0%	-2%	-8%	0%	-5%
System	14,628	-17%	29%	0%	-1%	2%	0%	-4%	5%	0%

Table 3 shows inpatient relative measures for each hospital for payments, costs and charges (the three major groupings from left to right) for Commercial + Medicaid (“System”) claims. For each of the groupings, the table shows the same 3 relative measures:

Table 3 Inpatient System Relative Measures, by Hospital

Commercial + Medicaid										
Hosp	n	Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
Bratt	554	-20%	25%	-3%	-7%	-4%	-5%	-22%	-15%	-19%
Cop	476	-6%	46%	13%	-1%	2%	1%	-3%	5%	1%
CVMC	1,118	-22%	21%	-7%	-14%	-11%	-12%	-14%	-6%	-10%
FAHC	6,627	-20%	24%	-4%	4%	7%	5%	-1%	8%	3%
Giff	469	-6%	47%	14%	-4%	-1%	-2%	11%	21%	16%
Grace	23	-31%	7%	-17%	6%	9%	8%	-40%	-34%	-37%
Mt. A.	58	13%	75%	36%	73%	79%	76%	8%	18%	12%
NCH	444	-24%	17%	-9%	-21%	-19%	-20%	-21%	-14%	-18%
NVRH	460	-23%	20%	-7%	-33%	-31%	-33%	-2%	7%	2%
NW	761	-23%	19%	-8%	-9%	-7%	-8%	-19%	-12%	-16%
Port	511	-5%	48%	15%	15%	19%	17%	11%	21%	15%
RRMC	1,835	-3%	50%	16%	9%	12%	10%	7%	17%	12%
SVMC	709	-16%	30%	1%	-19%	-17%	-18%	-13%	-5%	-9%
Spring	583	-21%	22%	-6%	-12%	-9%	-10%	-21%	-13%	-17%
Commercial	7,706	0%	55%	20%	0%	3%	1%	0%	9%	4%
Medicaid	6,922	-36%	0%	-23%	-3%	0%	-2%	-8%	0%	-5%
System	14,628	-17%	29%	0%	-1%	2%	0%	-4%	5%	0%

Table 4 shows inpatient relative measures for each payer for payments, costs and charges (the three major groupings from left to right) for Prospective Payment System (PPS) hospital claims. For each of the groupings, the table shows the same 3 relative measures:

Table 4 Inpatient System Relative Measures, by Payer, for PPS Hospitals

Payer	n	PPS								
		Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
BCBS	2,098	6%	62%	26%	3%	5%	4%	7%	14%	10%
Cigna	1,292	-10%	37%	7%	-19%	-18%	-18%	-15%	-10%	-13%
TVHP	832	-13%	33%	4%	-4%	-3%	-4%	0%	6%	3%
MVP	836	7%	64%	28%	-1%	0%	0%	6%	13%	9%
CBA Blue	218	9%	67%	30%	113%	116%	114%	1%	8%	4%
Apex	357	-7%	42%	11%	1%	2%	1%	0%	6%	3%
WellPoint	260	25%	90%	48%	13%	14%	13%	21%	29%	25%
UHC	141	1%	54%	20%	-31%	-31%	-31%	-16%	-10%	-13%
Aetna	135	-8%	40%	9%	-19%	-19%	-19%	-23%	-18%	-21%
Other	77	3%	57%	22%	-4%	-3%	-3%	-5%	1%	-2%
Commercial	6,246	0%	53%	19%	0%	1%	0%	0%	7%	3%
Medicaid	5,358	-35%	0%	-22%	-1%	0%	-1%	-6%	0%	-3%
System	11,604	-16%	28%	0%	0%	1%	0%	-3%	4%	0%

Table 5 shows inpatient relative measures for each payer for payments, costs and charges (the three major groupings from left to right) for Critical Access Hospital (CAH) claims. For each of the groupings, the table shows the same 3 relative measures:

Table 5 Inpatient System Relative Measures, by Payer, for CAH Hospitals

Payer	n	CAH								
		Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
BCBS	460	-1%	65%	25%	7%	18%	13%	10%	32%	20%
Cigna	328	-19%	34%	2%	-31%	-24%	-27%	-33%	-20%	-27%
TVHP	167	11%	83%	39%	21%	33%	27%	20%	44%	32%
MVP	204	12%	87%	41%	17%	29%	23%	15%	38%	26%
CBA Blue	180	-2%	62%	23%	-8%	1%	-3%	-9%	9%	0%
Apex	5	-11%	48%	12%	-4%	5%	0%	-11%	7%	-2%
WellPoint	64	25%	108%	58%	20%	32%	26%	22%	47%	34%
UHC	18	69%	181%	113%	34%	47%	40%	39%	66%	52%
Aetna	12	58%	163%	99%	26%	39%	33%	30%	56%	42%
Other	22	-37%	5%	-20%	-40%	-34%	-37%	-44%	-33%	-39%
Commercial	1,460	0%	66%	26%	0%	10%	5%	0%	20%	9%
Medicaid	1,564	-40%	0%	-24%	-9%	0%	-5%	-17%	0%	-9%
System	3,024	-21%	32%	0%	-5%	5%	0%	-9%	10%	0%



Table 6 shows inpatient relative measures for each payer for payments, costs and charges (the three major groupings from left to right) for PPS + CAH hospital claims. For each of the groupings, the table shows the same 3 relative measures:

Table 6 Inpatient System Relative Measures, by Payer, for PPS + CAH Hospitals

PPS + CAH										
Payer	n	Payments Relative to			Cost Relative to			Charge Relative to		
		Commercial	Medicaid	System	Commercial	Medicaid	System	Commercial	Medicaid	System
BCBS	2,558	5%	62%	26%	4%	7%	6%	7%	17%	12%
Cigna	1,620	-12%	36%	6%	-21%	-19%	-20%	-19%	-11%	-16%
TVHP	999	-9%	42%	10%	0%	3%	1%	3%	13%	8%
MVP	1,040	8%	68%	30%	3%	6%	4%	8%	18%	12%
CBA Blue	398	6%	65%	28%	58%	63%	60%	-2%	7%	2%
Apex	362	-9%	42%	10%	1%	4%	3%	-1%	8%	3%
WellPoint	324	25%	94%	50%	14%	18%	16%	22%	33%	27%
UHC	159	8%	68%	30%	-24%	-22%	-23%	-10%	-1%	-6%
Aetna	147	-3%	50%	16%	-16%	-13%	-14%	-19%	-12%	-16%
Other	99	-6%	45%	12%	-12%	-9%	-10%	-14%	-6%	-10%
Commercial	7,706	0%	55%	20%	0%	3%	1%	0%	9%	4%
Medicaid	6,922	-36%	0%	-23%	-3%	0%	-2%	-8%	0%	-5%
System	14,628	-17%	29%	0%	-1%	2%	0%	-4%	5%	0%

FY2012 Hospital Inpatient DRG Allowed Payment Amount Variation

FY2012 Hospital Inpatient DRG Allowed Payment Amount Variation (Min 5 Discharges)

775 - Vaginal Delivery W/O Complicating Diagnoses

470 - Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc

766 - Cesarean Section W/O Cc/Mcc

795 - Normal Newborn

793 - Full Term Neonate W Major Problems

765 - Cesarean Section W Cc/Mcc

794 - Neonate W Other Significant Problems

774 - Vaginal Delivery W Complicating Diagnoses

544 - Pathological Fractures & Musculoskelet & Conn Tiss Malig W/O Cc/Mcc

792 - Prematurity W/O Major Problems

392 - Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc

373 - Major Gastrointestinal Disorders & Peritoneal Infections W/O Cc/Mcc

462 - Bilateral Or Multiple Major Joint Procs Of Lower Extremity W/O Mcc

603 - Cellulitis W/O Mcc

371 - Major Gastrointestinal Disorders & Peritoneal Infections W Mcc

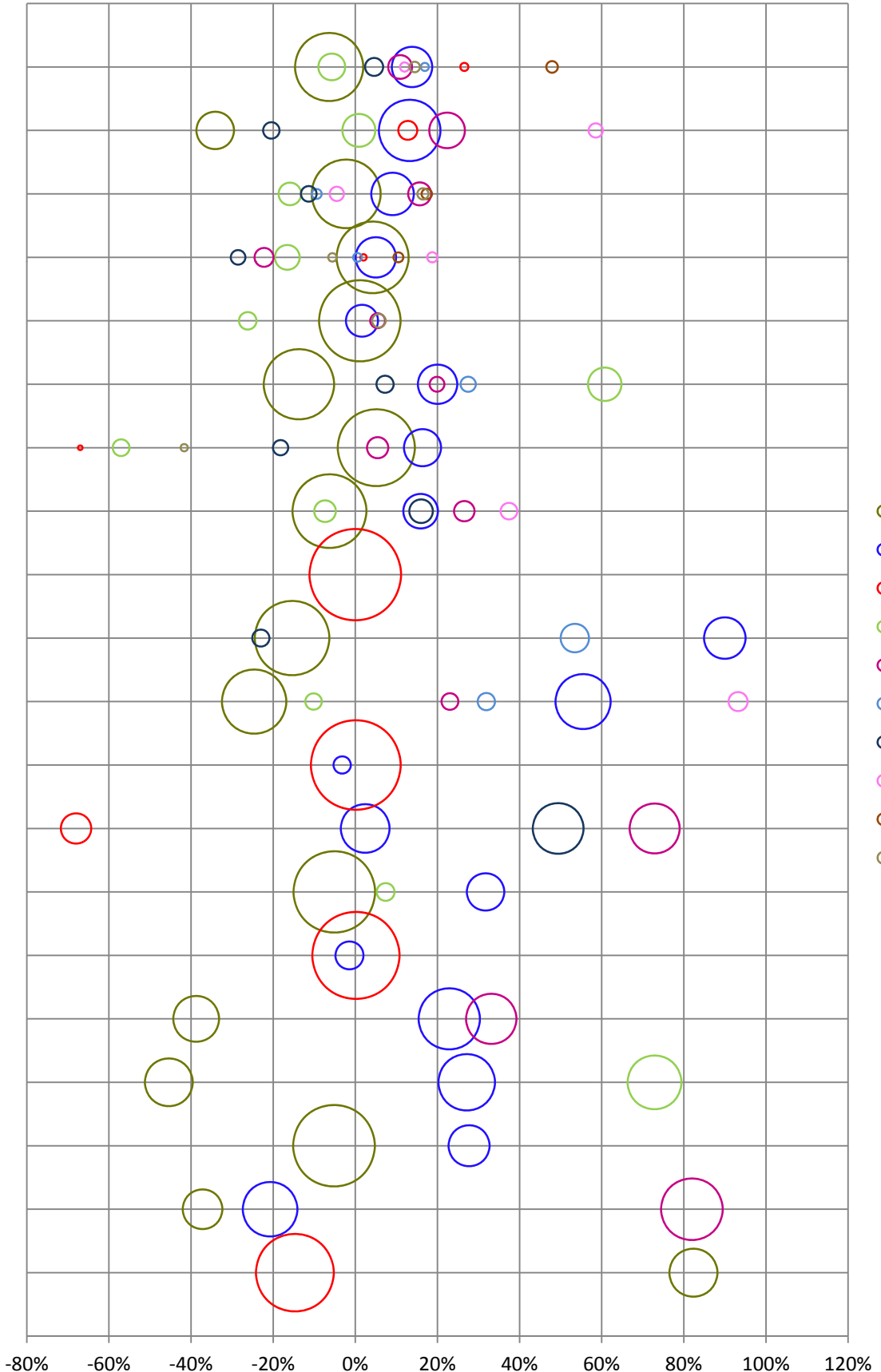
330 - Major Small & Large Bowel Procedures W Cc

743 - Uterine & Adnexa Proc For Non-Malignancy W/O Cc/Mcc

194 - Simple Pneumonia & Pleurisy W Cc

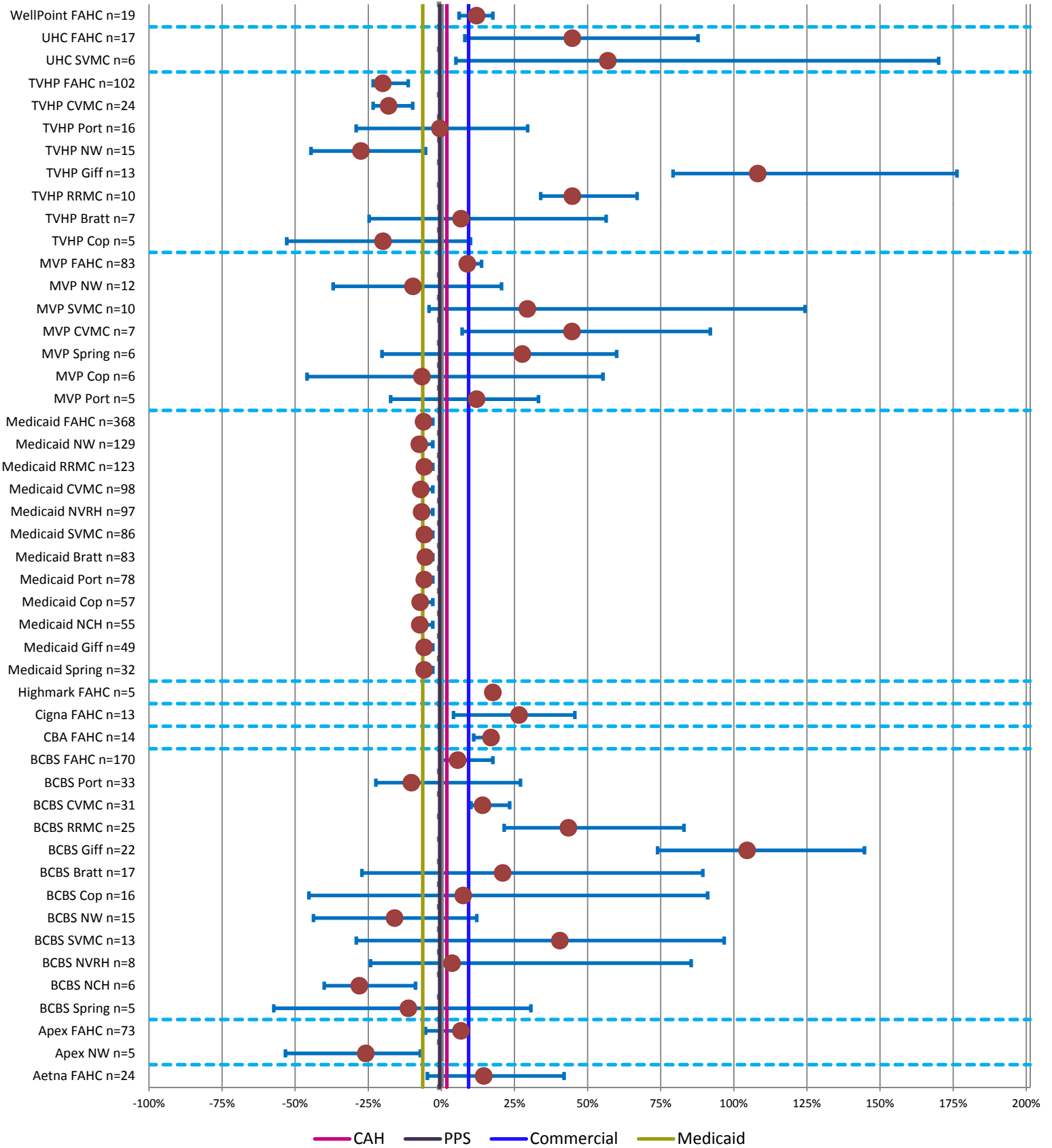
331 - Major Small & Large Bowel Procedures W/O Cc/Mcc

372 - Major Gastrointestinal Disorders & Peritoneal Infections W Cc

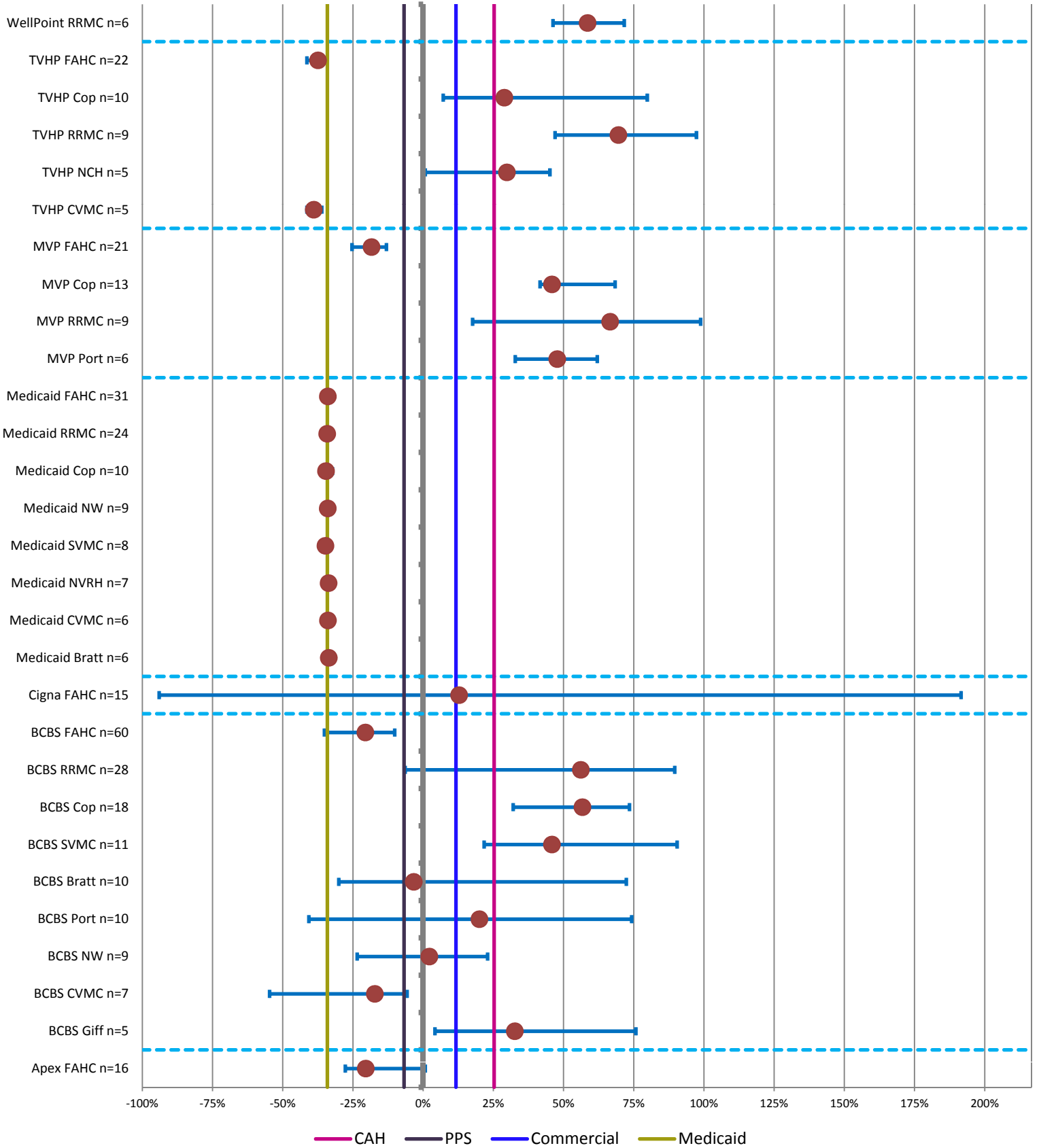


- Medicaid
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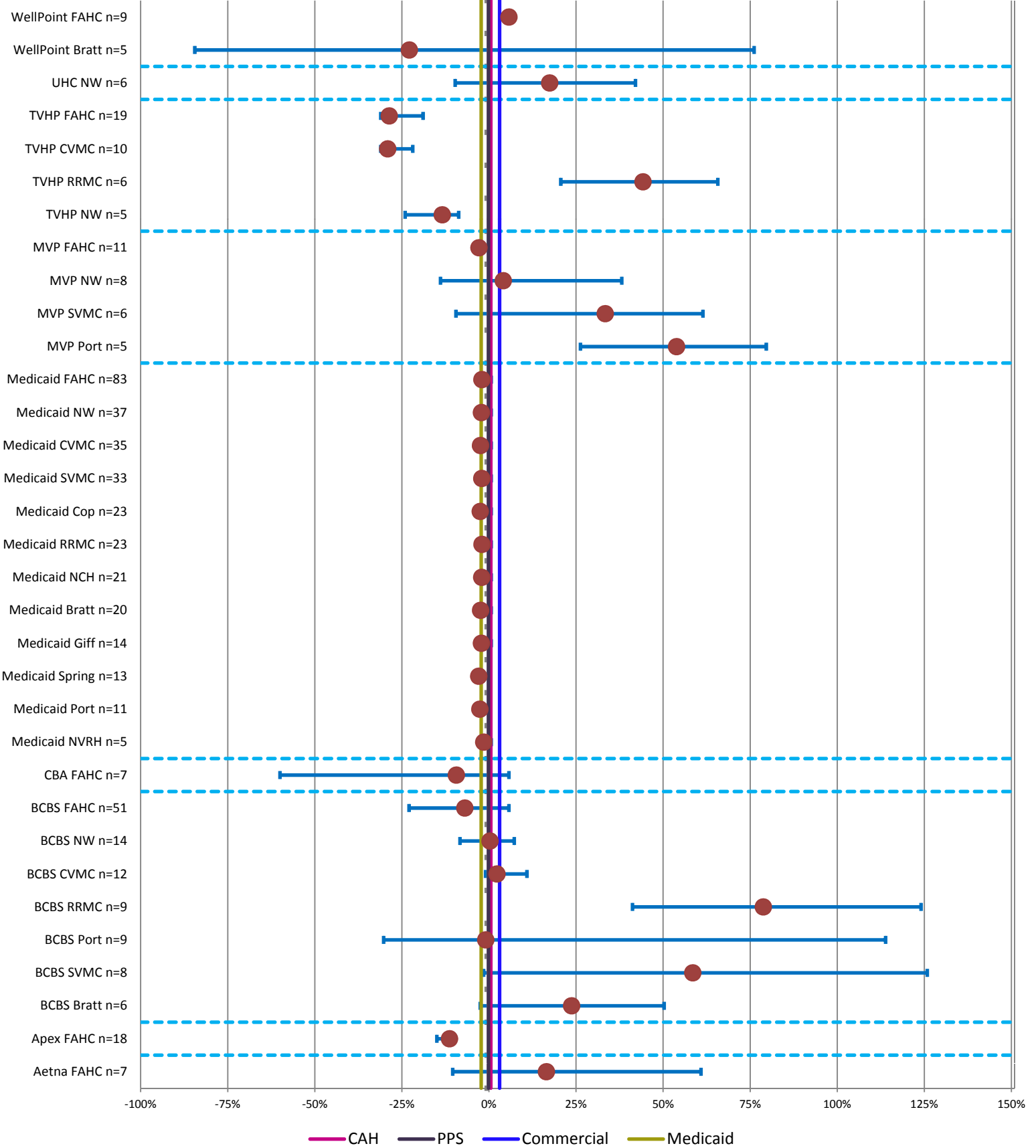
**FY2012 Hospital Inpatient DRG 775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES Allowed Payment
Amount Variation**



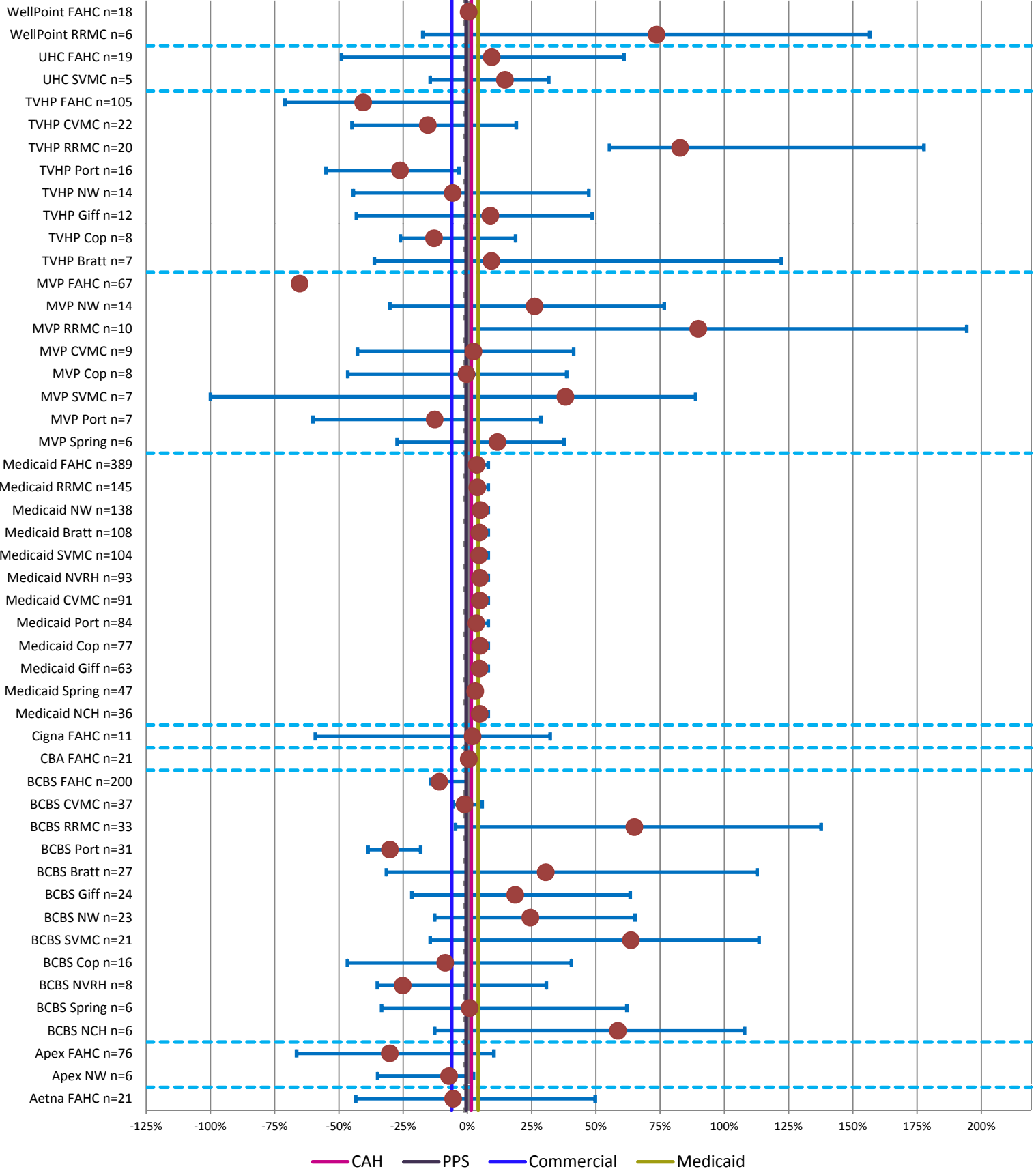
**FY2012 Hospital Inpatient DRG 470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY
W/O MCC Allowed Payment Amount Variation**



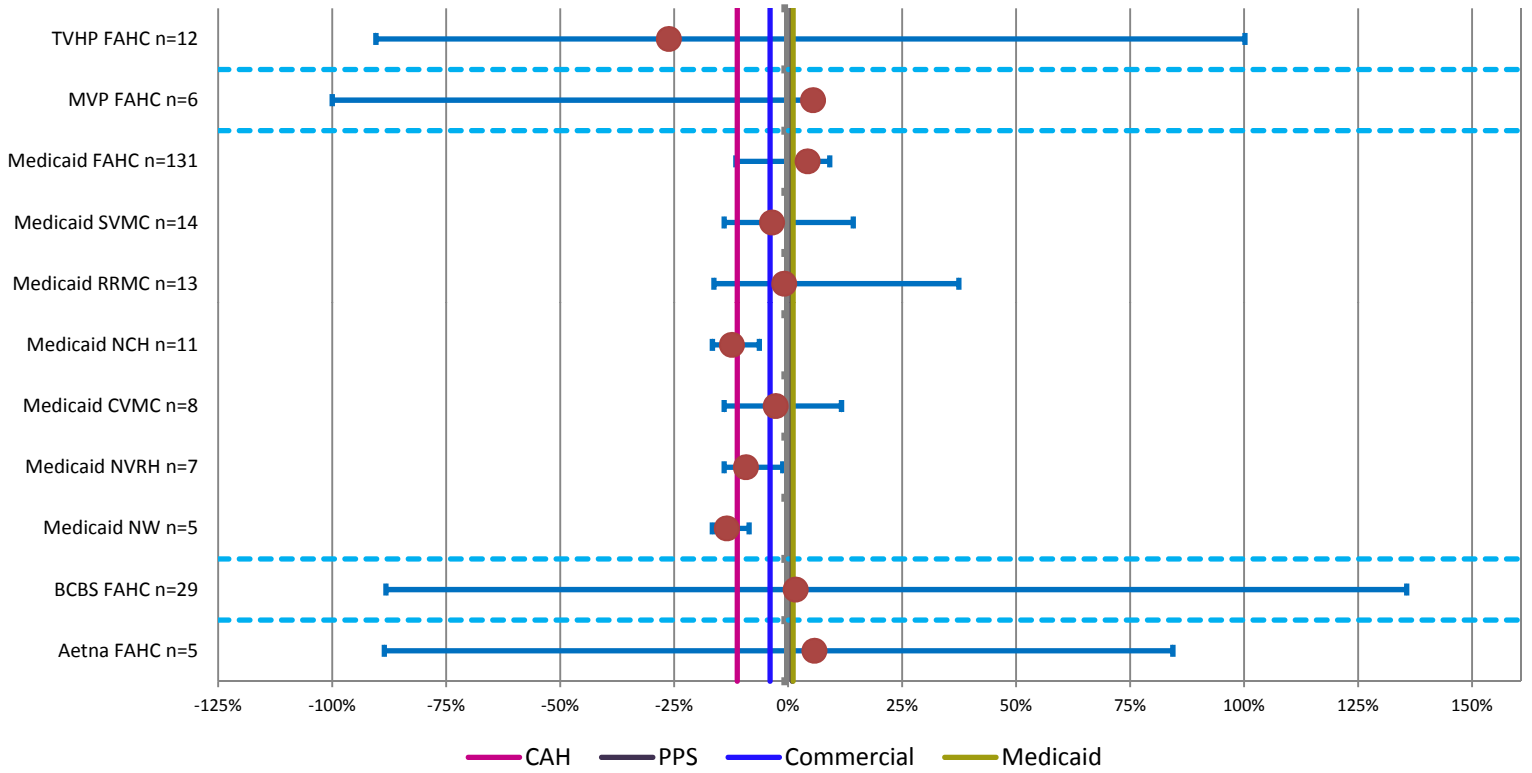
FY2012 Hospital Inpatient DRG 766 - CESAREAN SECTION W/O CC/MCC Allowed Payment Amount Variation



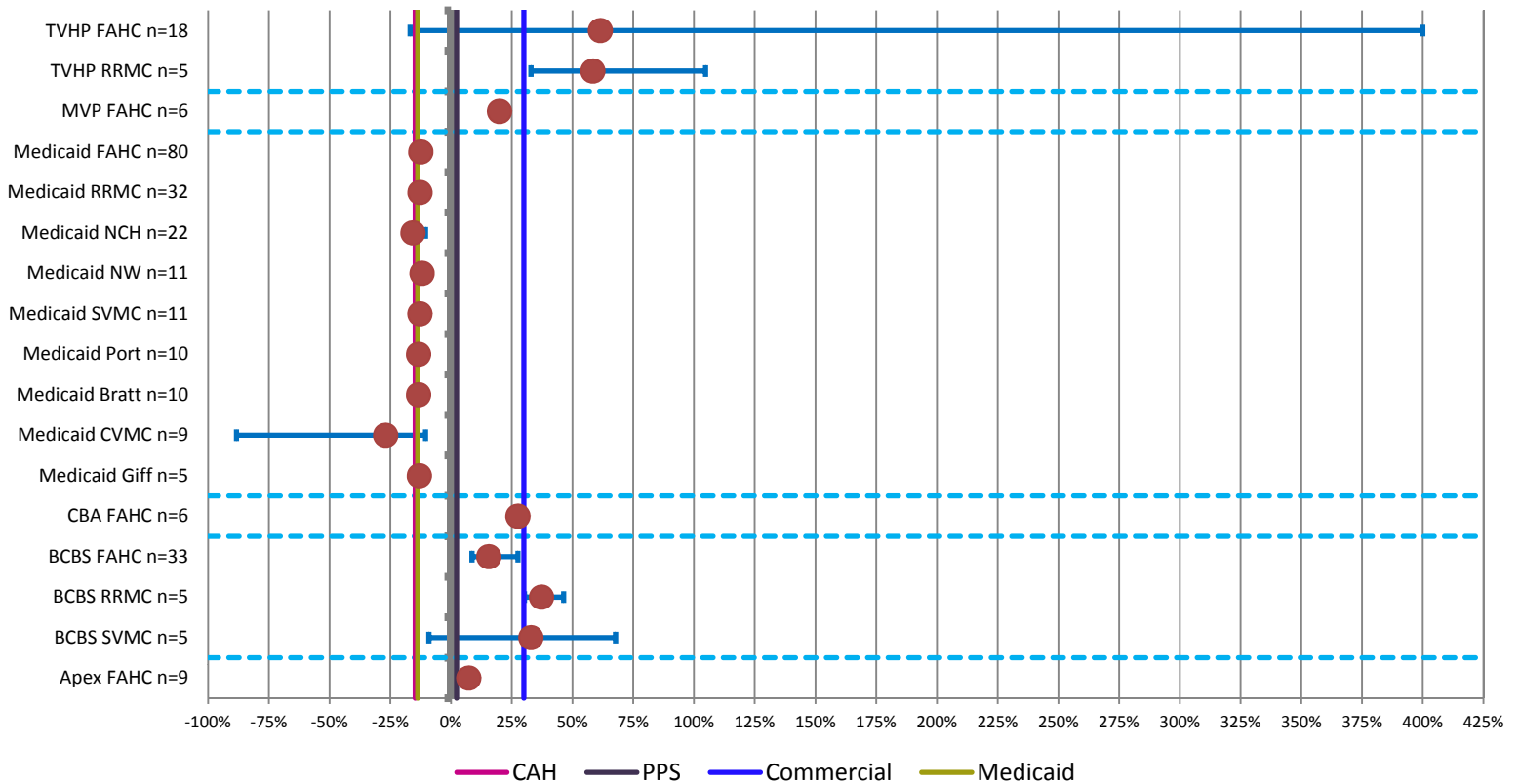
FY2012 Hospital Inpatient DRG 795 - NORMAL NEWBORN Allowed Payment Amount Variation



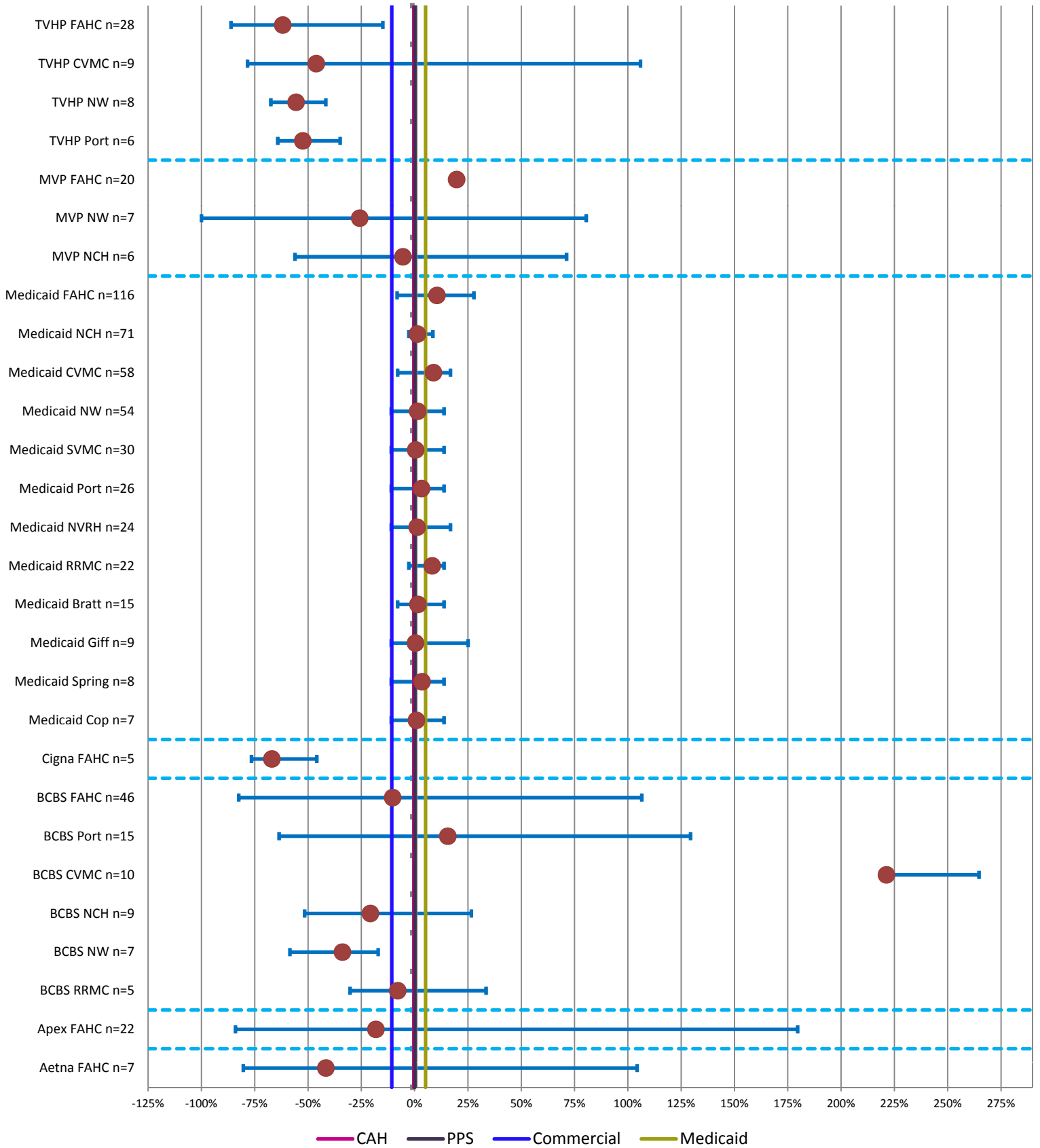
FY2012 Hospital Inpatient DRG 793 - FULL TERM NEONATE W MAJOR PROBLEMS Allowed Payment Amount Variation



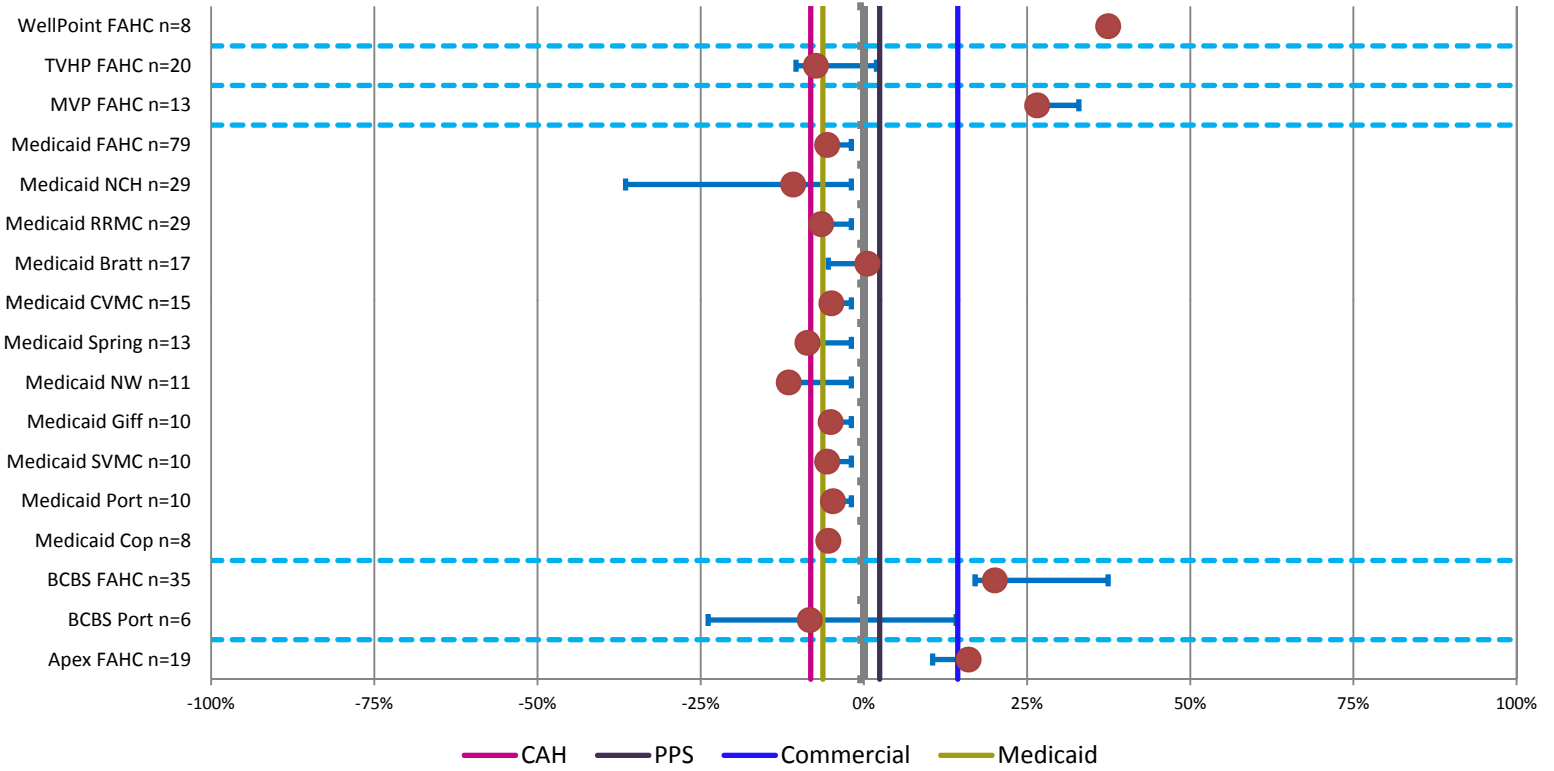
FY2012 Hospital Inpatient DRG 765 - CESAREAN SECTION W CC/MCC Allowed Payment Amount Variation



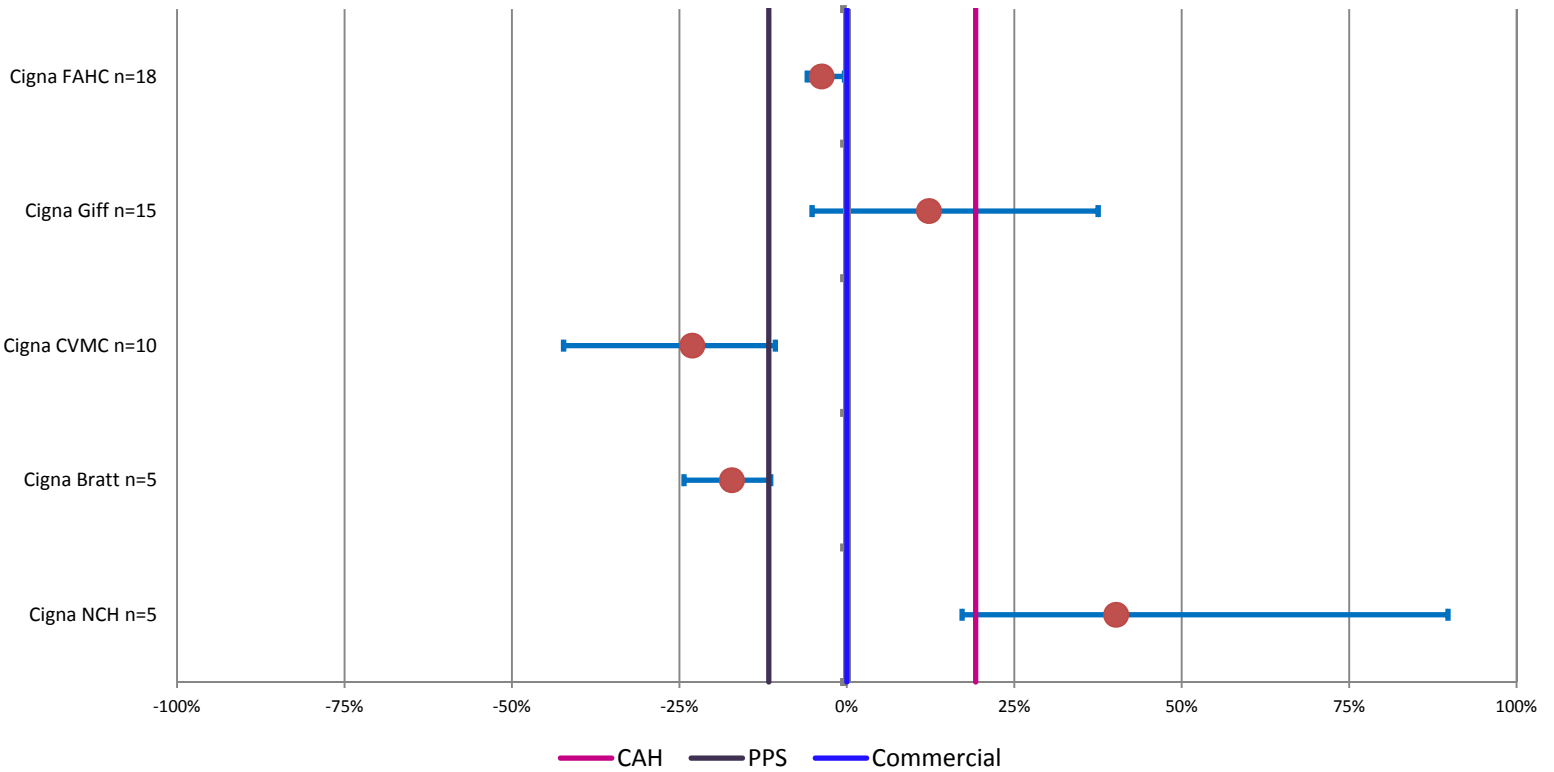
FY2012 Hospital Inpatient DRG 794 - NEONATE W OTHER SIGNIFICANT PROBLEMS Allowed Payment Amount Variation



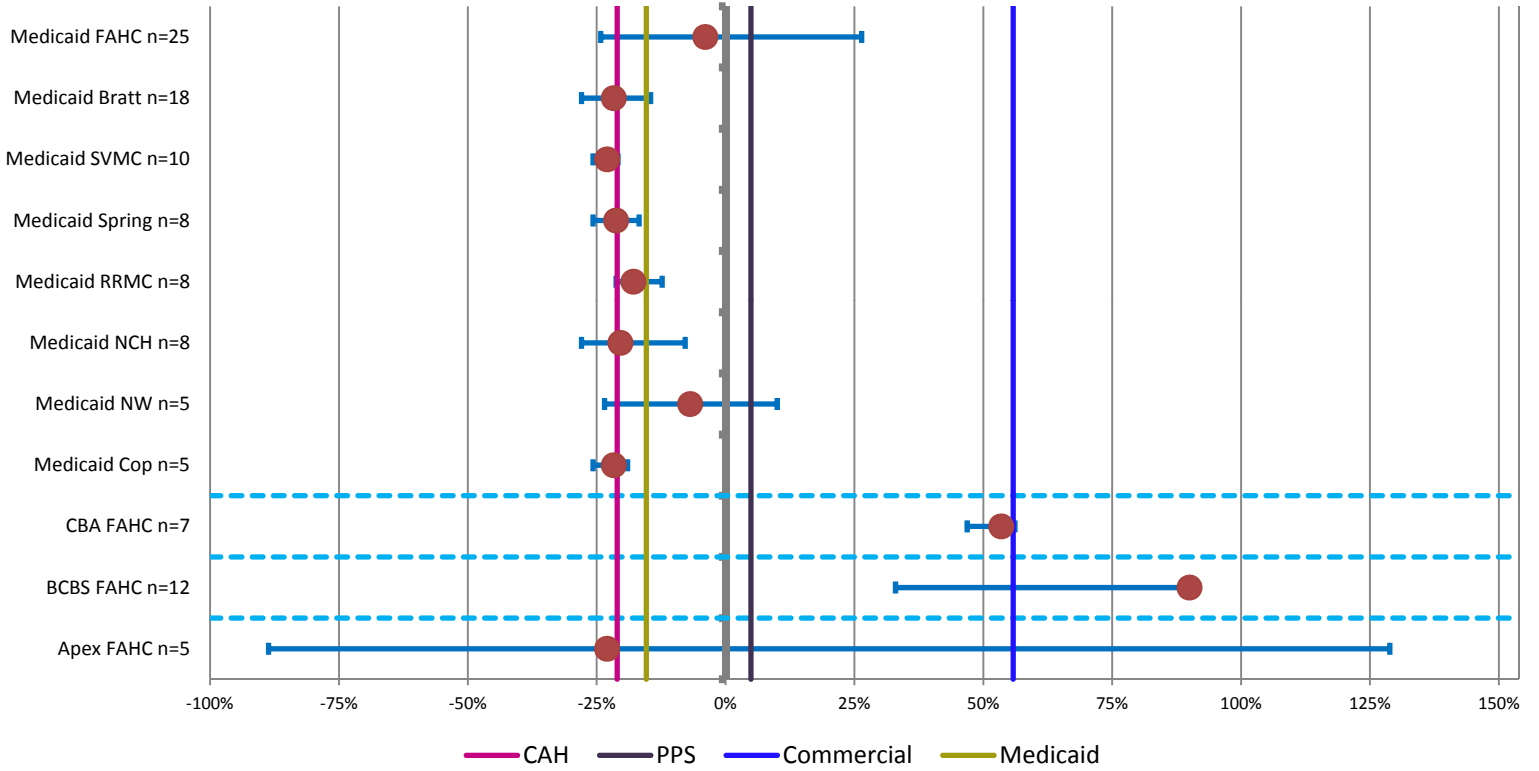
FY2012 Hospital Inpatient DRG 774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES Allowed Payment Amount Variation



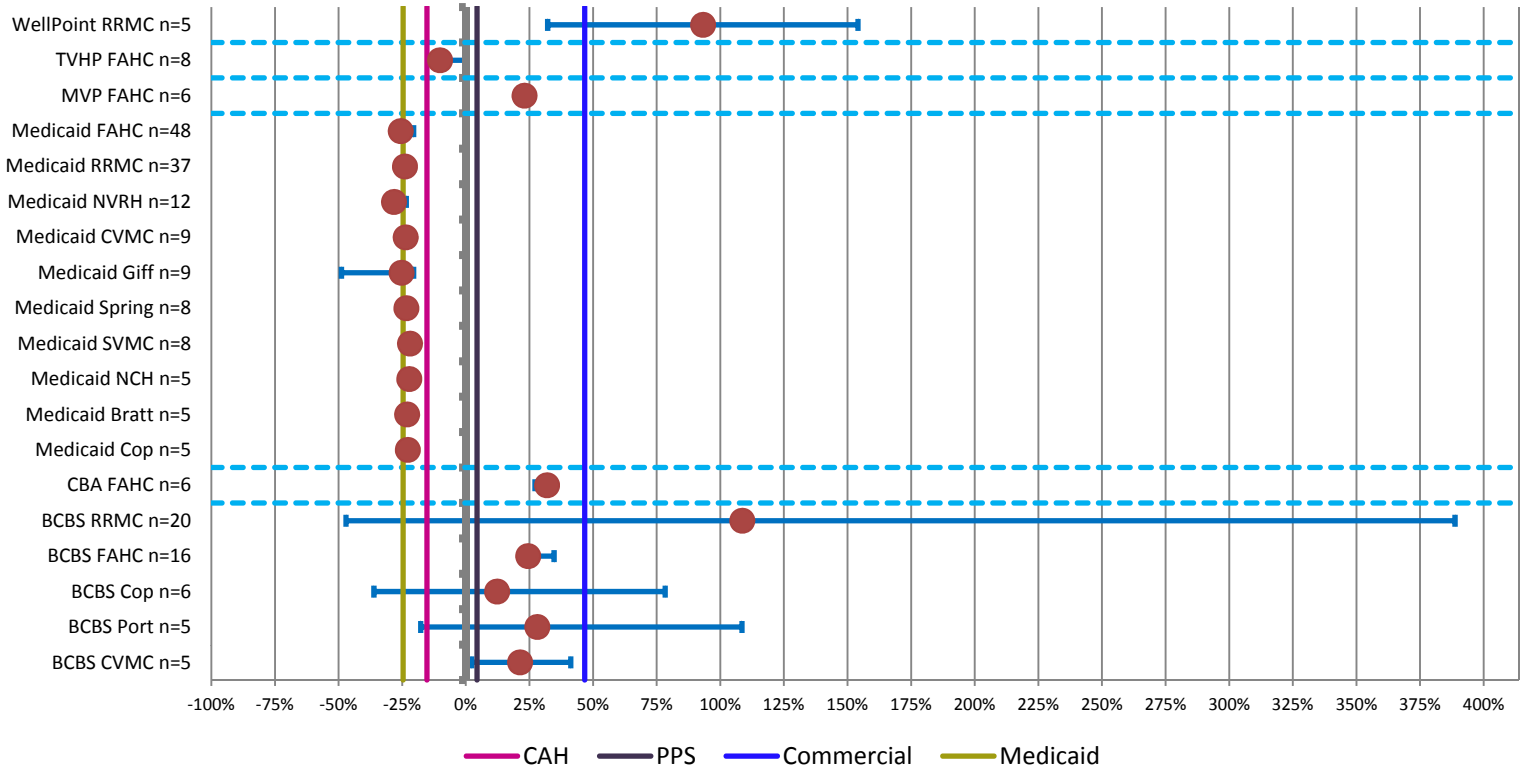
FY2012 Hospital Inpatient DRG 544 - PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC Allowed Payment Amount Variation



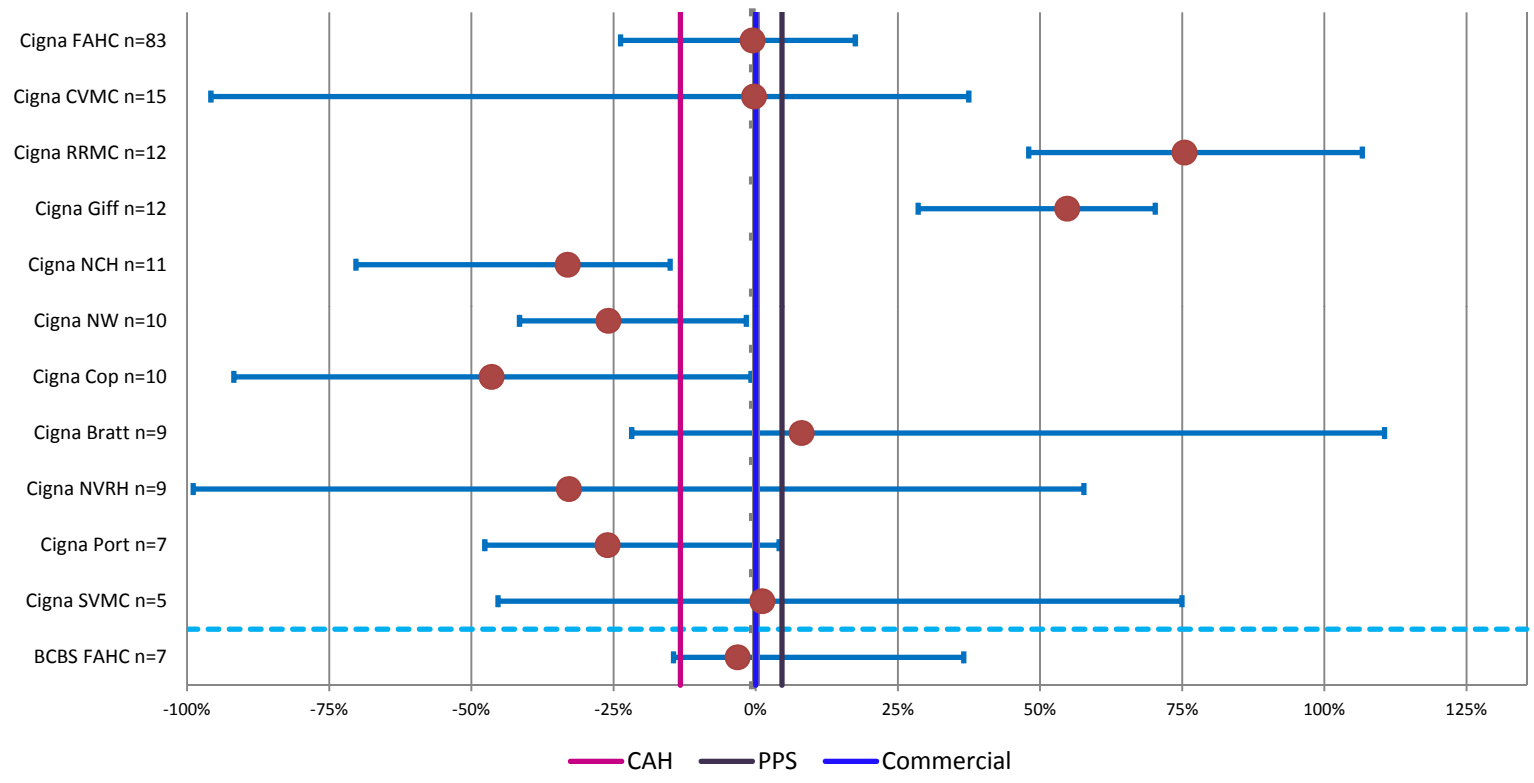
FY2012 Hospital Inpatient DRG 792 - PREMATURETY W/O MAJOR PROBLEMS Allowed Payment Amount Variation



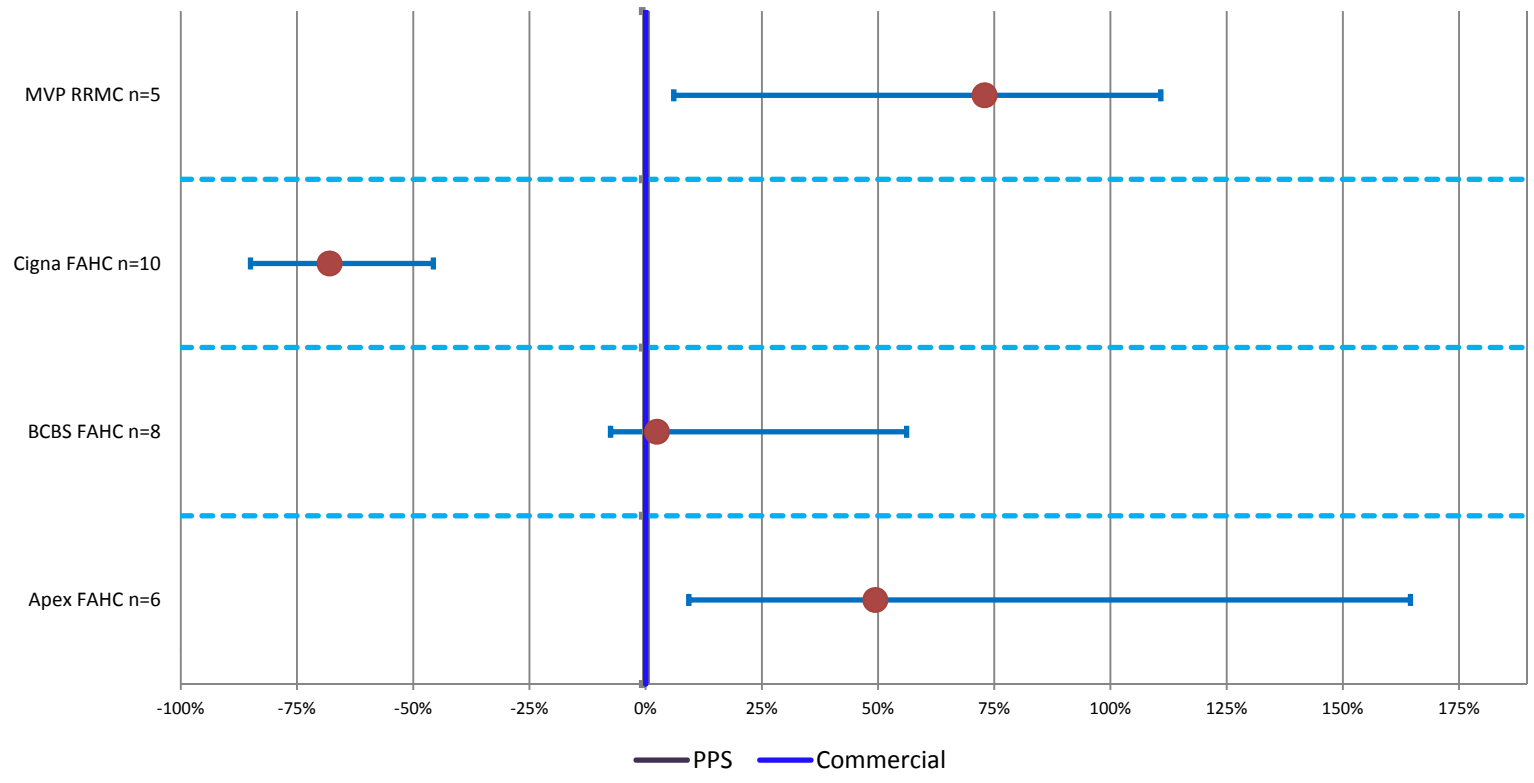
FY2012 Hospital Inpatient DRG 392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC Allowed Payment Amount Variation



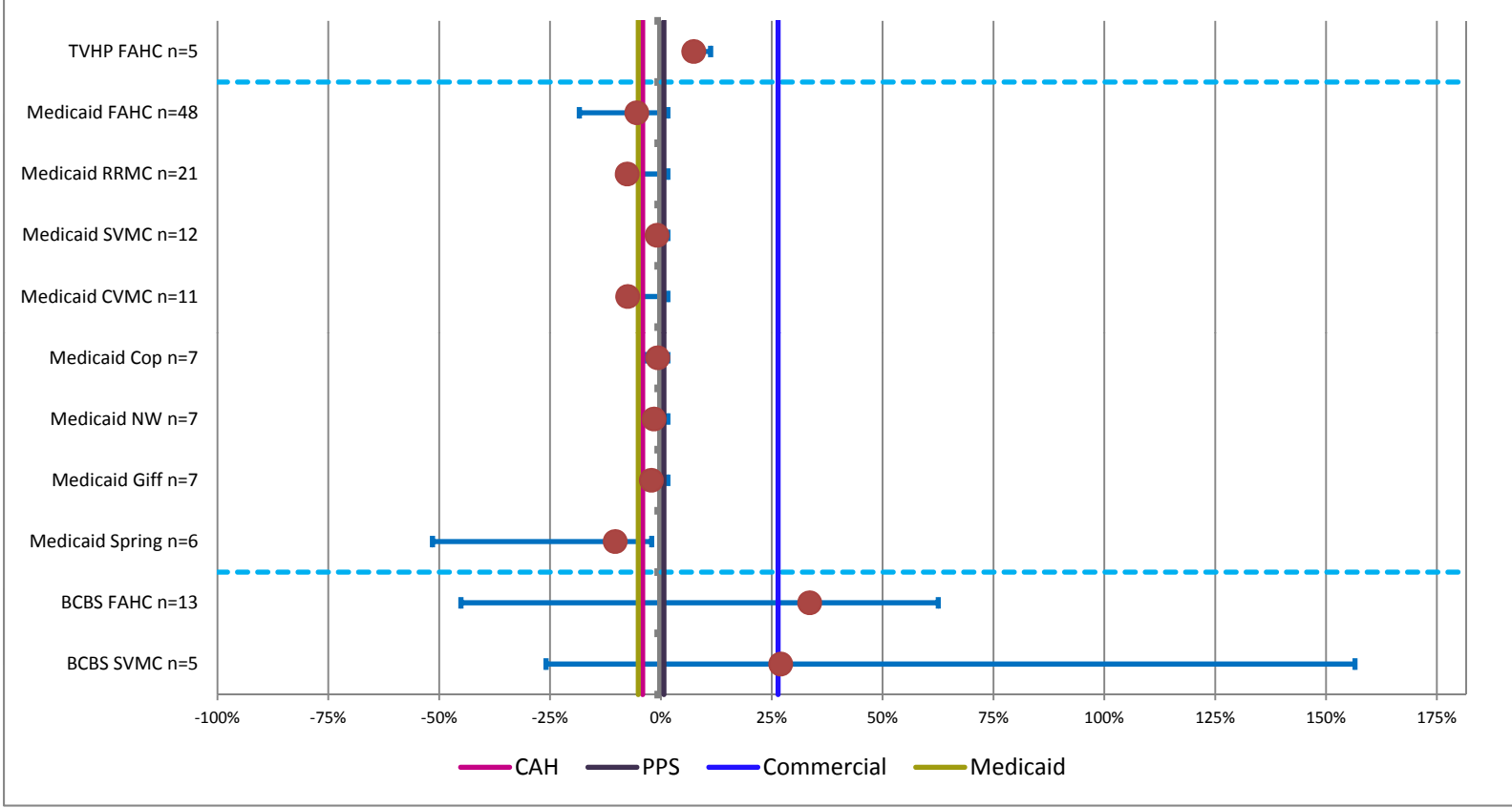
FY2012 Hospital Inpatient DRG 373 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC Allowed Payment Amount Variation



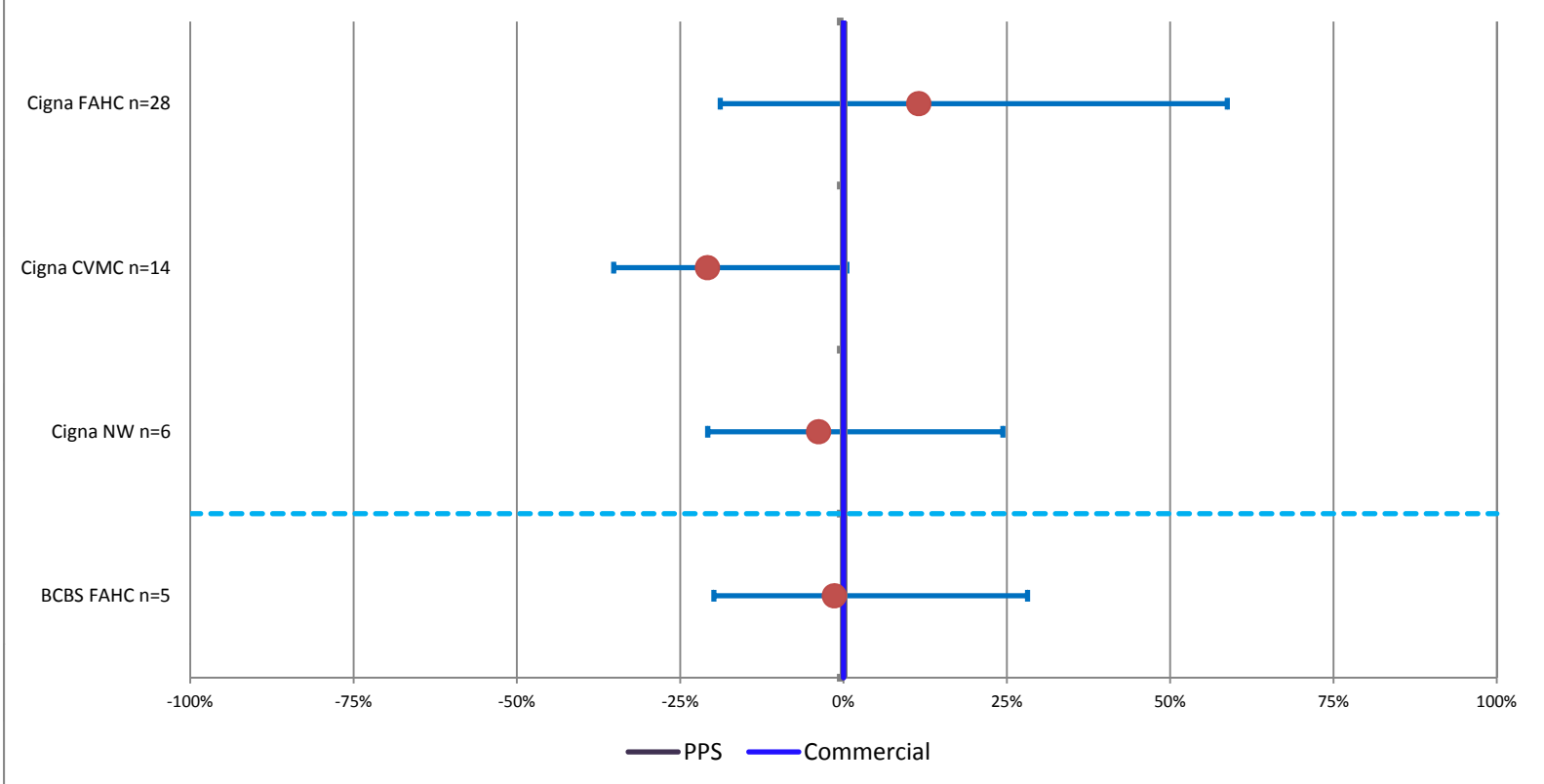
FY2012 Hospital Inpatient DRG 462 - BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC Allowed Payment Amount Variation



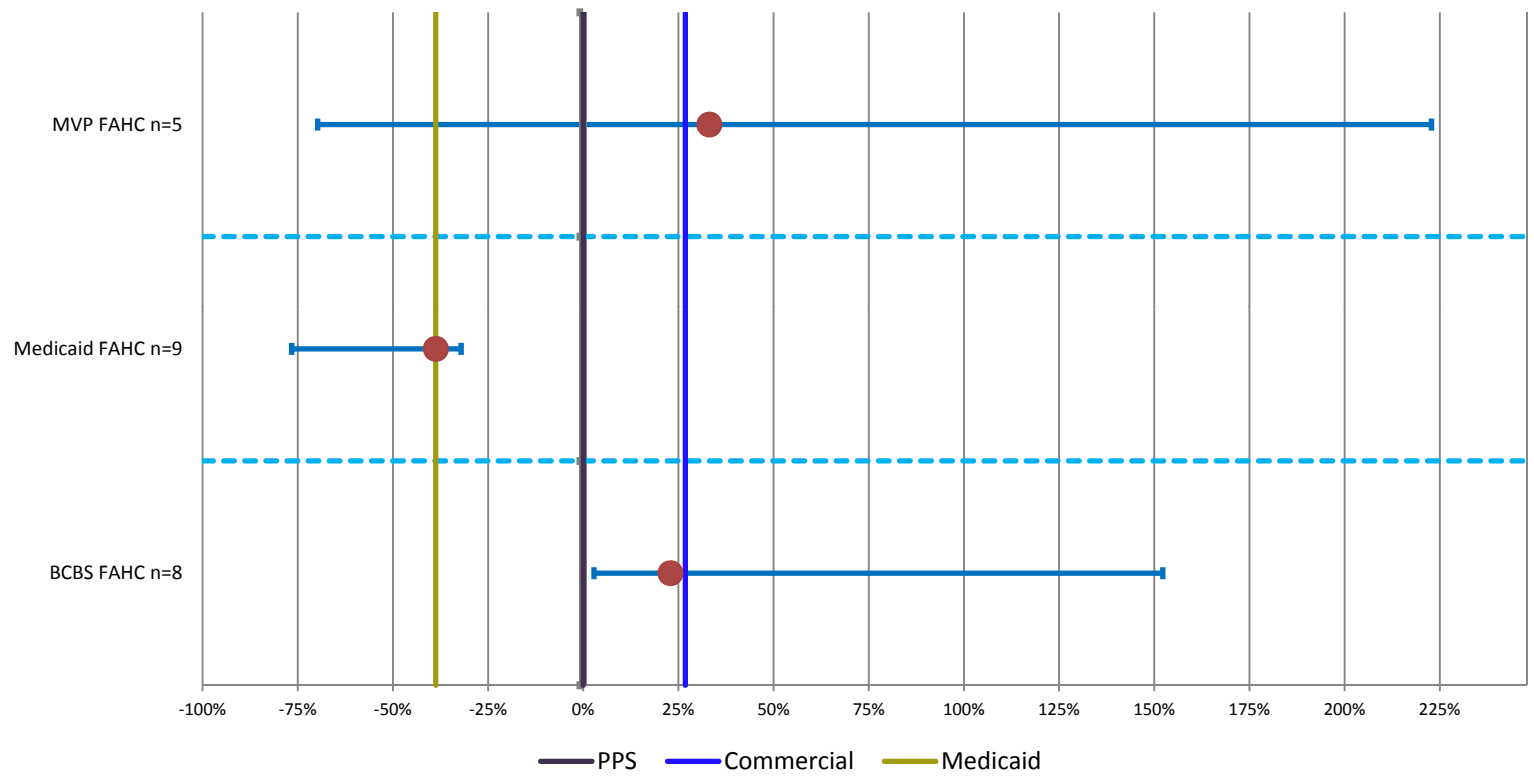
FY2012 Hospital Inpatient DRG 603 - CELLULITIS W/O MCC Allowed Payment Amount Variation



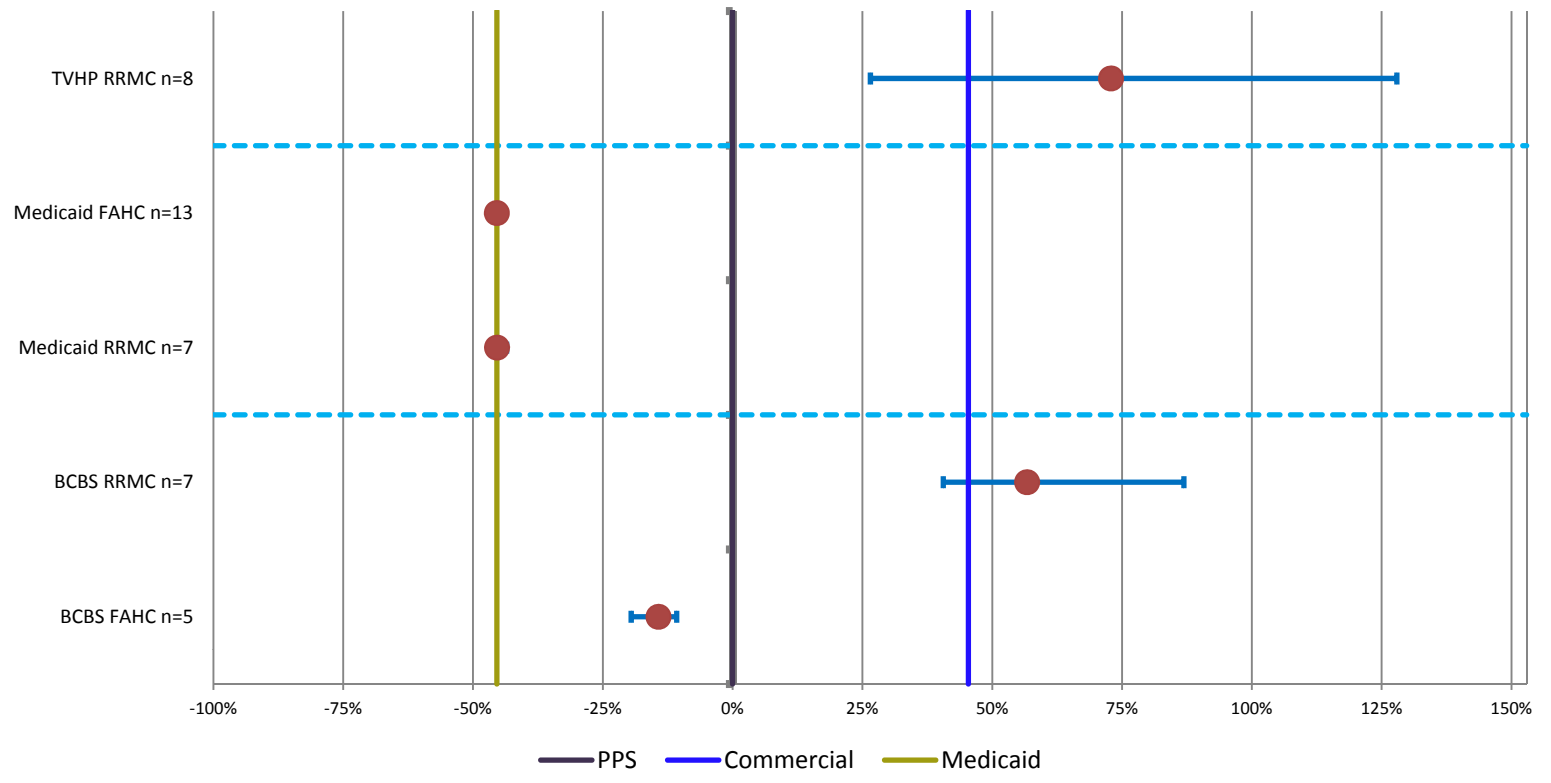
FY2012 Hospital Inpatient DRG 371 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC Allowed Payment Amount Variation



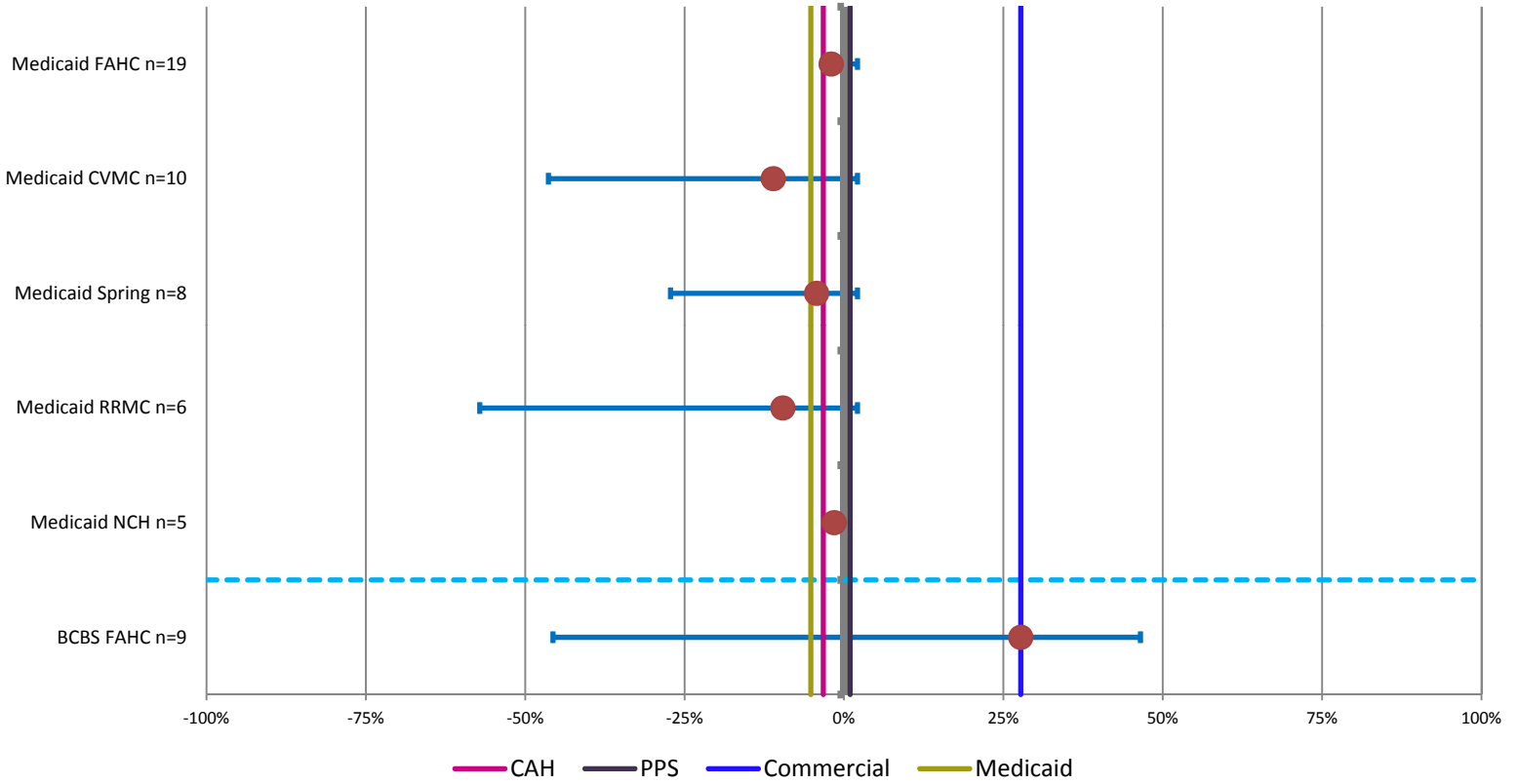
FY2012 Hospital Inpatient DRG 330 - MAJOR SMALL & LARGE BOWEL PROCEDURES W CC Allowed Payment Amount Variation



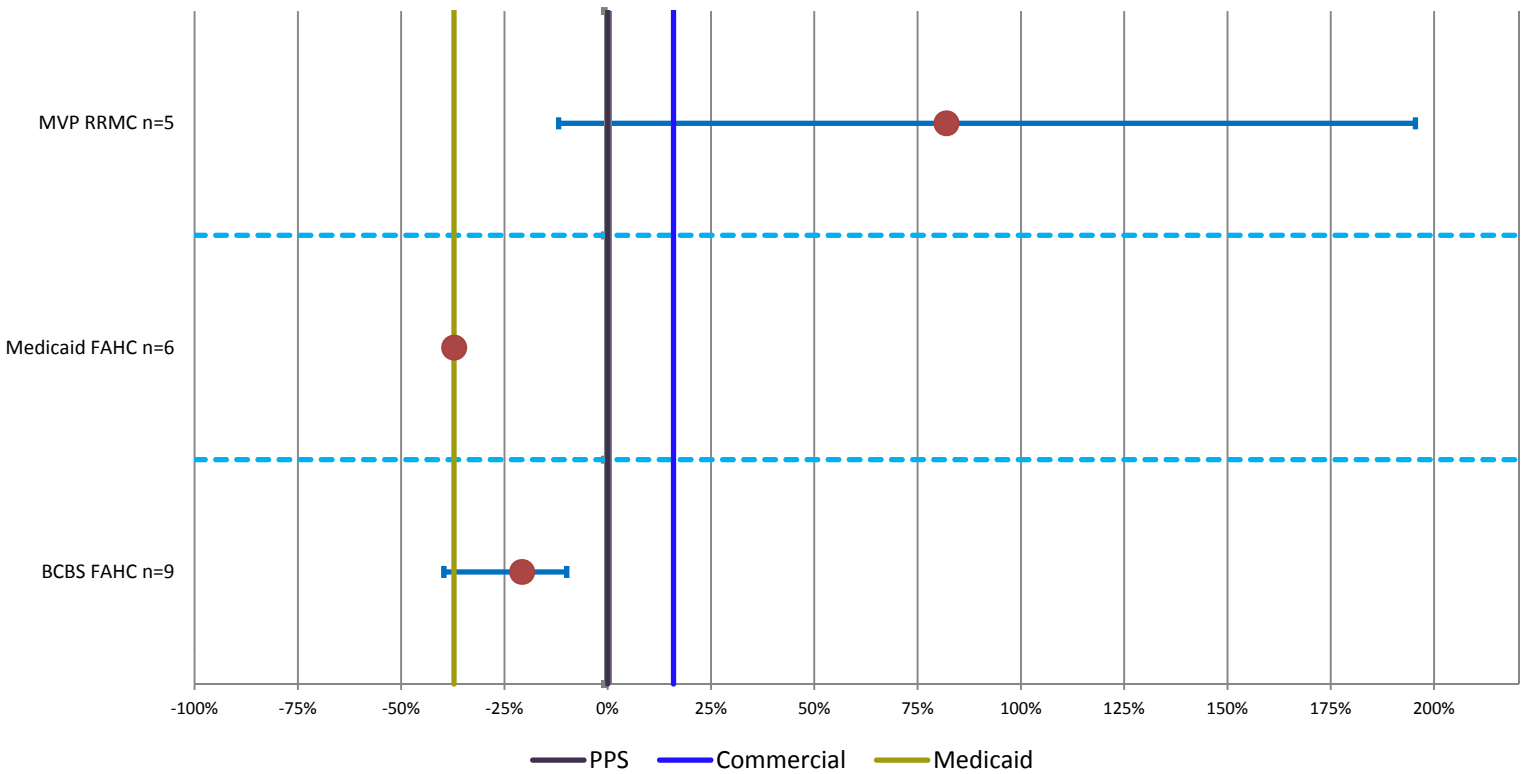
FY2012 Hospital Inpatient DRG 743 - UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC Allowed Payment Amount Variation



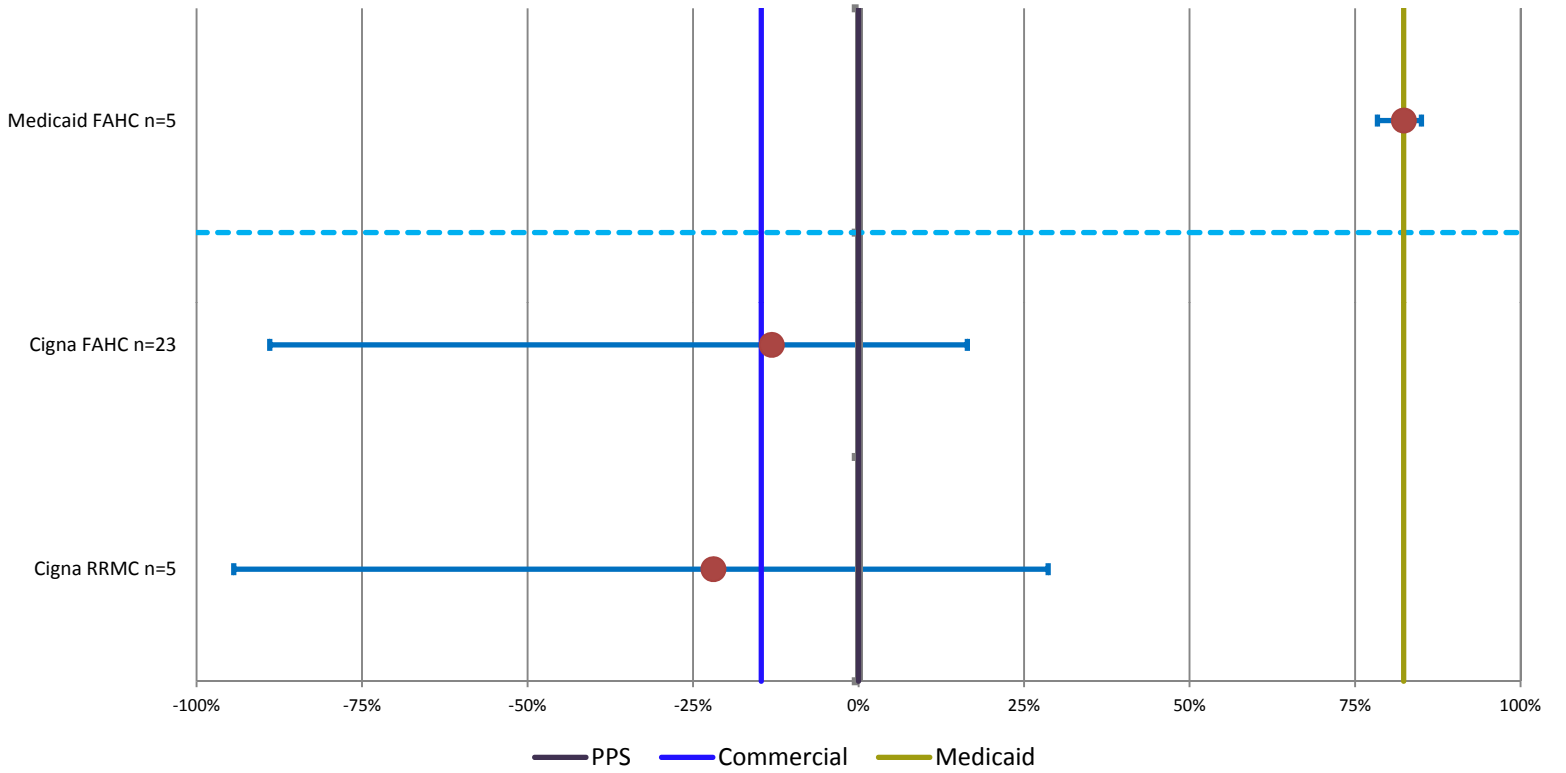
FY2012 Hospital Inpatient DRG 194 - SIMPLE PNEUMONIA & PLEURISY W CC Allowed Payment Amount Variation



FY2012 Hospital Inpatient DRG 331 - MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC Allowed Payment Amount Variation



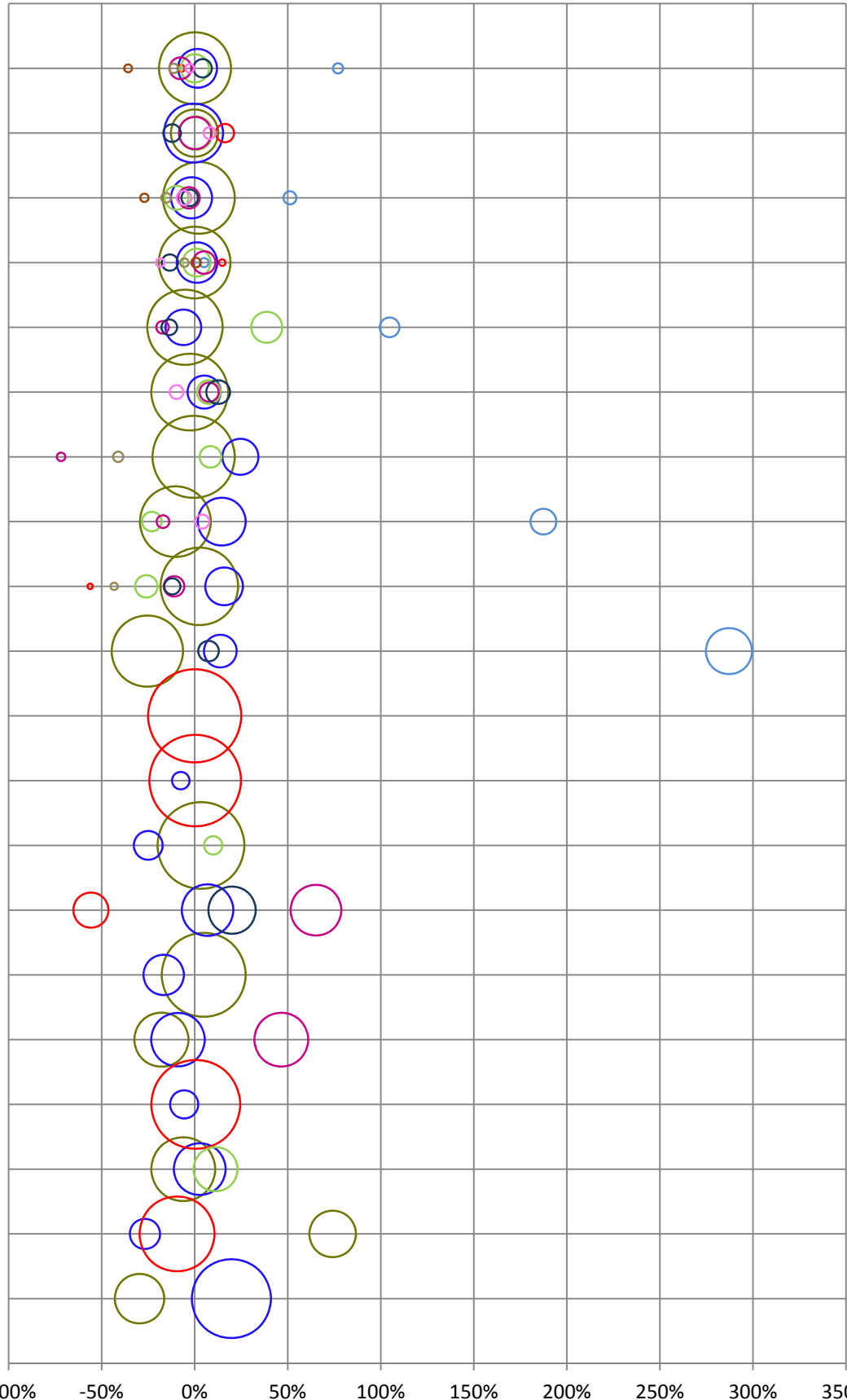
FY2012 Hospital Inpatient DRG 372 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC
Allowed Payment Amount Variation



FY2012 Hospital Inpatient DRG Cost Variation

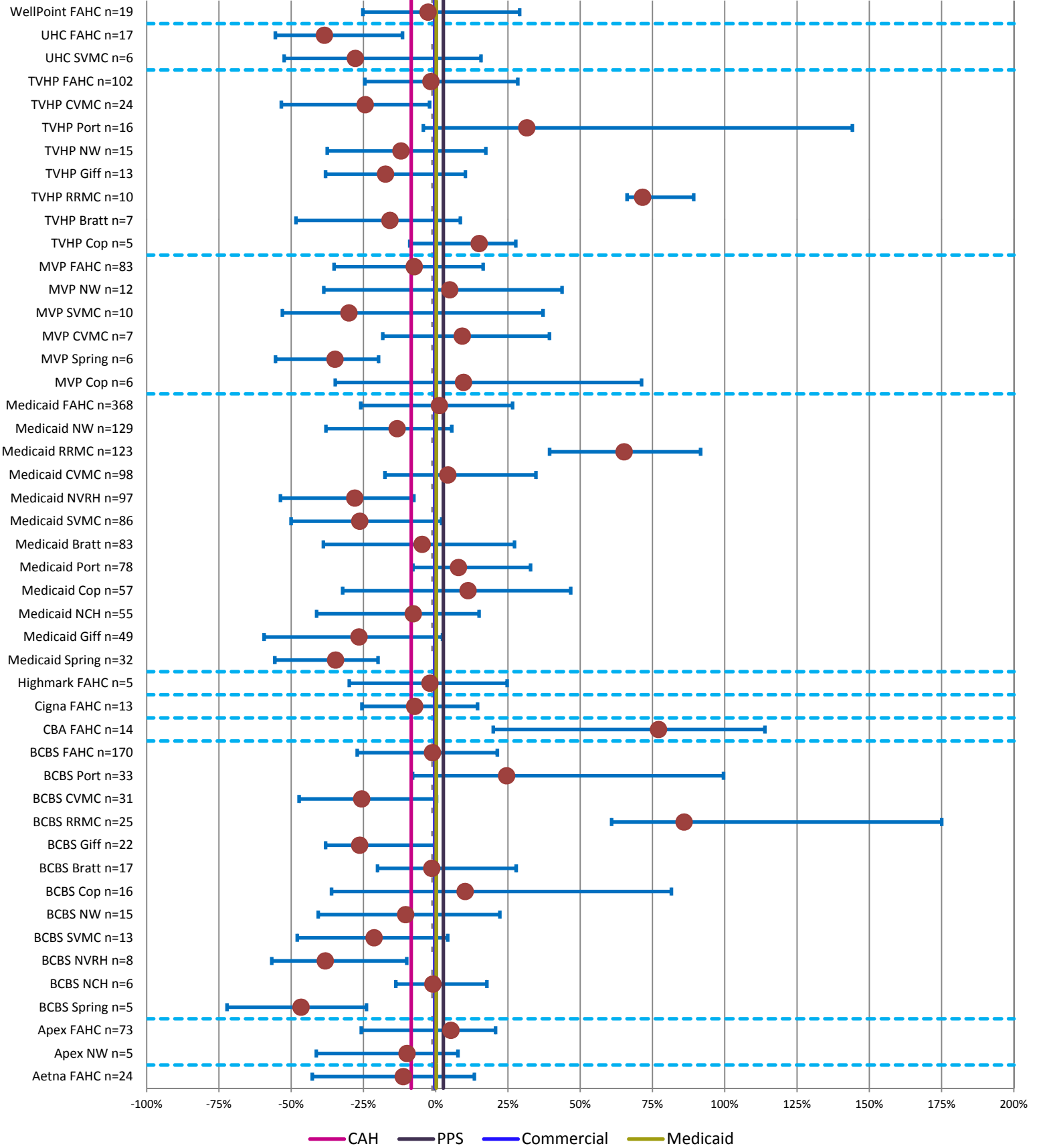
FY2012 Hospital Inpatient DRG Cost Variation (Min 5 Discharges)

- 775 - Vaginal Delivery W/O Complicating Diagnoses
- 470 - Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc
- 766 - Cesarean Section W/O Cc/Mcc
- 795 - Normal Newborn
- 765 - Cesarean Section W Cc/Mcc
- 774 - Vaginal Delivery W Complicating Diagnoses
- 793 - Full Term Neonate W Major Problems
- 392 - Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc
- 794 - Neonate W Other Significant Problems
- 792 - Prematurity W/O Major Problems
- 544 - Pathological Fractures & Musculoskelet & Conn Tiss Malig W/O Cc/Mcc
- 373 - Major Gastrointestinal Disorders & Peritoneal Infections W/O Cc/Mcc
- 603 - Cellulitis W/O Mcc
- 462 - Bilateral Or Multiple Major Joint Procs Of Lower Extremity W/O Mcc
- 194 - Simple Pneumonia & Pleurisy W Cc
- 330 - Major Small & Large Bowel Procedures W Cc
- 371 - Major Gastrointestinal Disorders & Peritoneal Infections W Mcc
- 743 - Uterine & Adnexa Proc For Non-Malignancy W/O Cc/Mcc
- 372 - Major Gastrointestinal Disorders & Peritoneal Infections W Cc
- 331 - Major Small & Large Bowel Procedures W/O Cc/Mcc

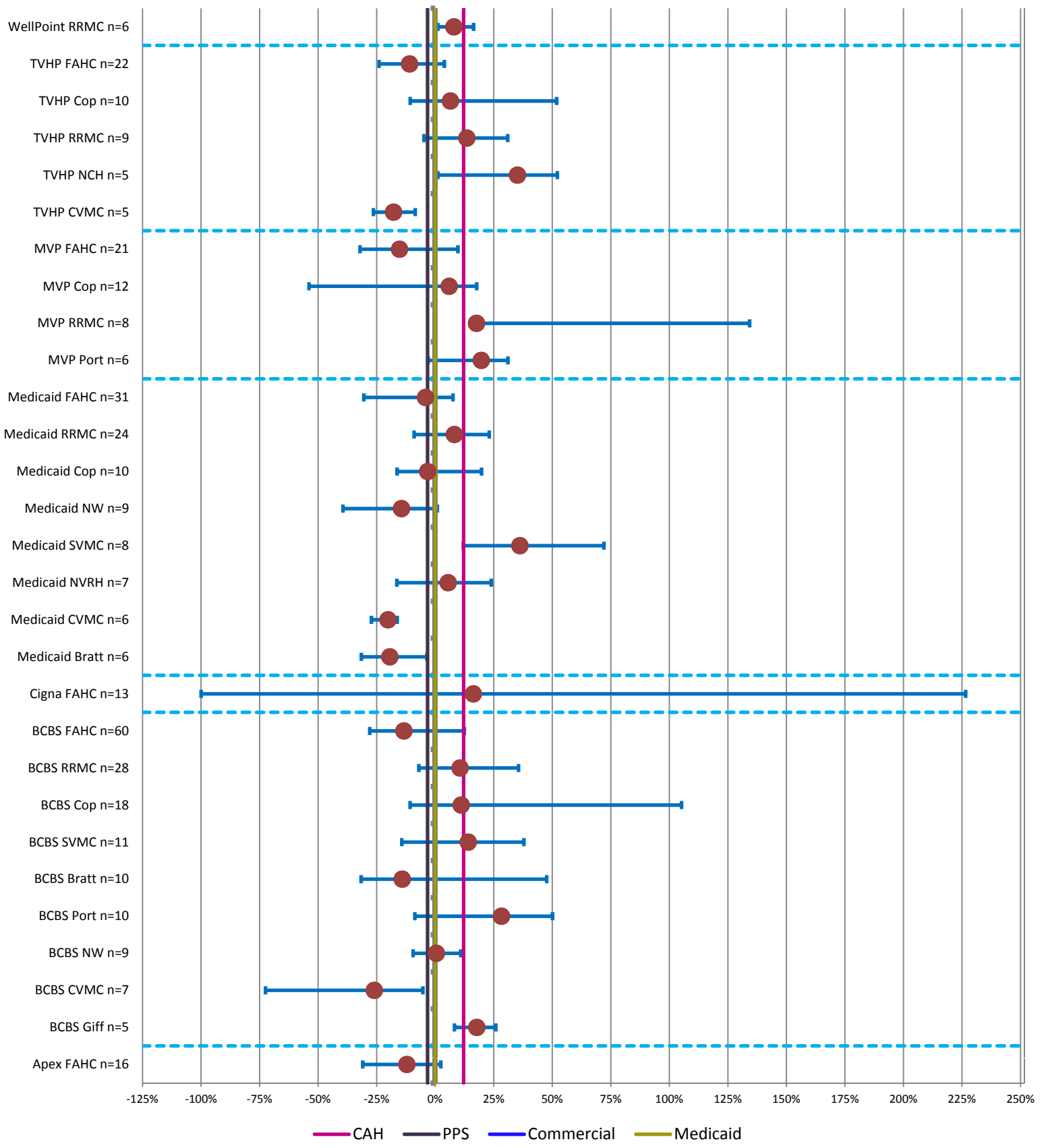


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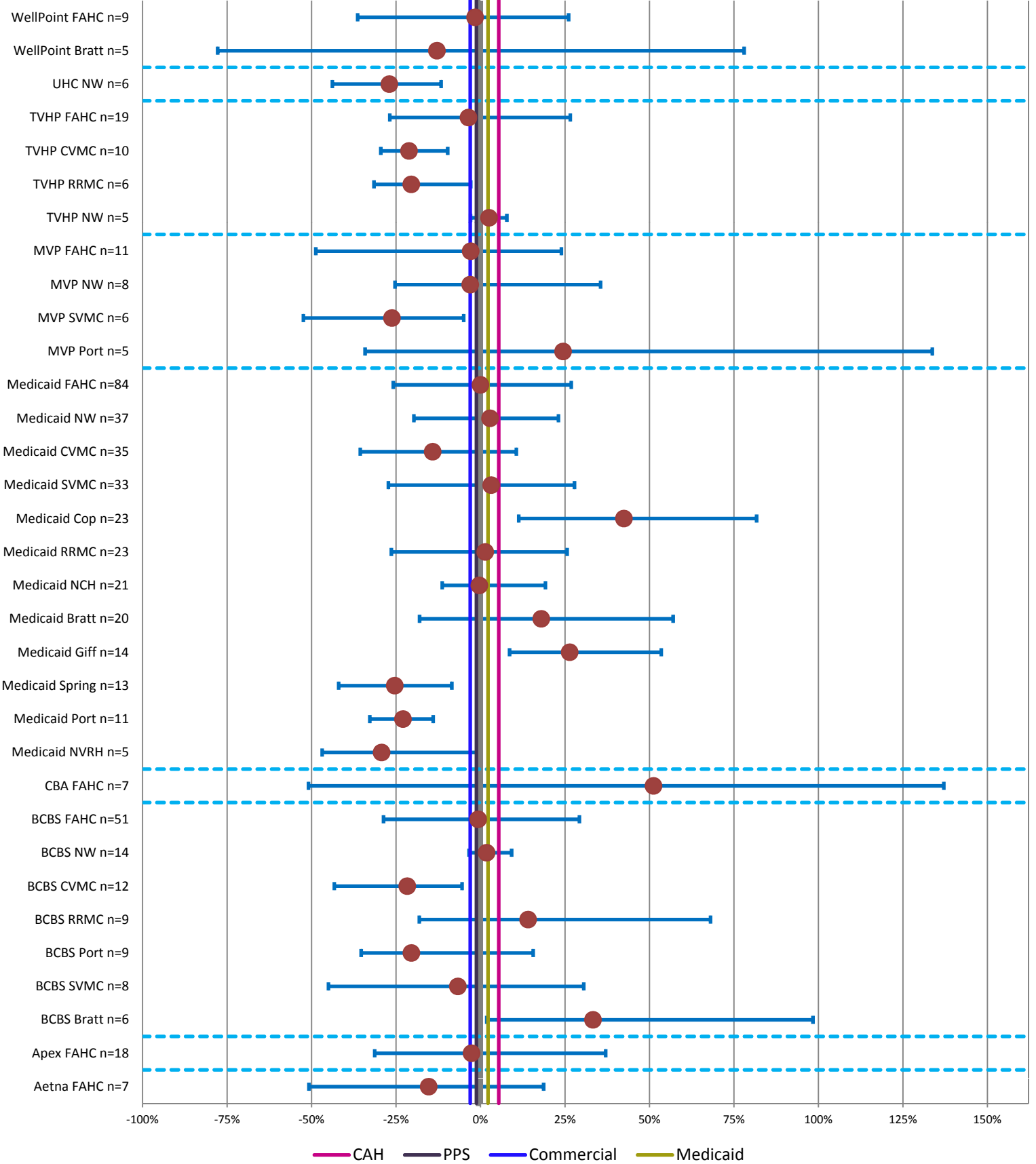
FY2012 Hospital Inpatient DRG 775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES Cost Variation



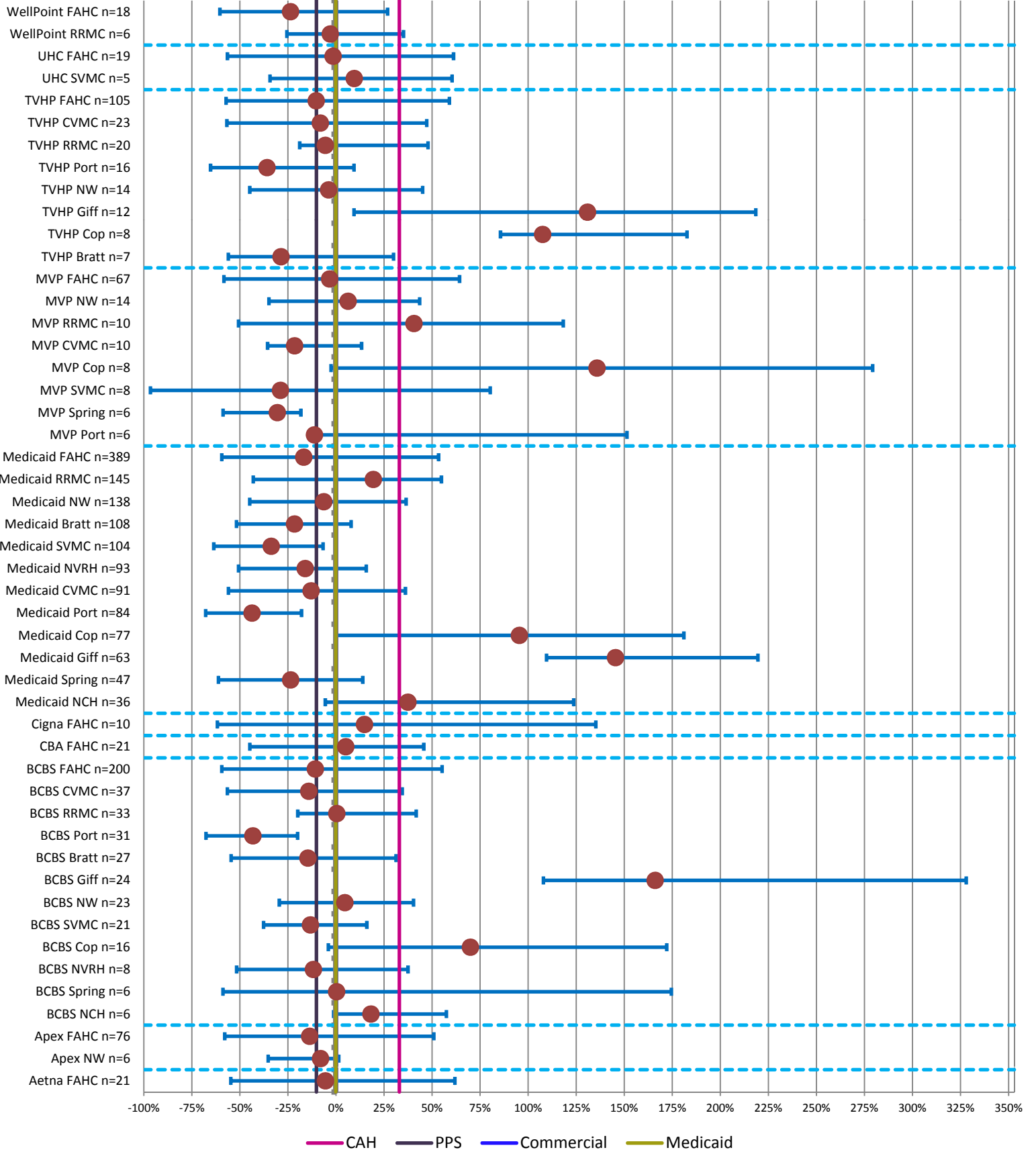
**FY2012 Hospital Inpatient DRG 470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY
W/O MCC Cost Variation**



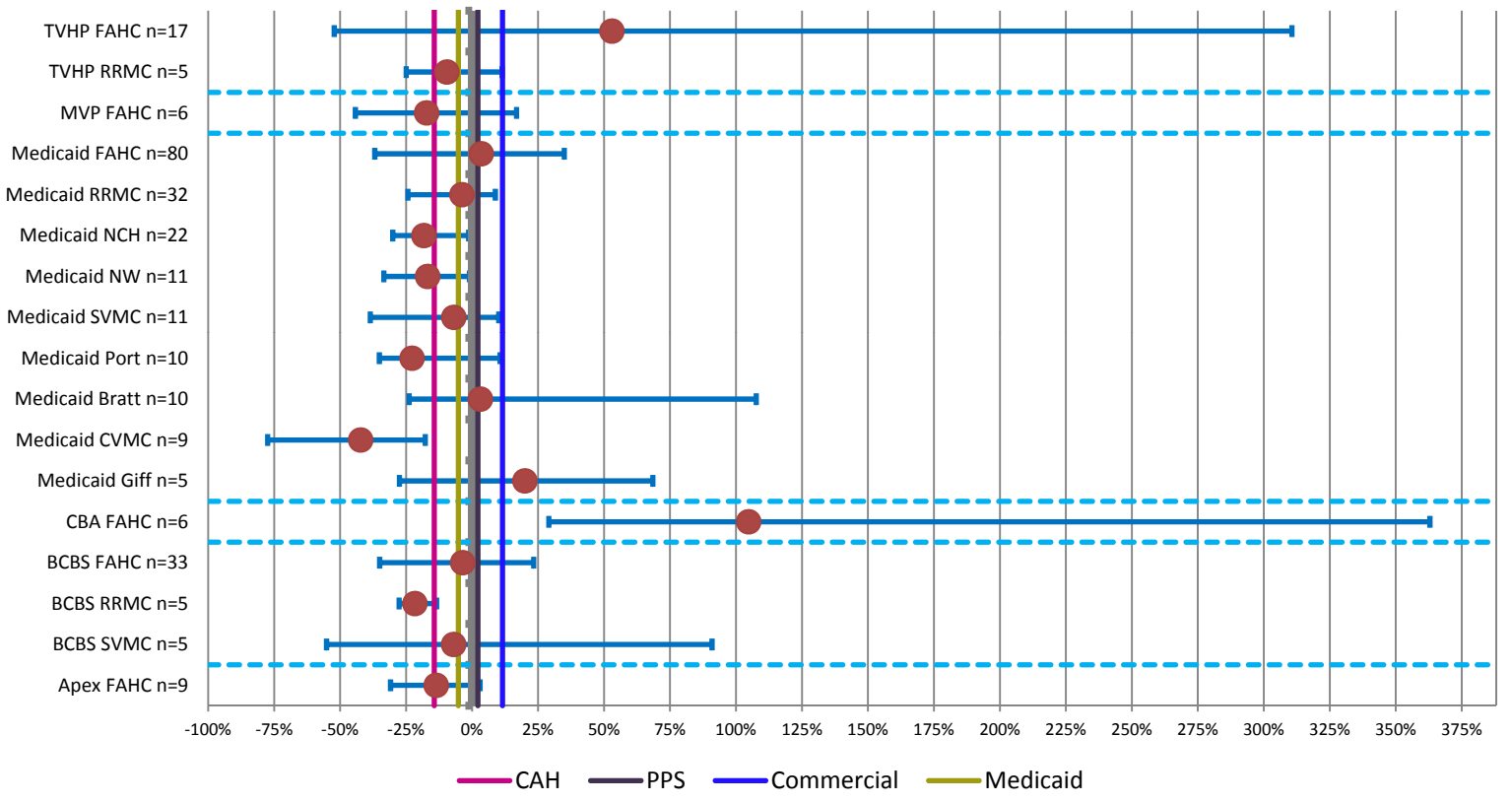
FY2012 Hospital Inpatient DRG 766 - CESAREAN SECTION W/O CC/MCC Cost Variation



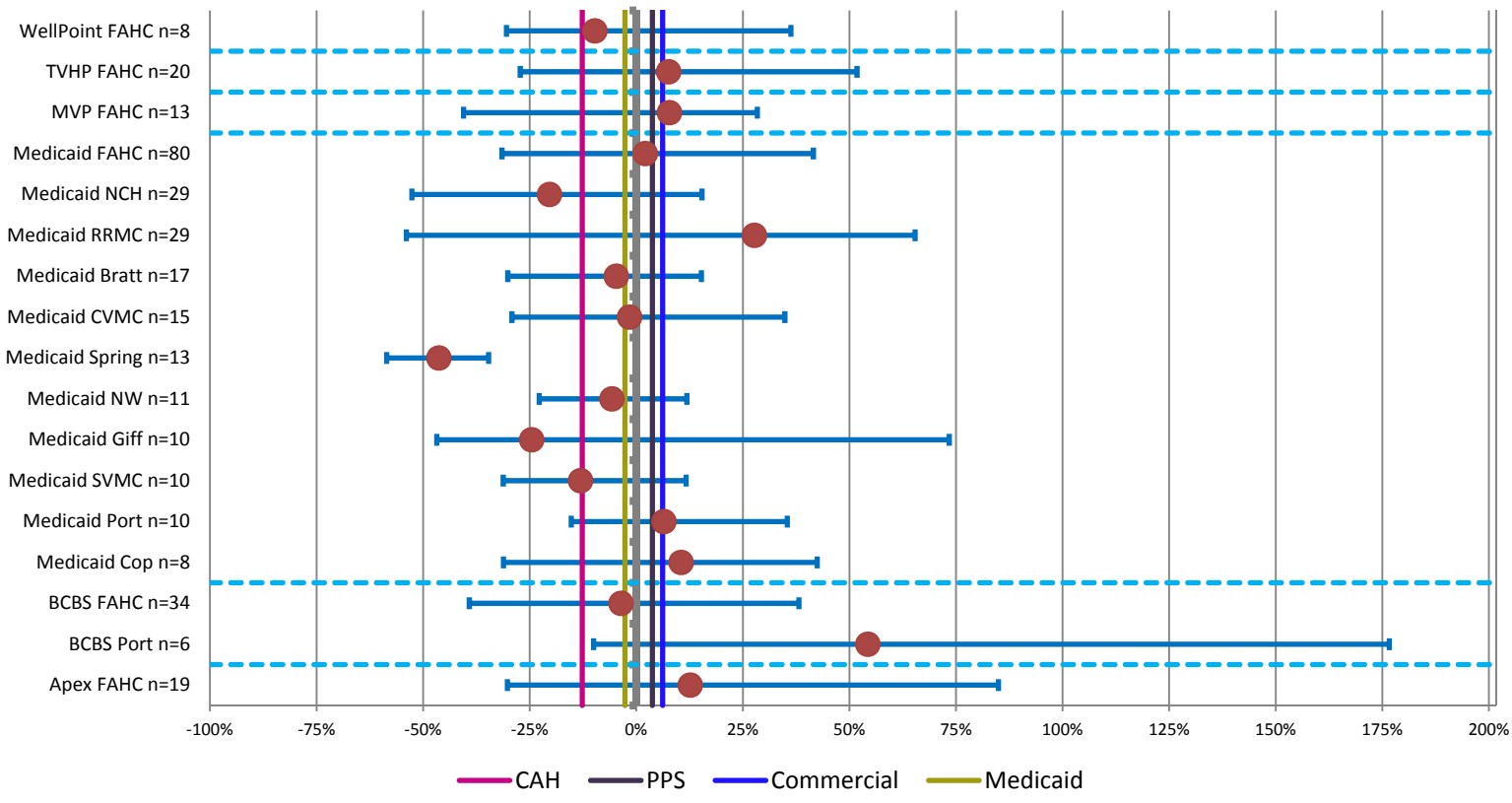
FY2012 Hospital Inpatient DRG 795 - NORMAL NEWBORN Cost Variation



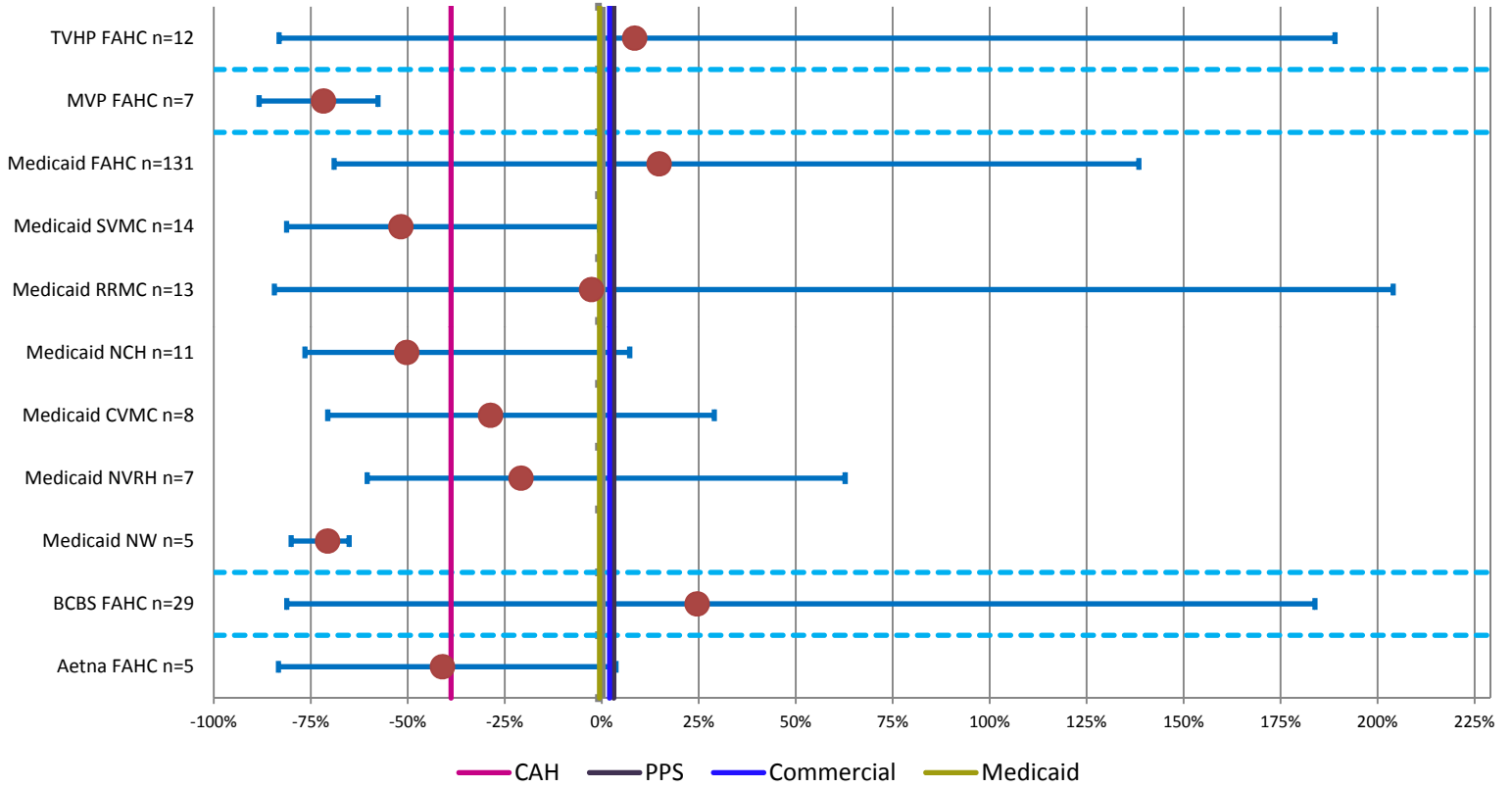
FY2012 Hospital Inpatient DRG 765 - CESAREAN SECTION W CC/MCC Cost Variation



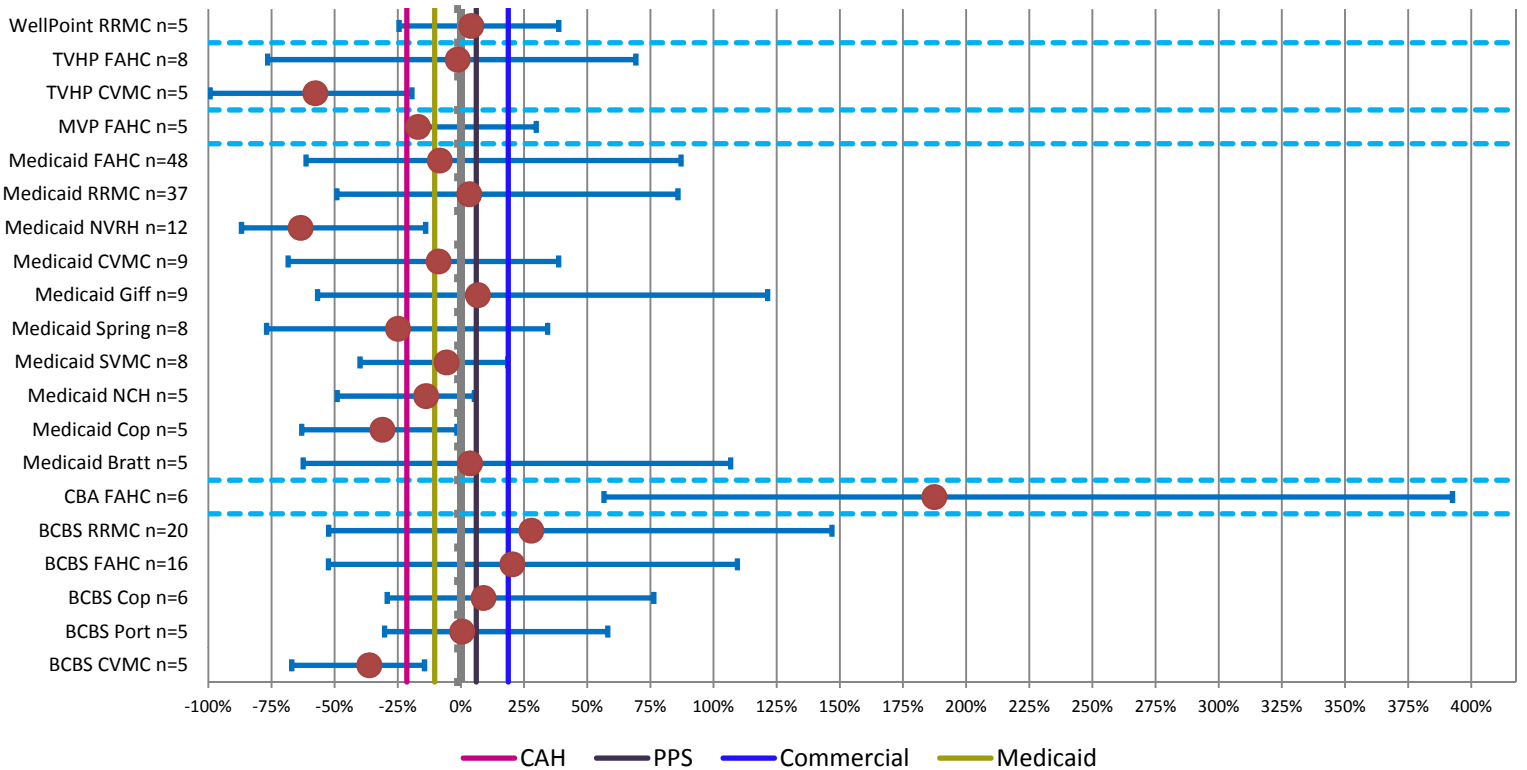
FY2012 Hospital Inpatient DRG 774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES Cost Variation



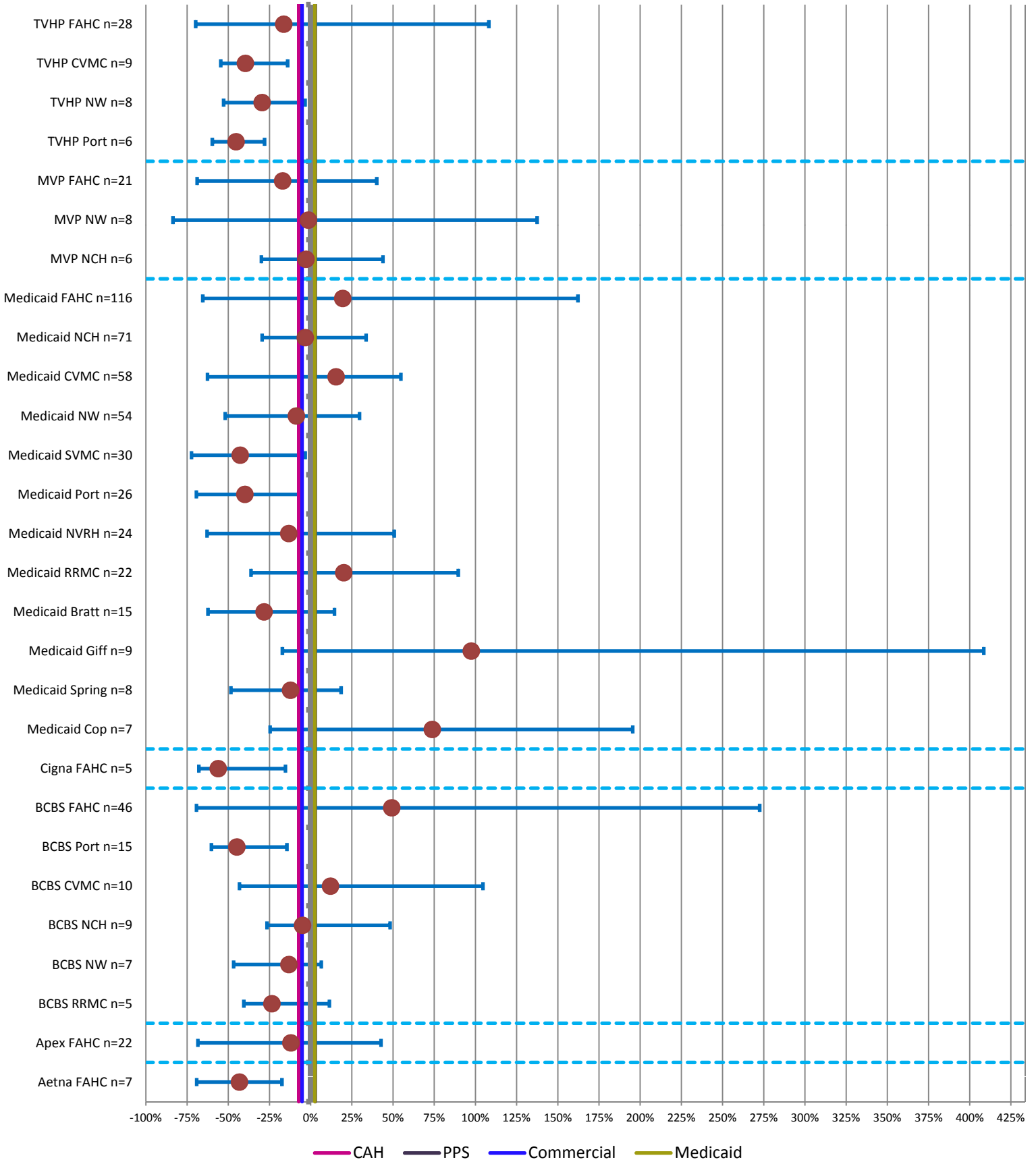
FY2012 Hospital Inpatient DRG 793 - FULL TERM NEONATE W MAJOR PROBLEMS Cost Variation



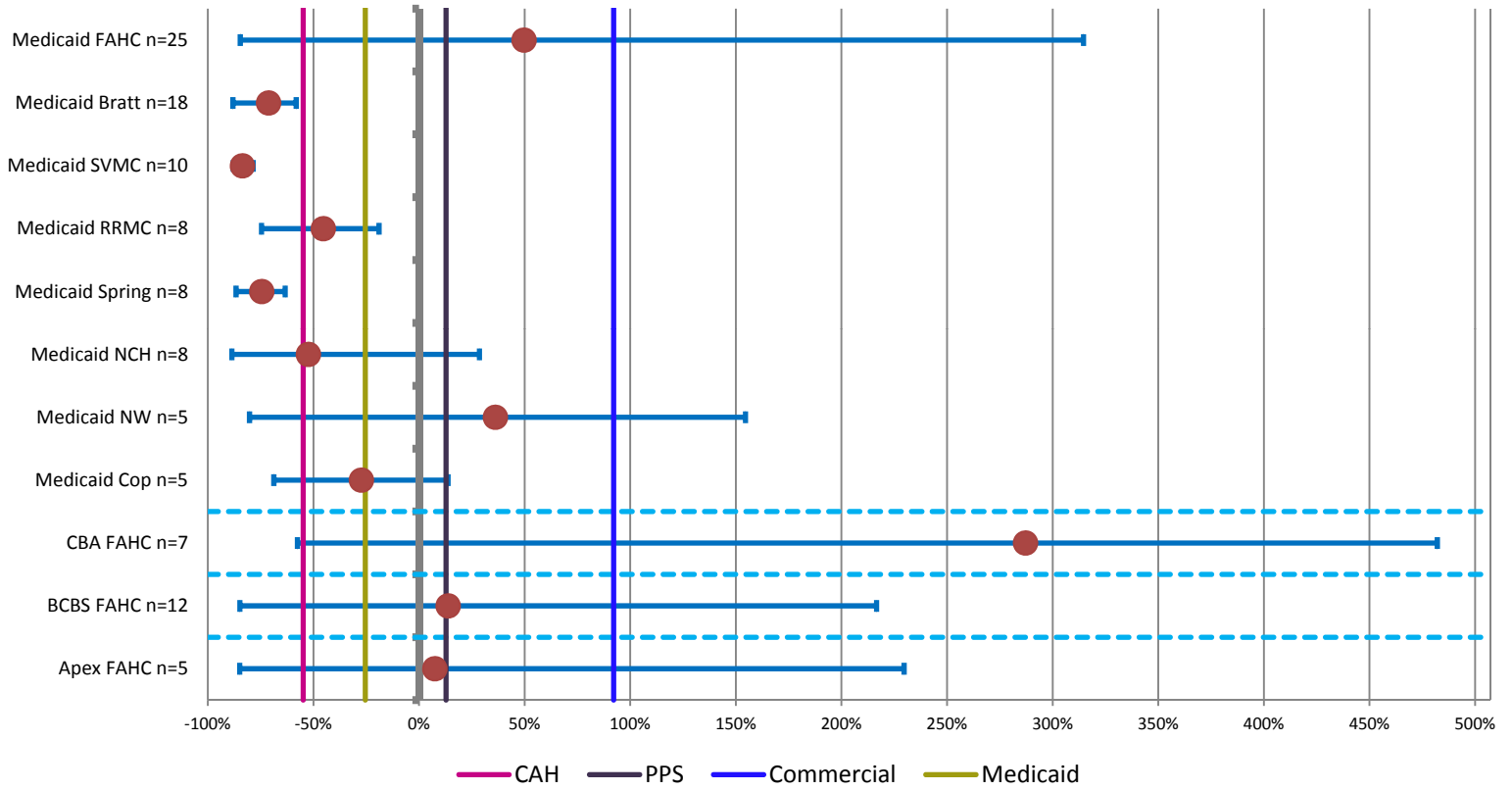
FY2012 Hospital Inpatient DRG 392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC Cost Variation



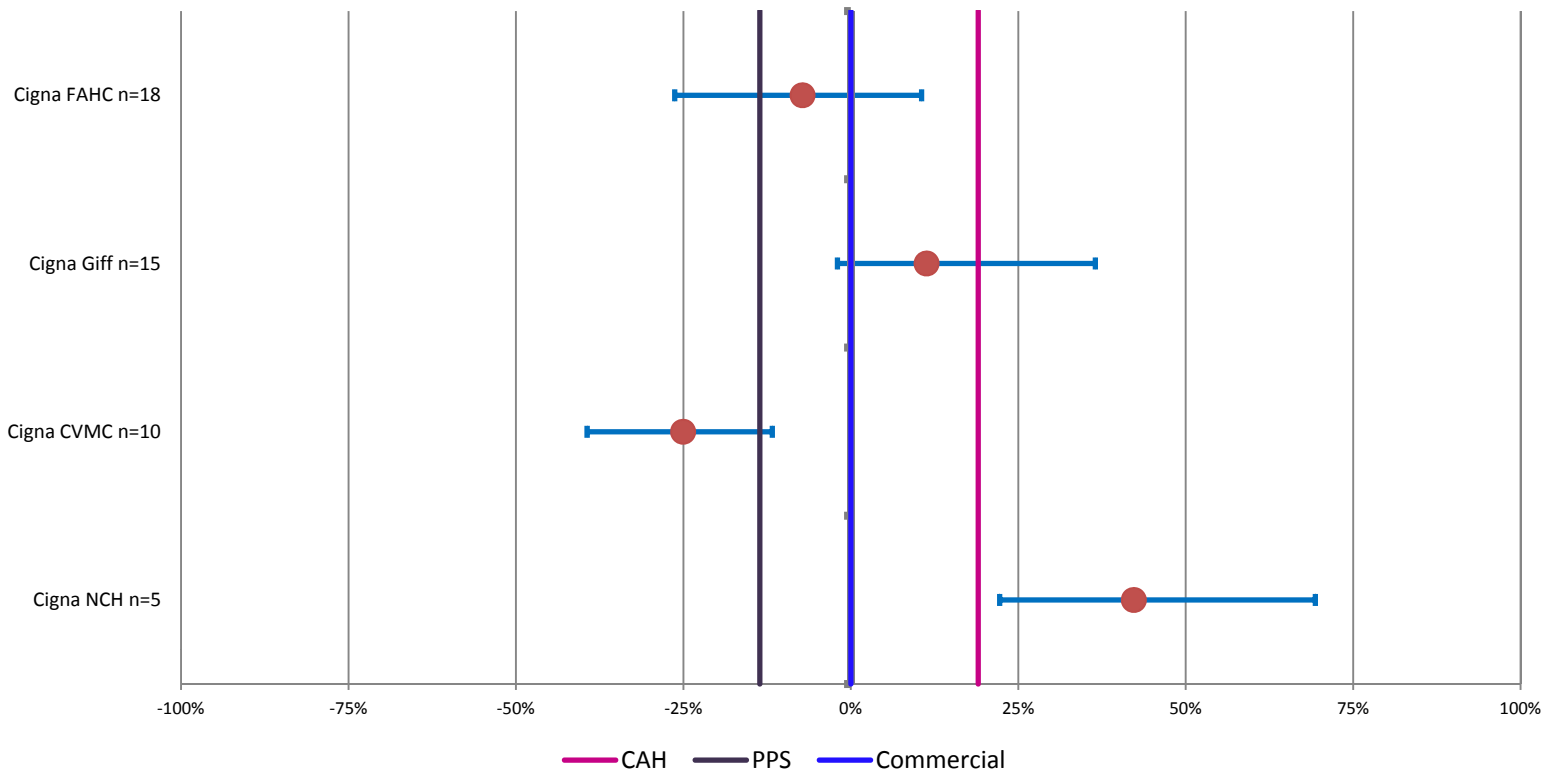
FY2012 Hospital Inpatient DRG 794 - NEONATE W OTHER SIGNIFICANT PROBLEMS Cost Variation



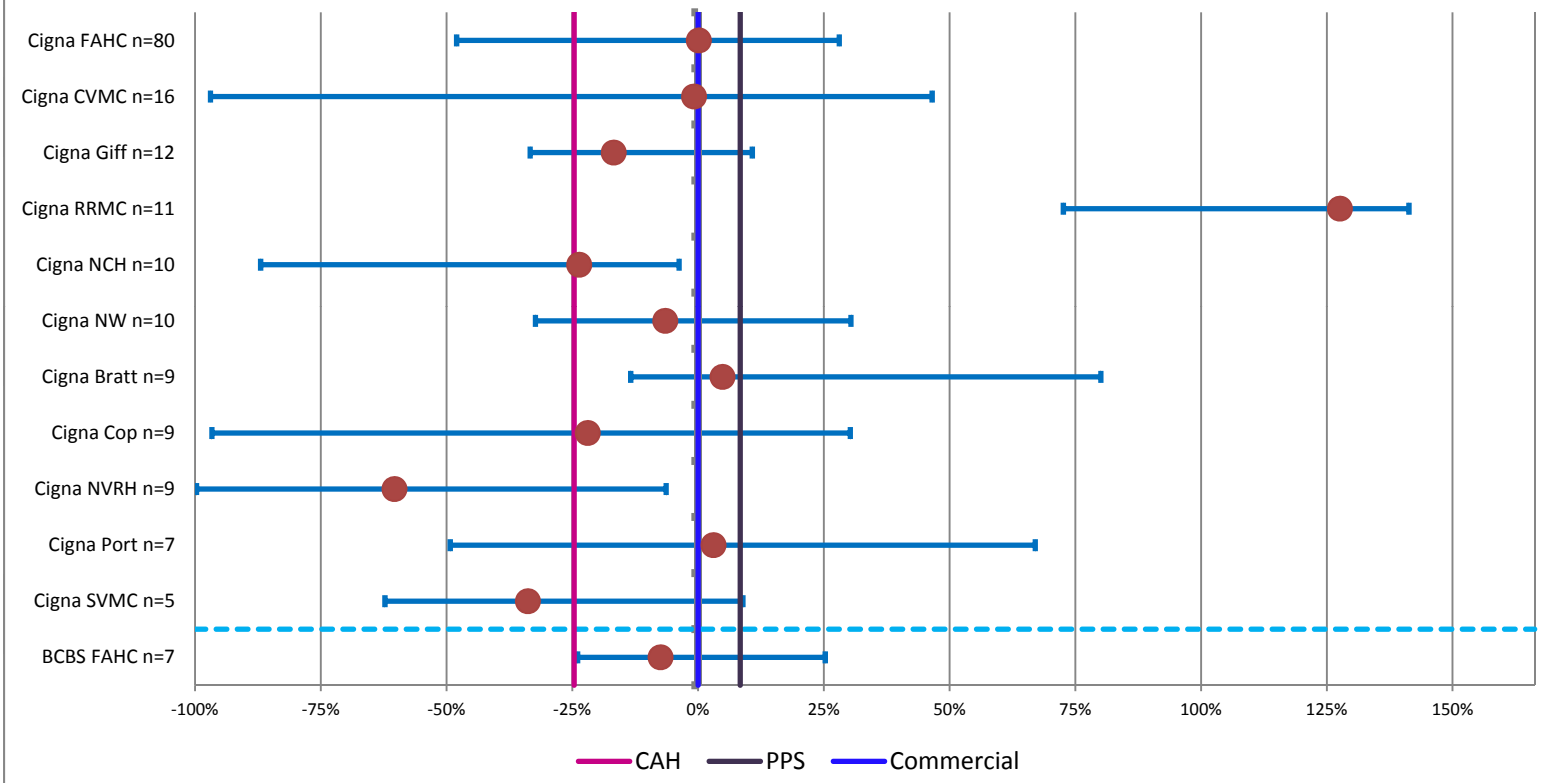
FY2012 Hospital Inpatient DRG 792 - PREMATURETY W/O MAJOR PROBLEMS Cost Variation



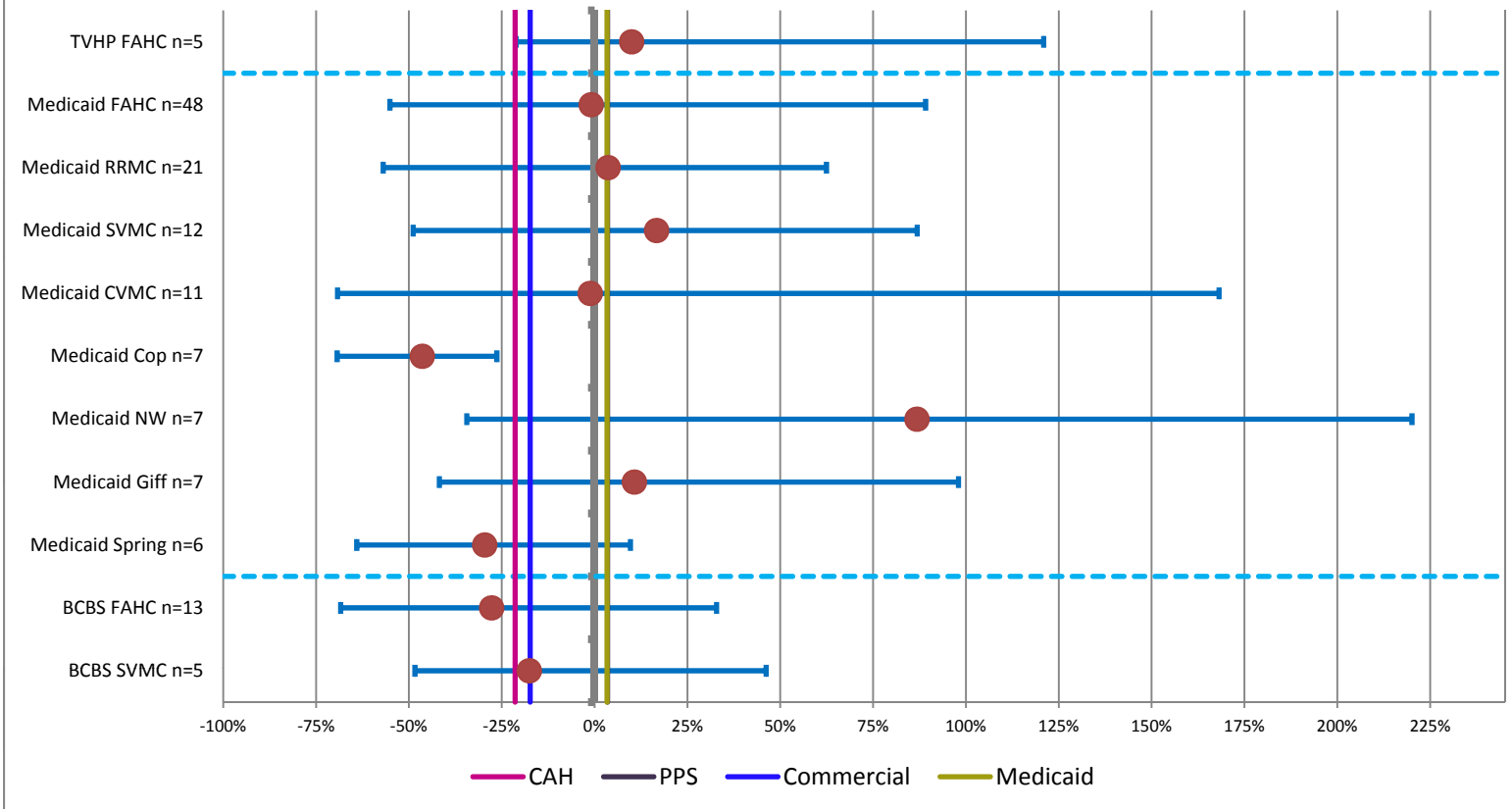
FY2012 Hospital Inpatient DRG 544 - PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC Cost Variation



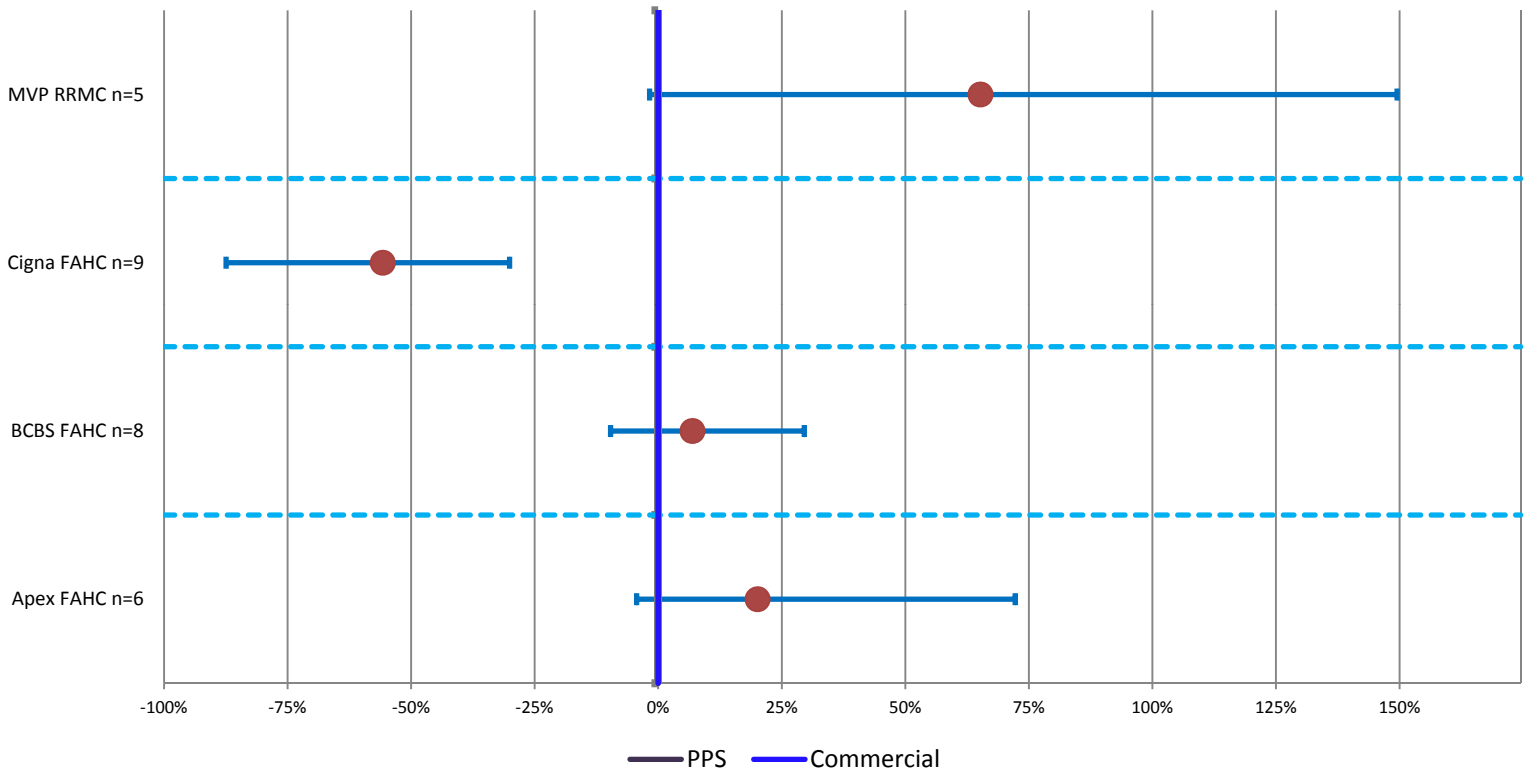
FY2012 Hospital Inpatient DRG 373 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC Cost Variation



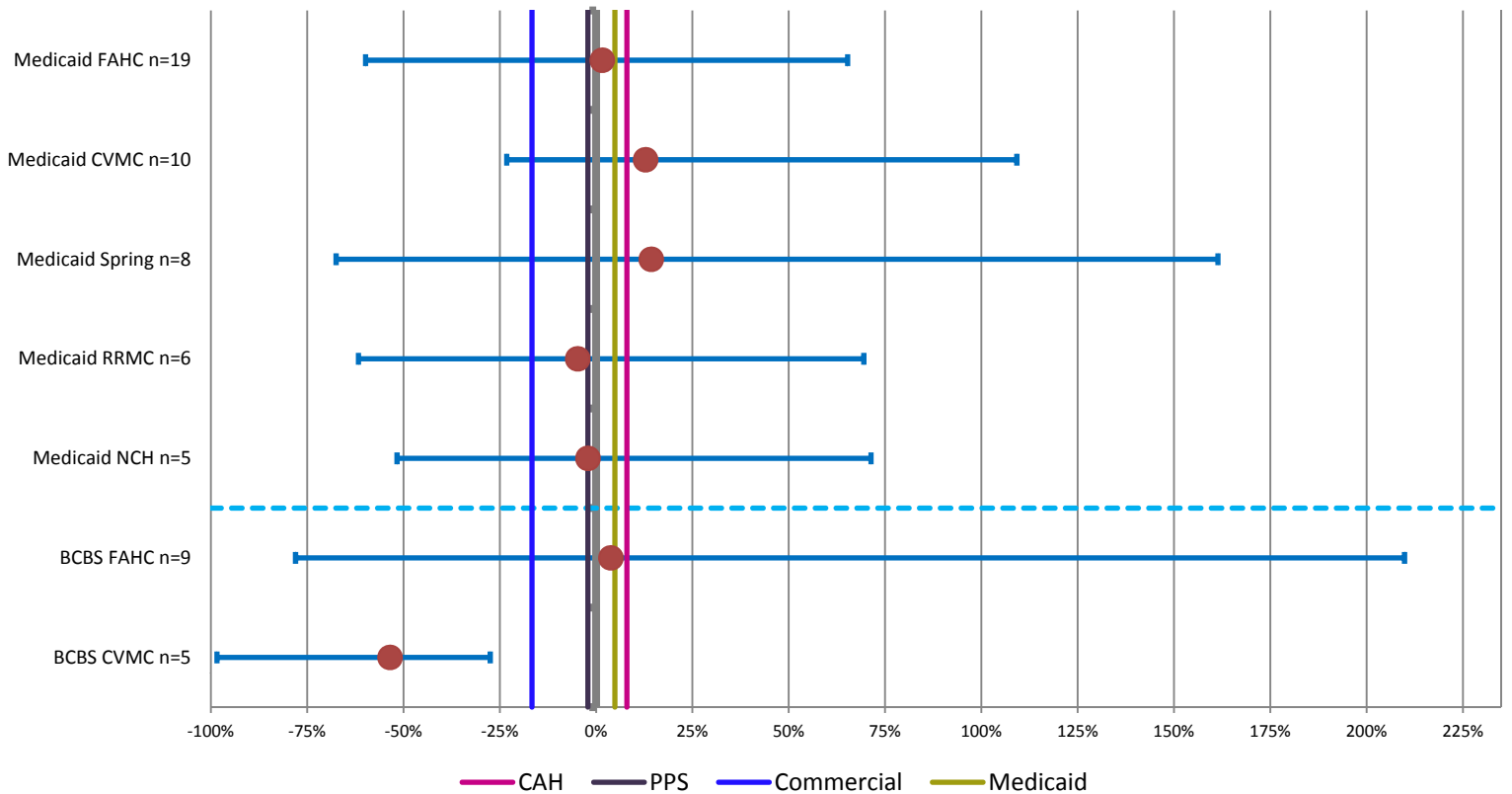
FY2012 Hospital Inpatient DRG 603 - CELLULITIS W/O MCC Cost Variation



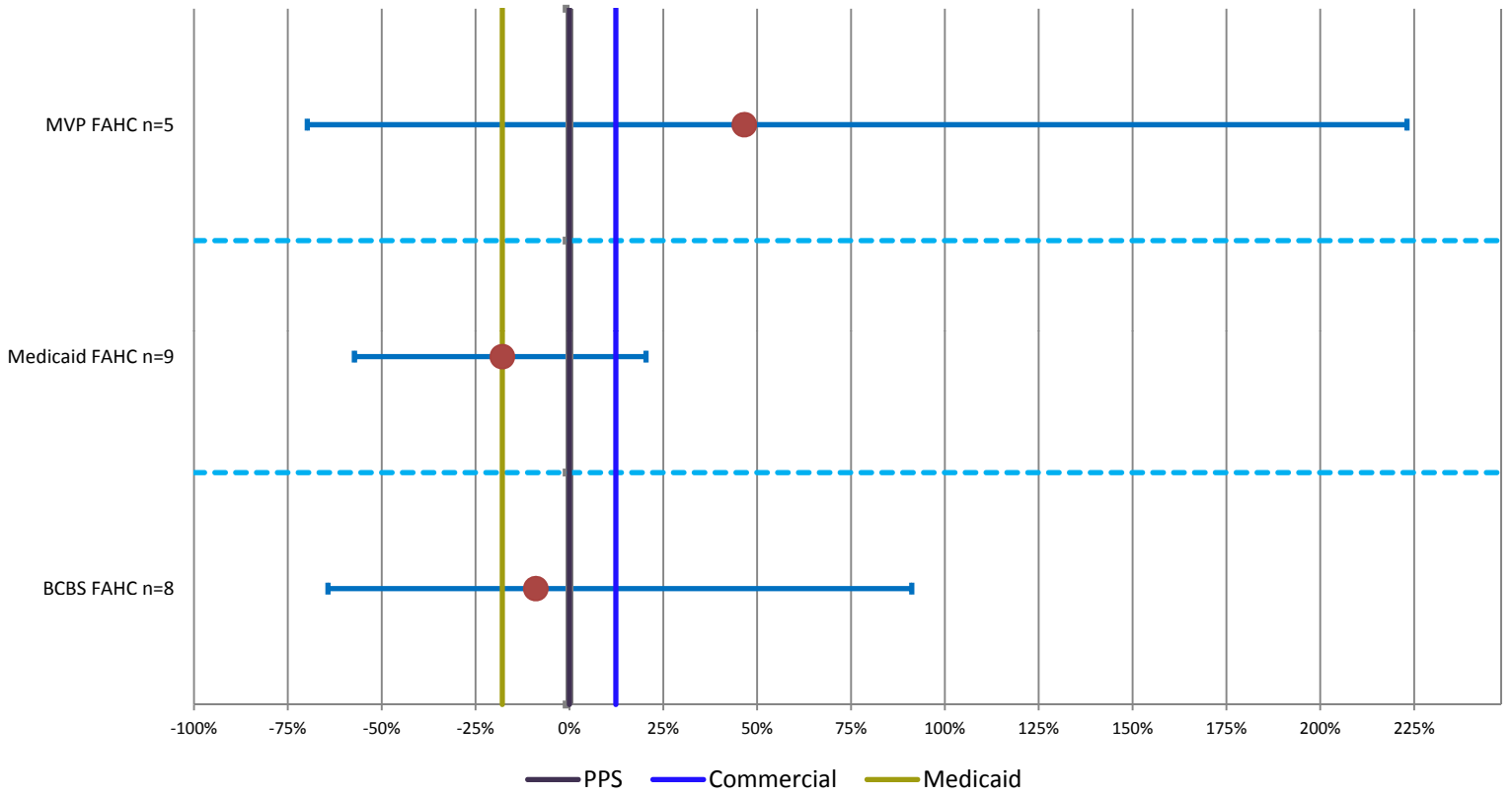
FY2012 Hospital Inpatient DRG 462 - BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC Cost Variation



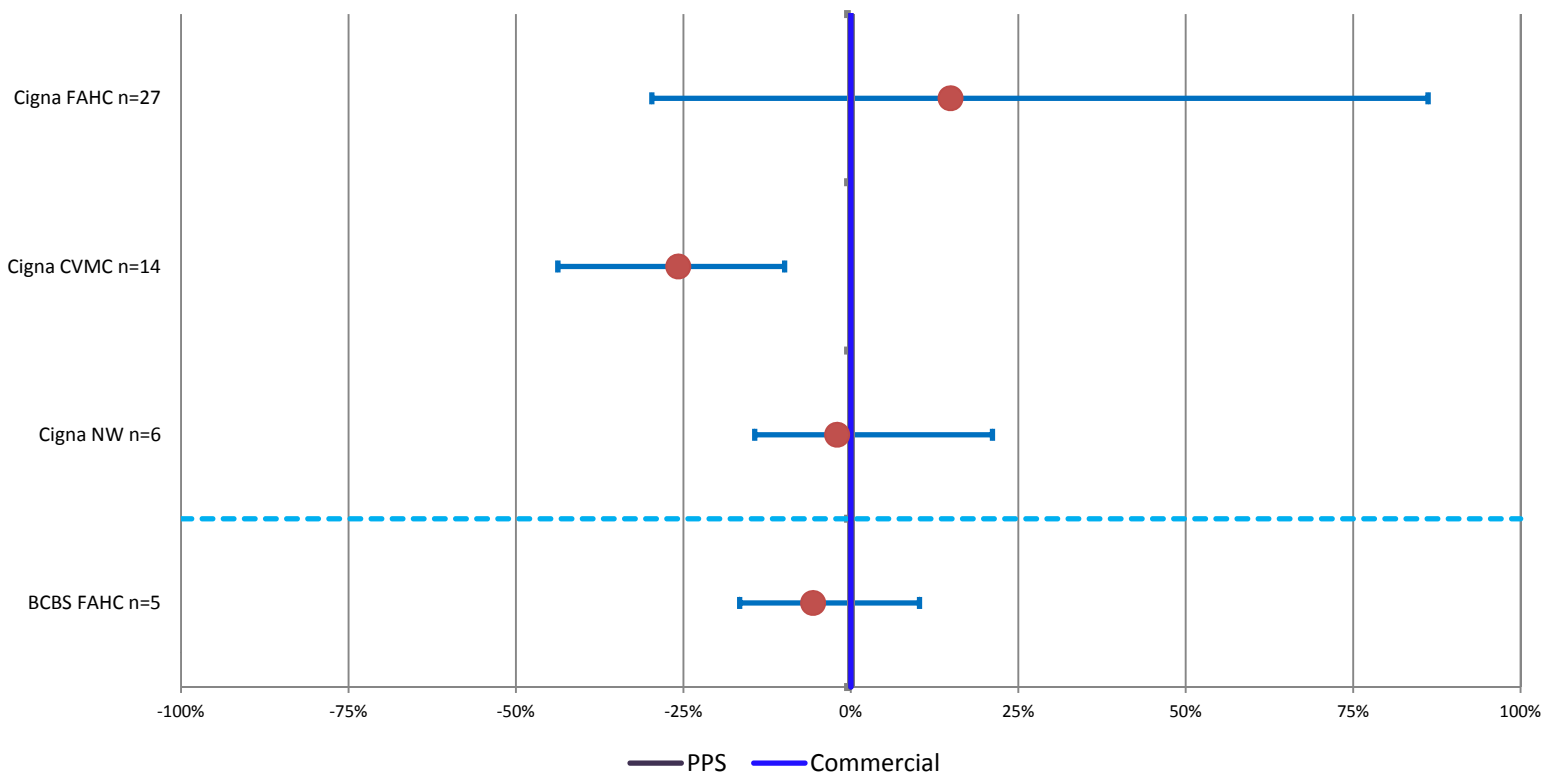
FY2012 Hospital Inpatient DRG 194 - SIMPLE PNEUMONIA & PLEURISY W CC Cost Variation



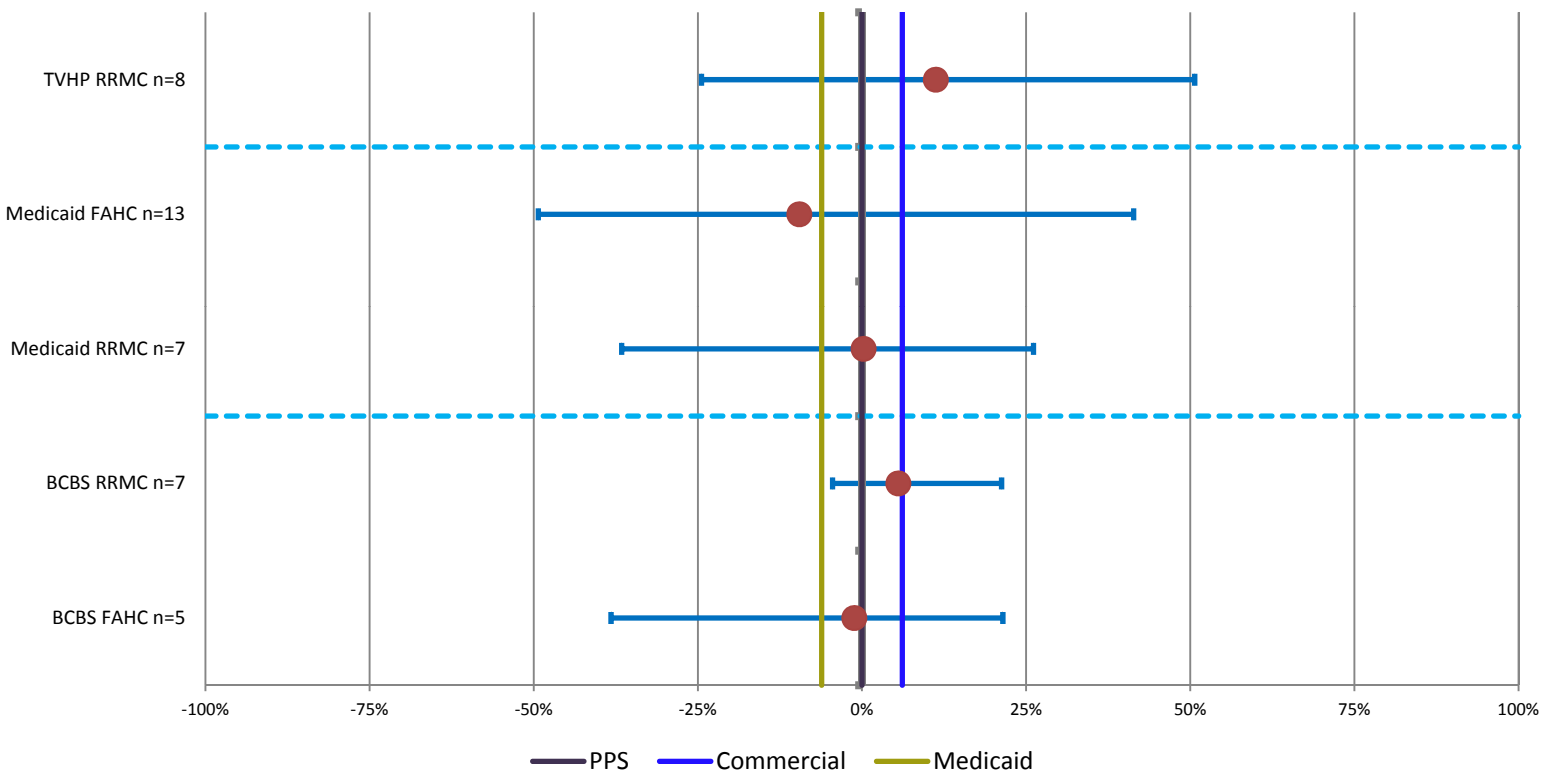
FY2012 Hospital Inpatient DRG 330 - MAJOR SMALL & LARGE BOWEL PROCEDURES W CC Cost Variation



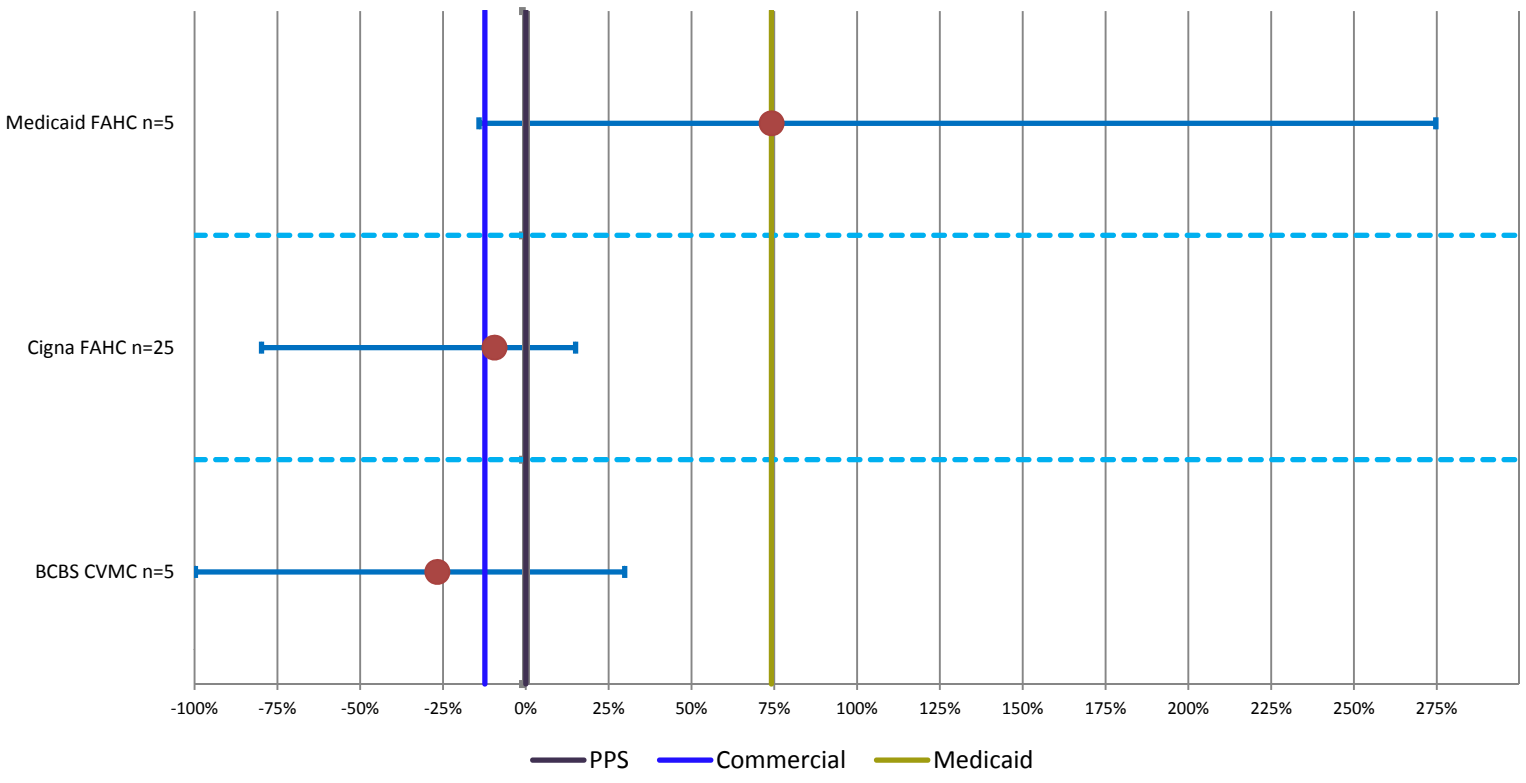
FY2012 Hospital Inpatient DRG 371 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC Cost Variation



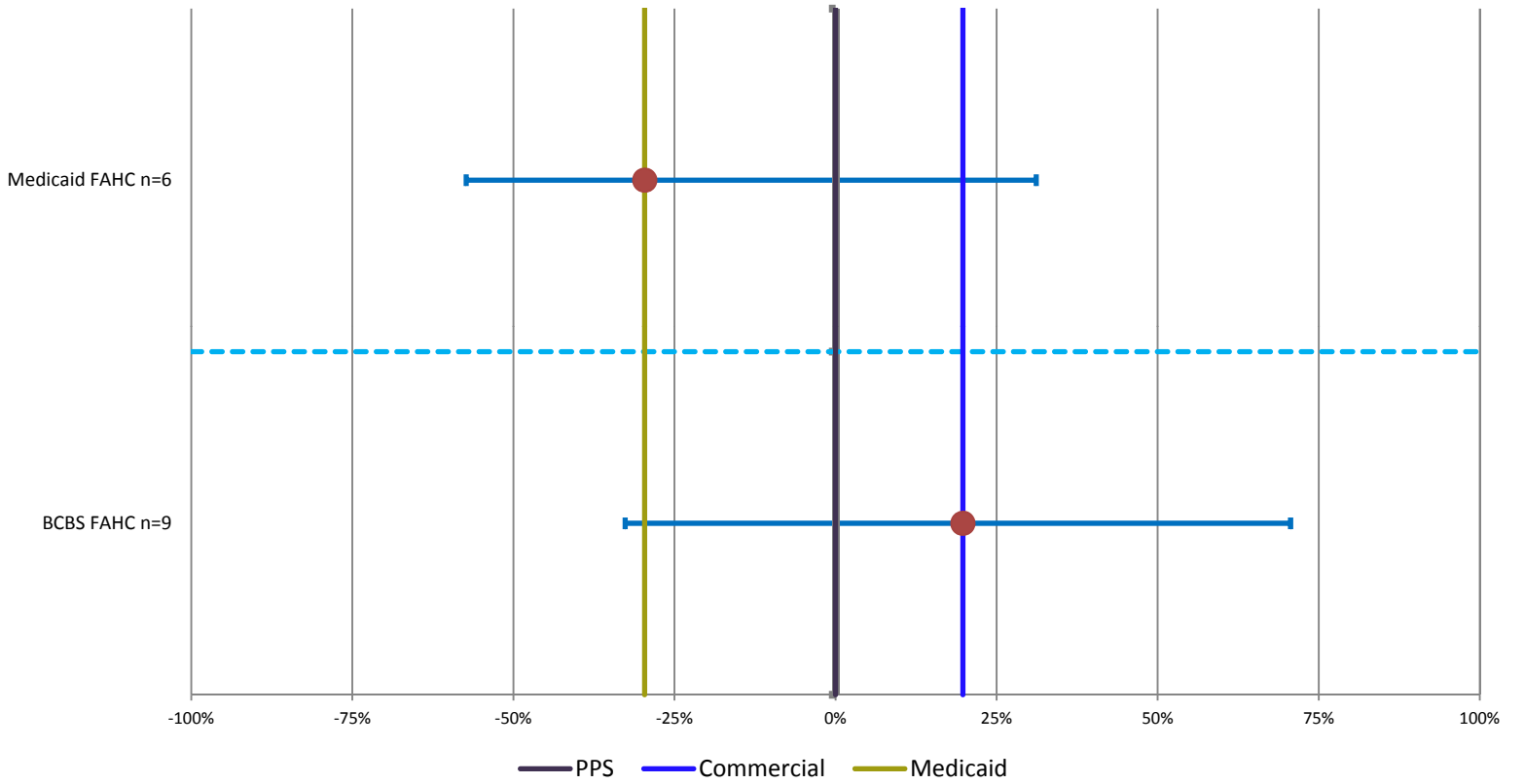
FY2012 Hospital Inpatient DRG 743 - UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC Cost Variation



FY2012 Hospital Inpatient DRG 372 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC Cost Variation



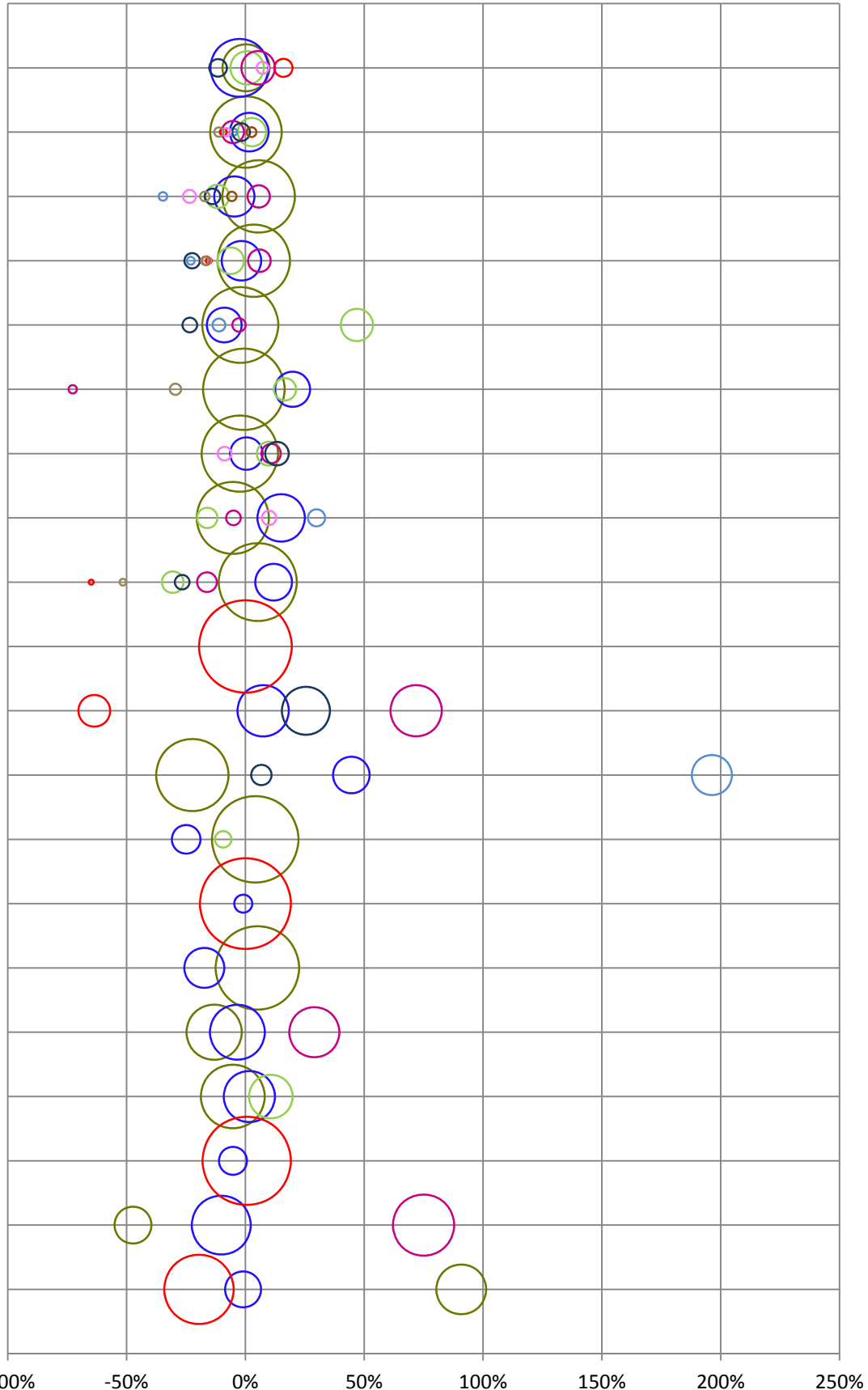
FY2012 Hospital Inpatient DRG 331 - MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC Cost Variation



FY2012 Hospital Inpatient DRG Charge Variation

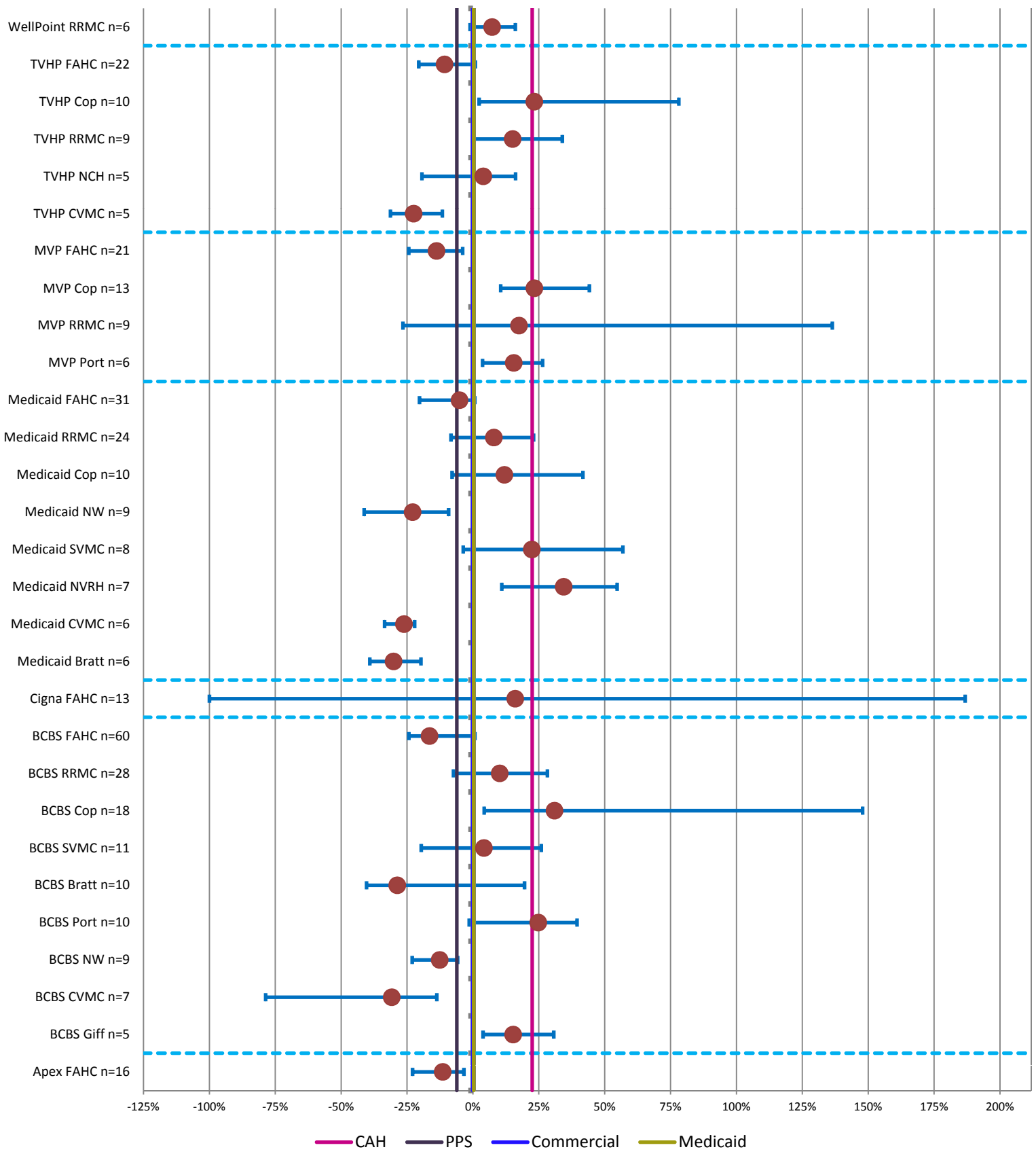
FY2012 Hospital Inpatient DRG Charge Variation (Min 5 Discharges)

- 470 - Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc
- 775 - Vaginal Delivery W/O Complicating Diagnoses
- 766 - Cesarean Section W/O Cc/Mcc
- 795 - Normal Newborn
- 765 - Cesarean Section W Cc/Mcc
- 793 - Full Term Neonate W Major Problems
- 774 - Vaginal Delivery W Complicating Diagnoses
- 392 - Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc
- 794 - Neonate W Other Significant Problems
- 544 - Pathological Fractures & Musculoskelet & Conn Tiss Malig W/O Cc/Mcc
- 462 - Bilateral Or Multiple Major Joint Procs Of Lower Extremity W/O Mcc
- 792 - Prematurity W/O Major Problems
- 603 - Cellulitis W/O Mcc
- 373 - Major Gastrointestinal Disorders & Peritoneal Infections W/O Cc/Mcc
- 194 - Simple Pneumonia & Pleurisy W Cc
- 330 - Major Small & Large Bowel Procedures W Cc
- 743 - Uterine & Adnexa Proc For Non-Malignancy W/O Cc/Mcc
- 371 - Major Gastrointestinal Disorders & Peritoneal Infections W Mcc
- 331 - Major Small & Large Bowel Procedures W/O Cc/Mcc
- 372 - Major Gastrointestinal Disorders & Peritoneal Infections W Cc

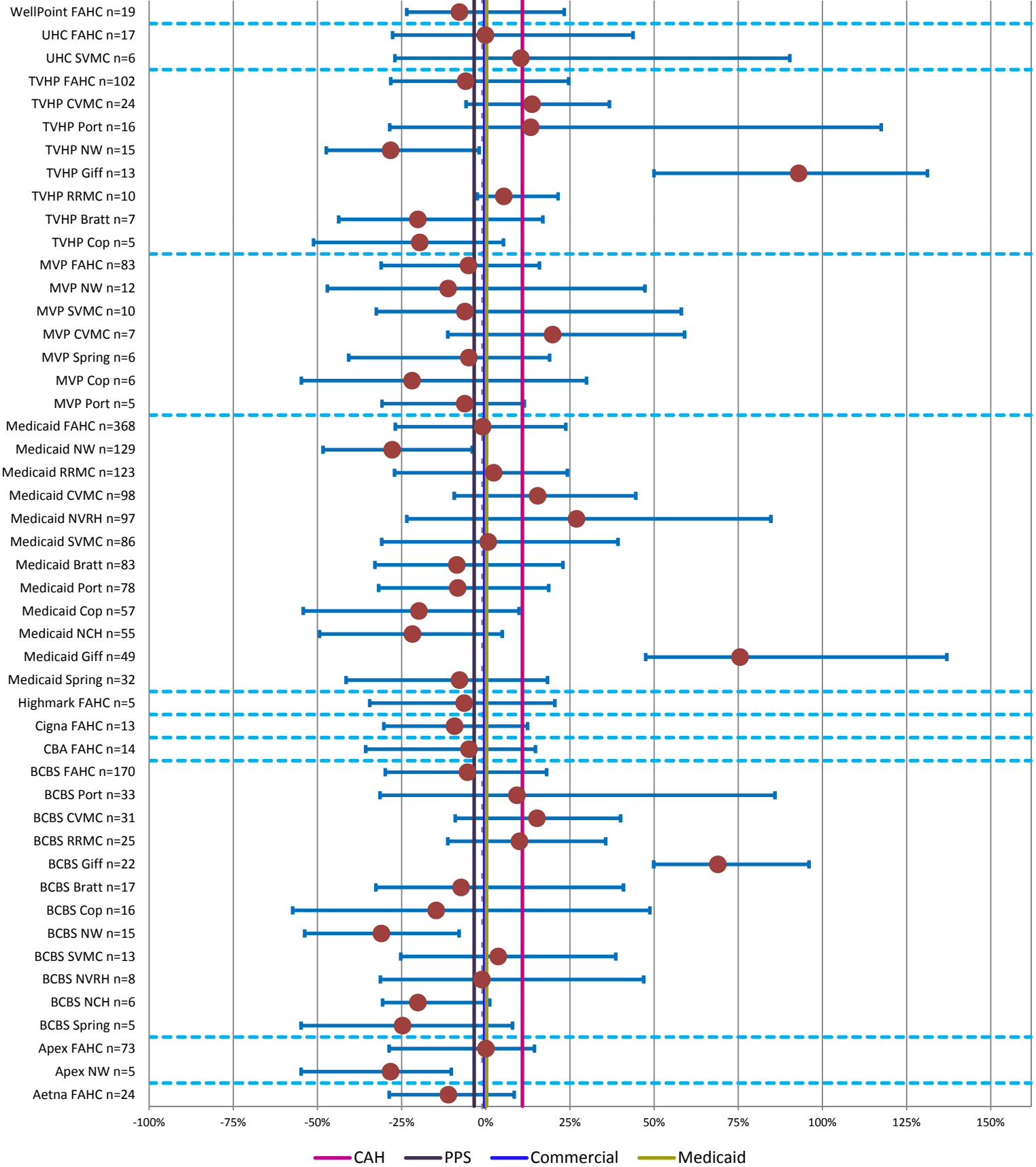


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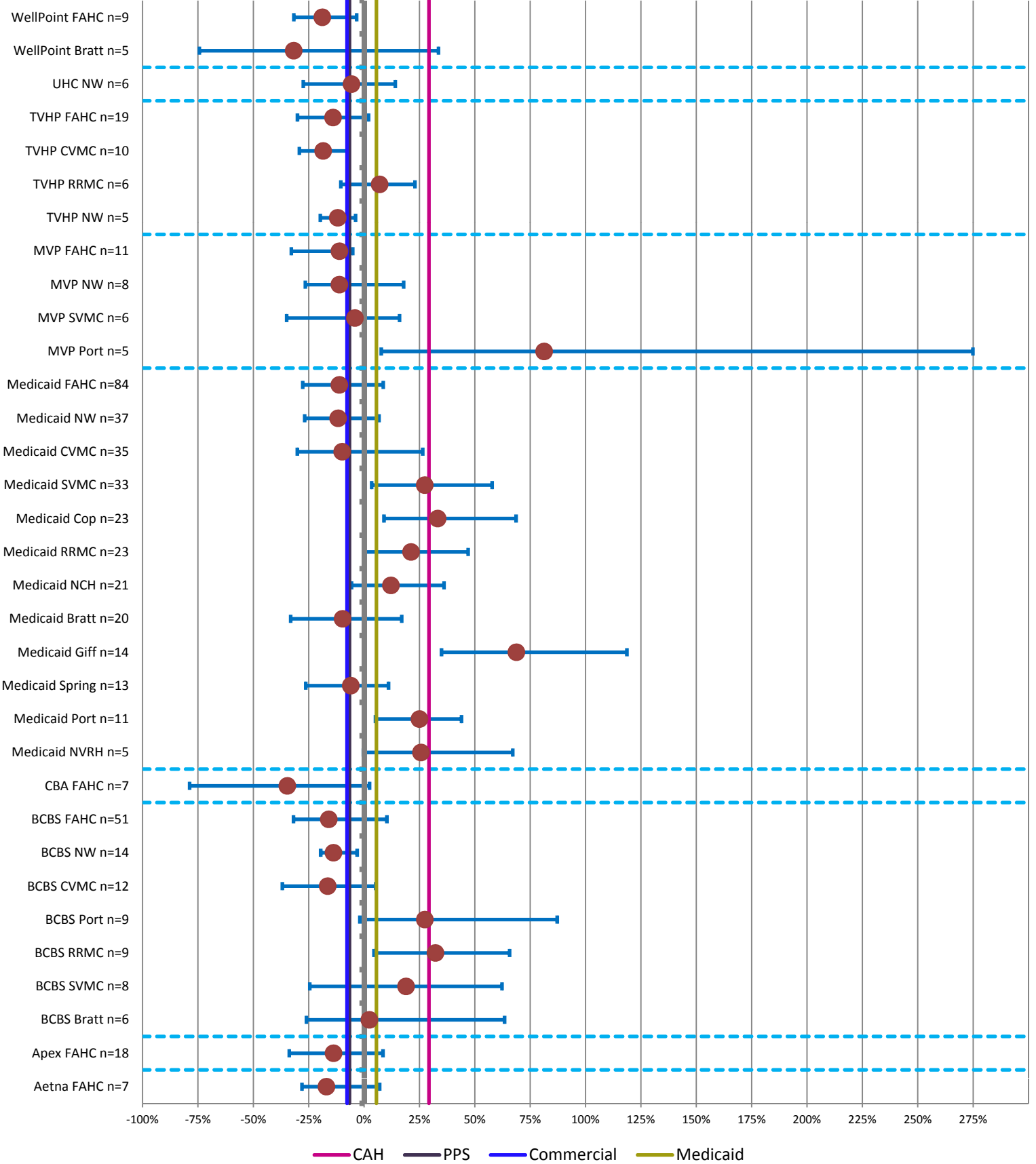
**FY2012 Hospital Inpatient DRG 470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY
W/O MCC Charge Variation**



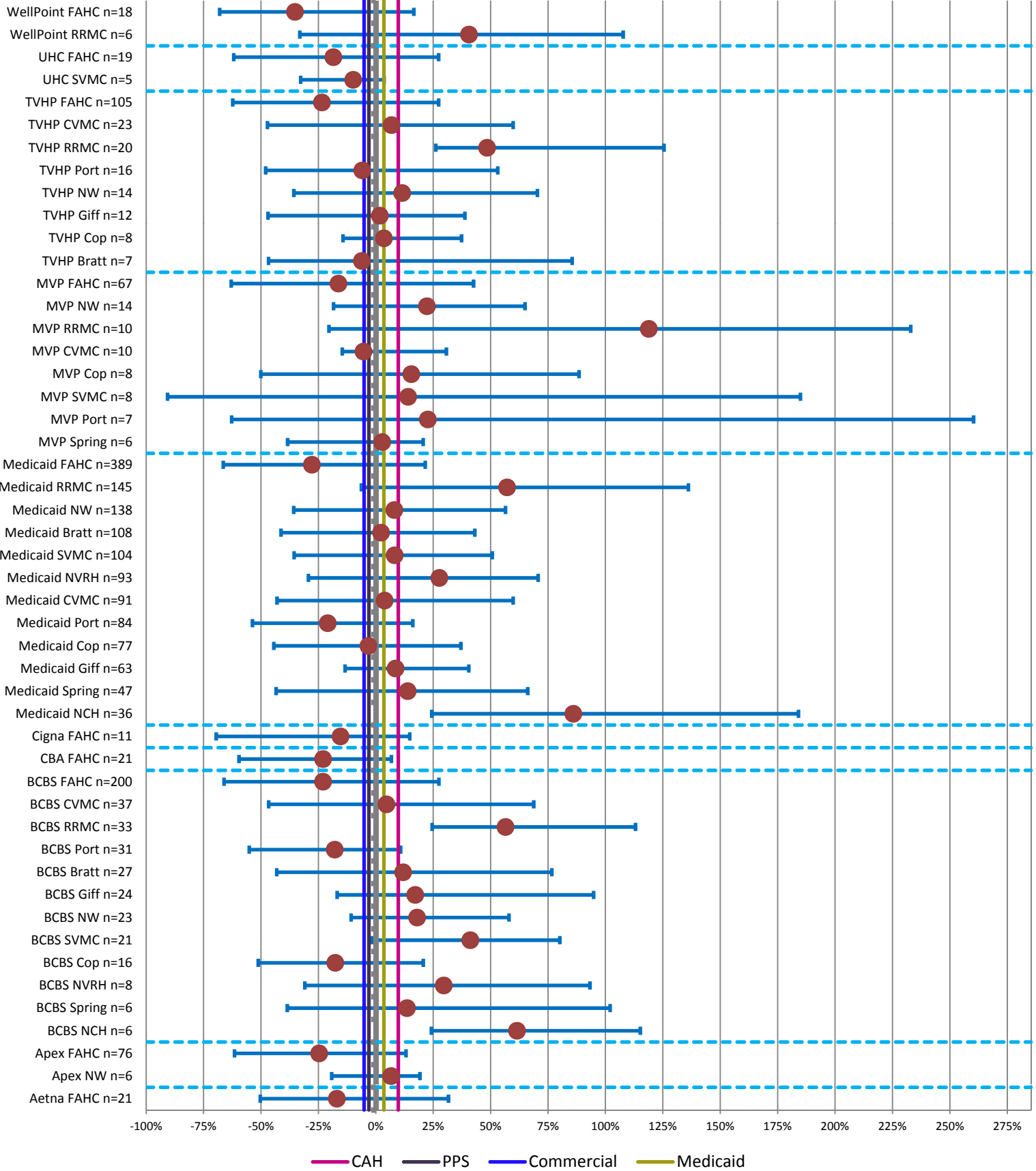
FY2012 Hospital Inpatient DRG 775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES Charge Variation



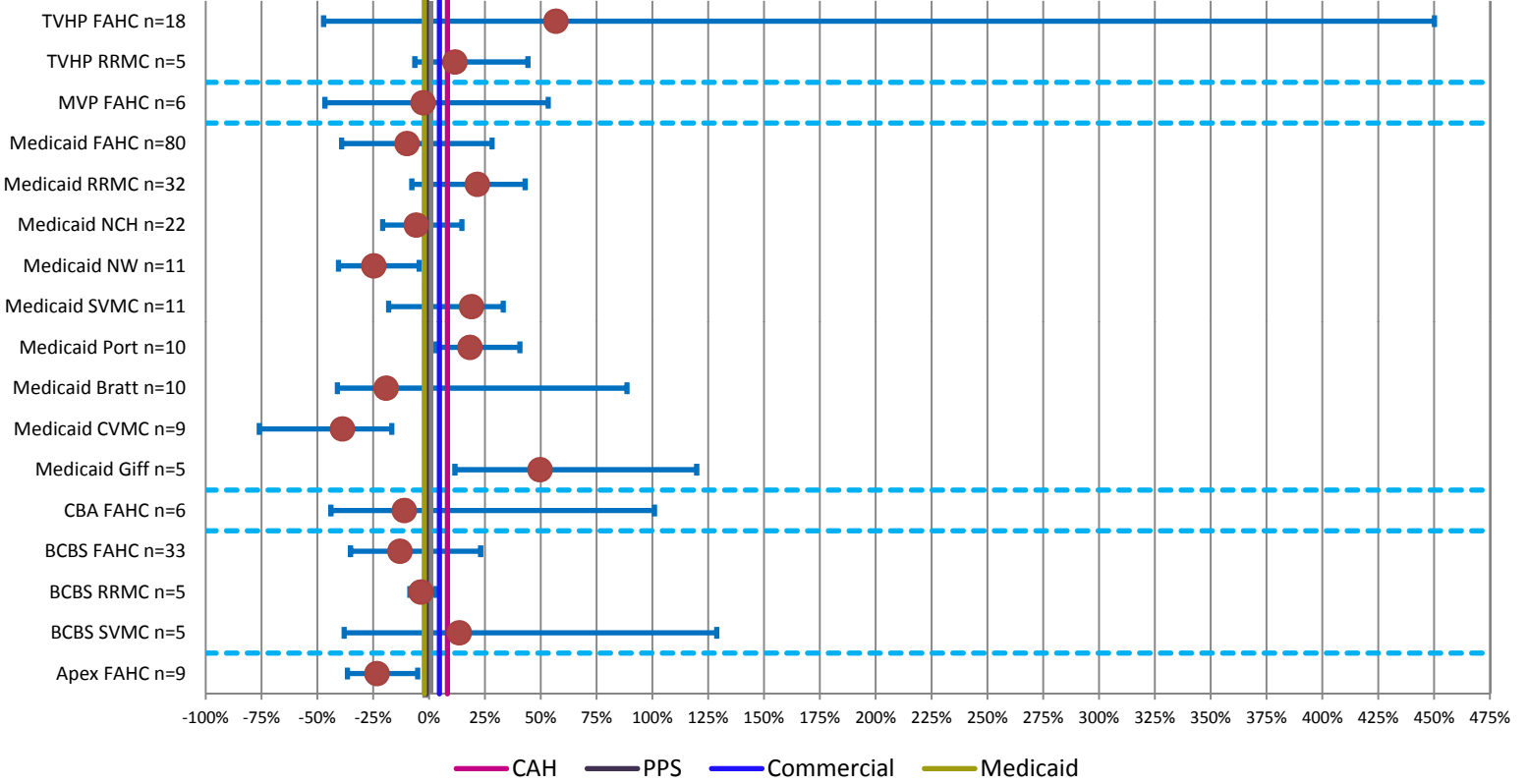
FY2012 Hospital Inpatient DRG 766 - CESAREAN SECTION W/O CC/MCC Charge Variation



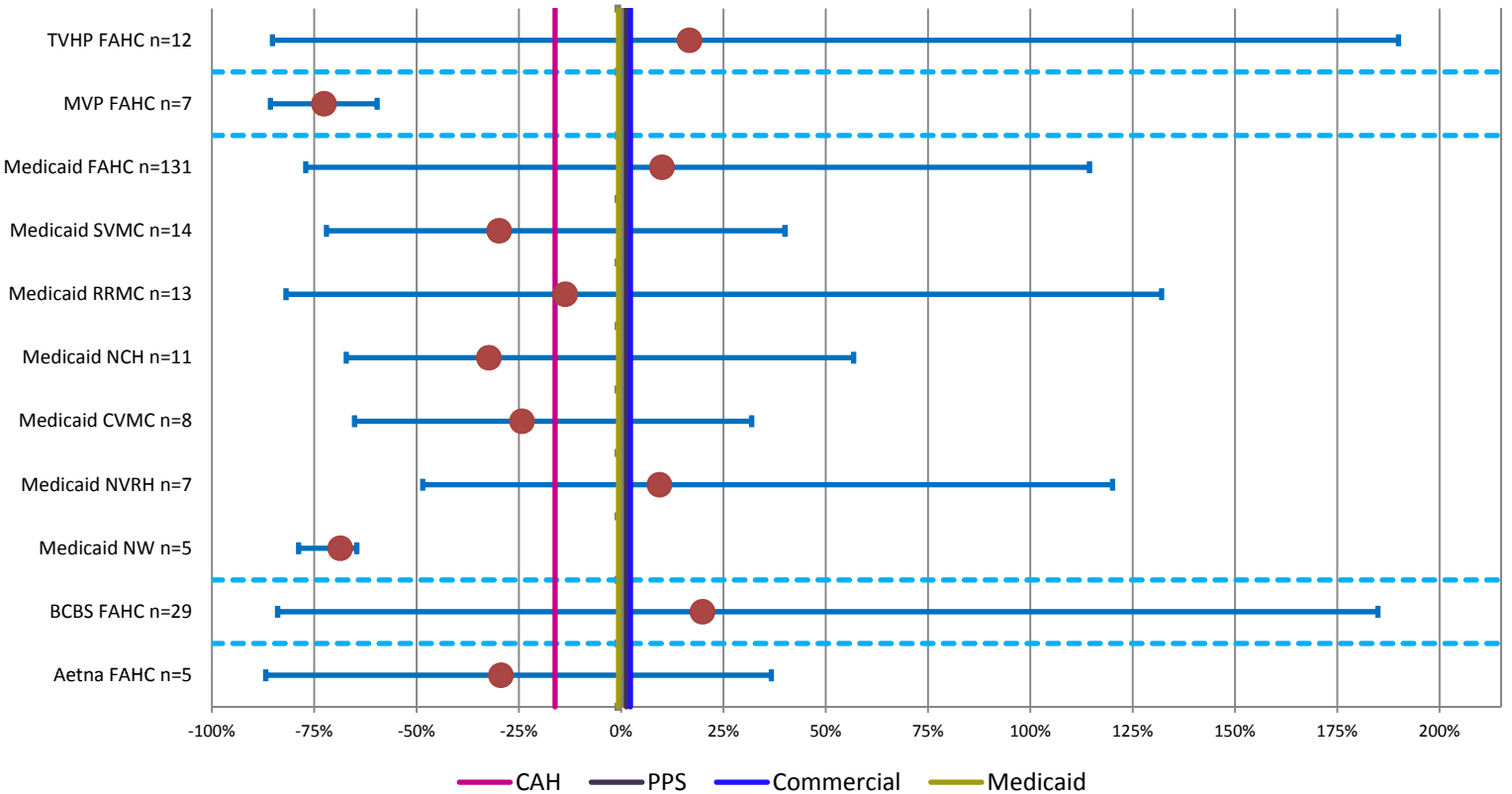
FY2012 Hospital Inpatient DRG 795 - NORMAL NEWBORN Charge Variation



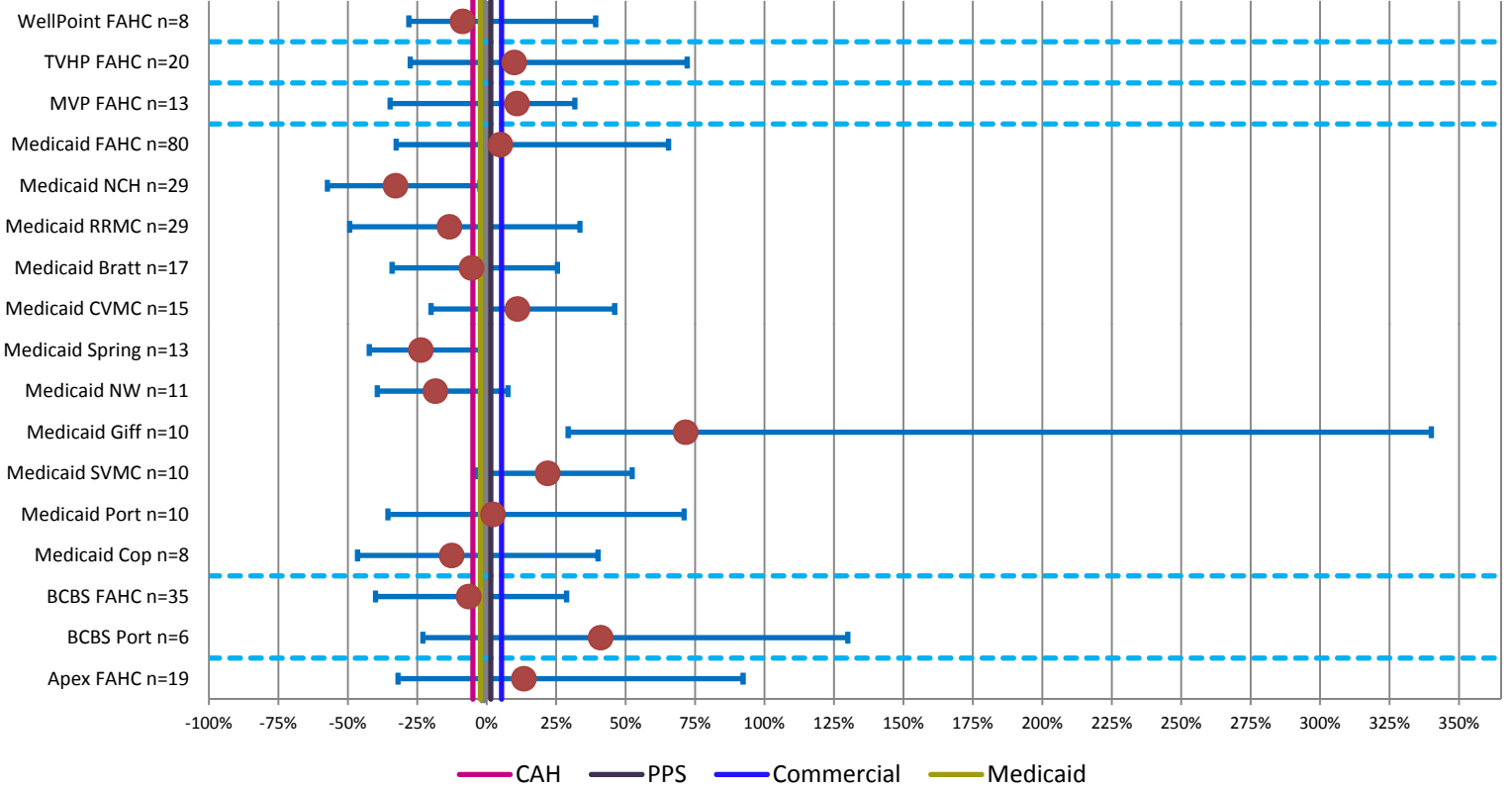
FY2012 Hospital Inpatient DRG 765 - CESAREAN SECTION W CC/MCC Charge Variation



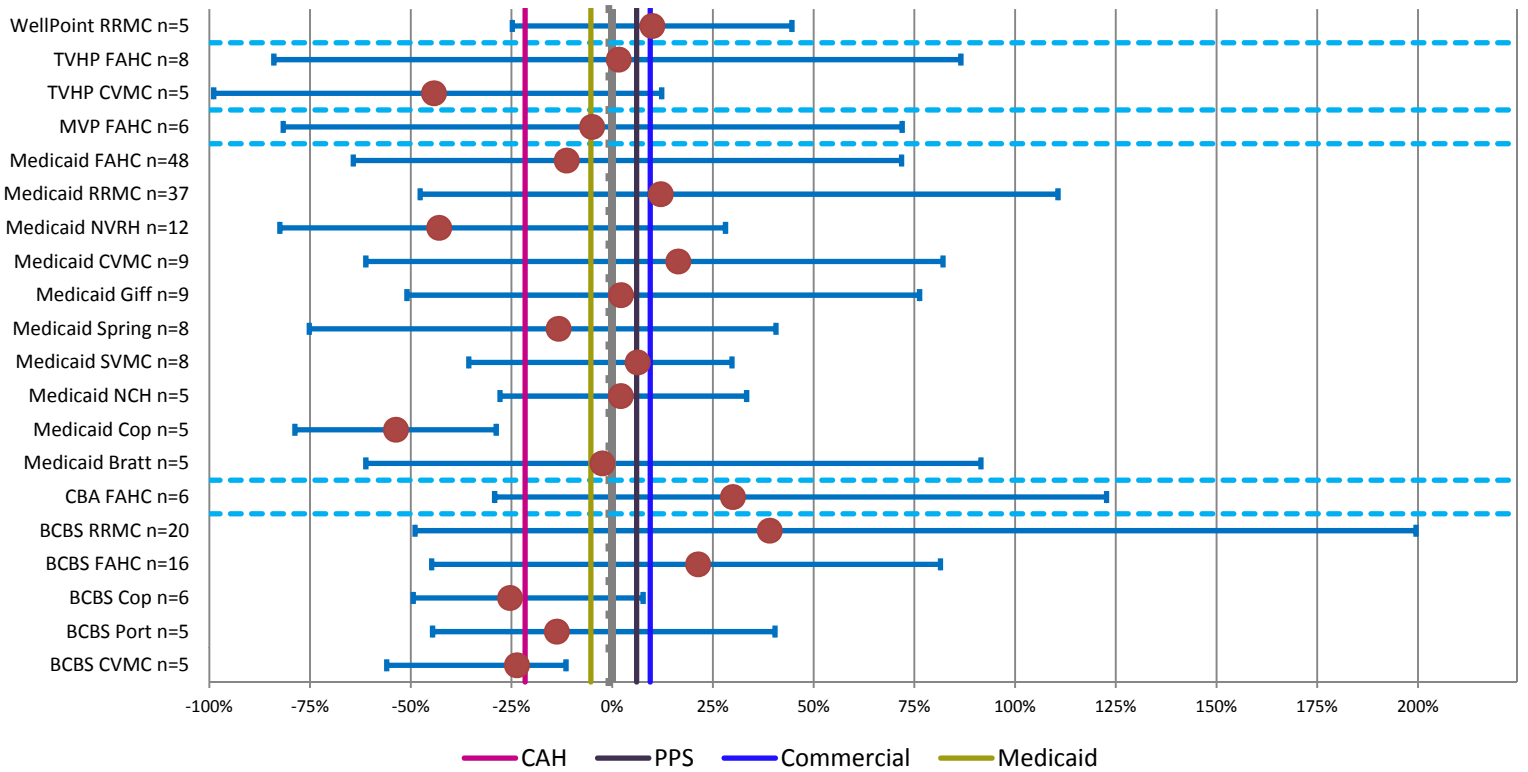
FY2012 Hospital Inpatient DRG 793 - FULL TERM NEONATE W MAJOR PROBLEMS Charge Variation



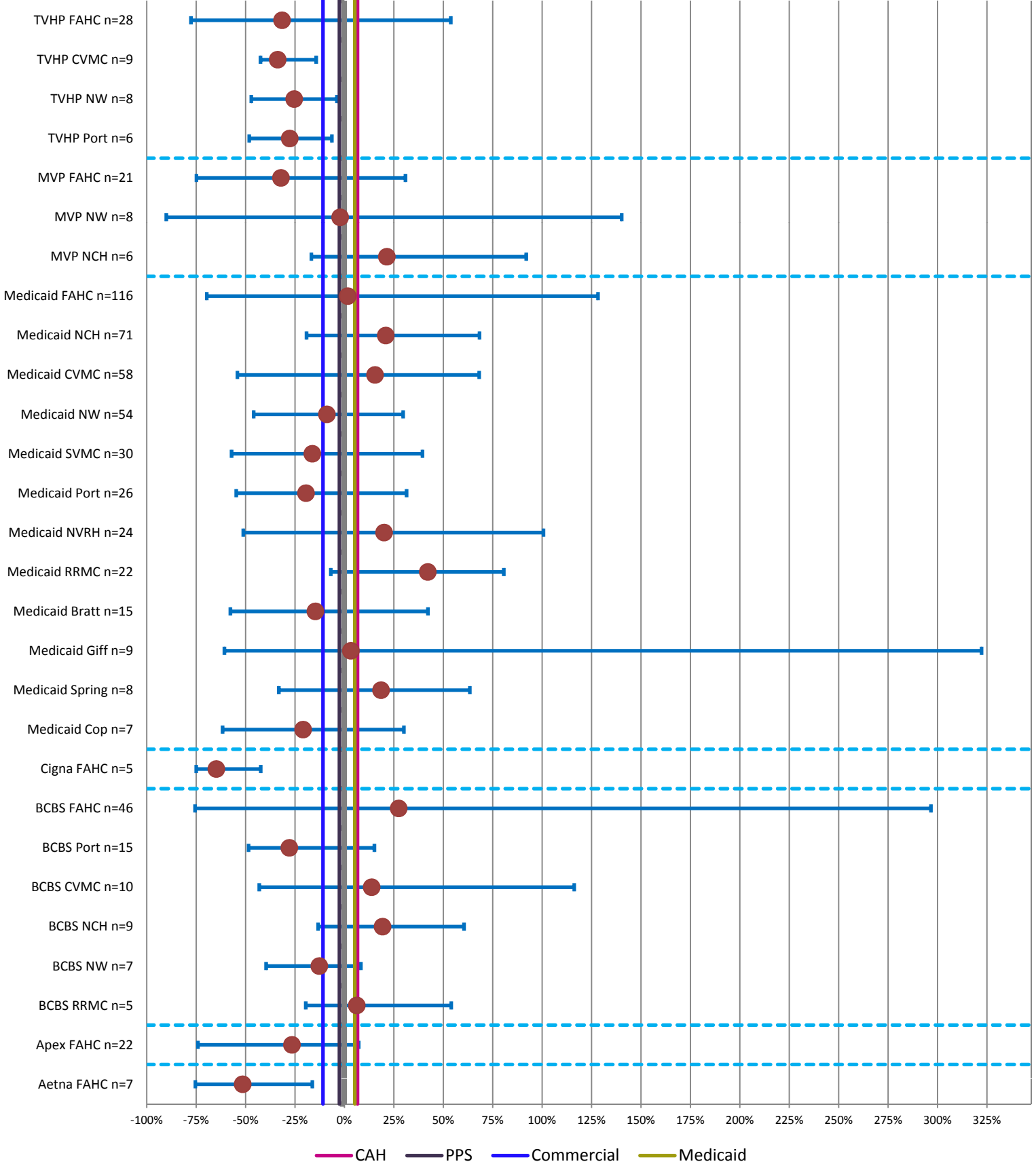
FY2012 Hospital Inpatient DRG 774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES Charge Variation



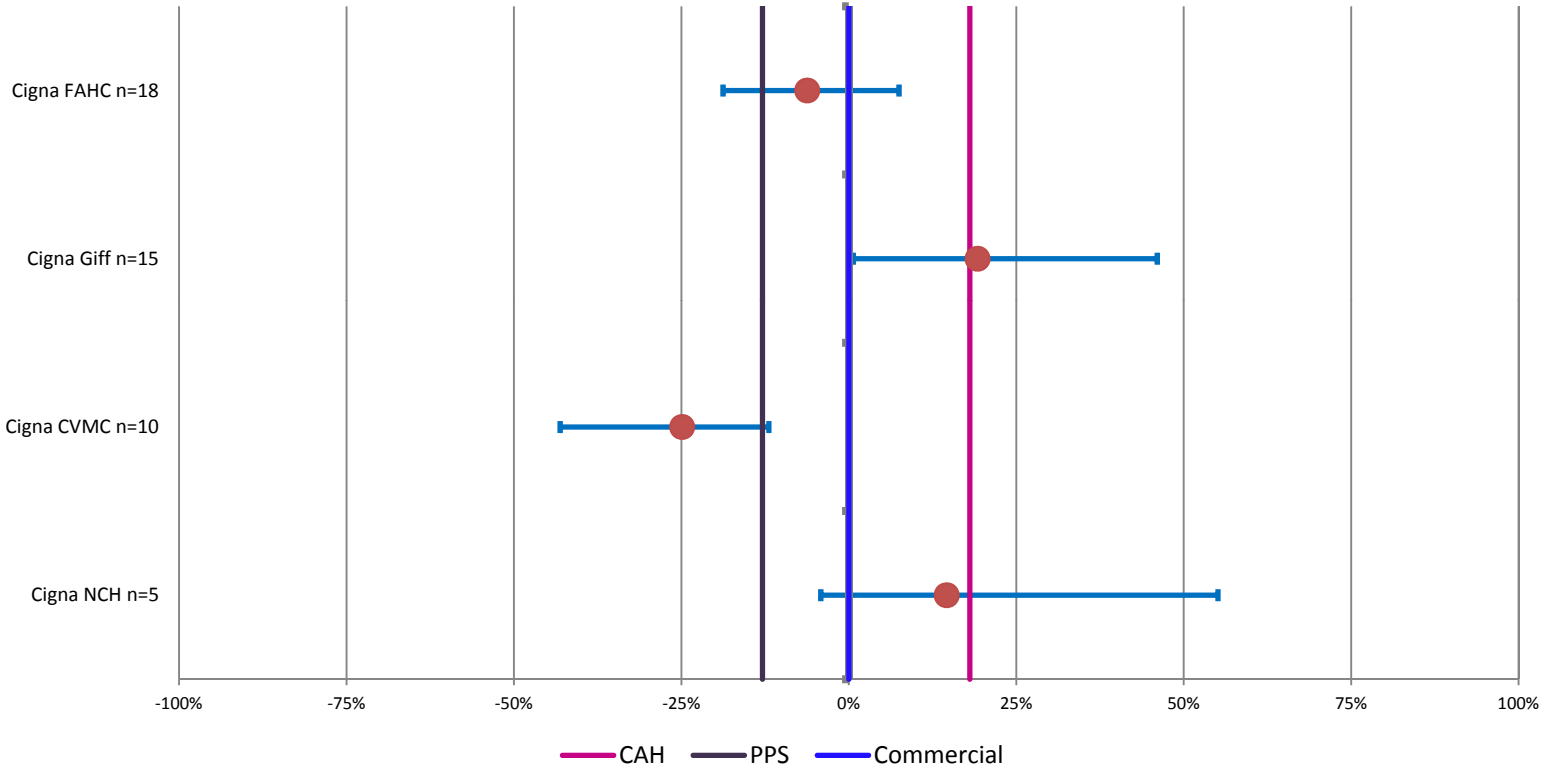
FY2012 Hospital Inpatient DRG 392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC Charge Variation



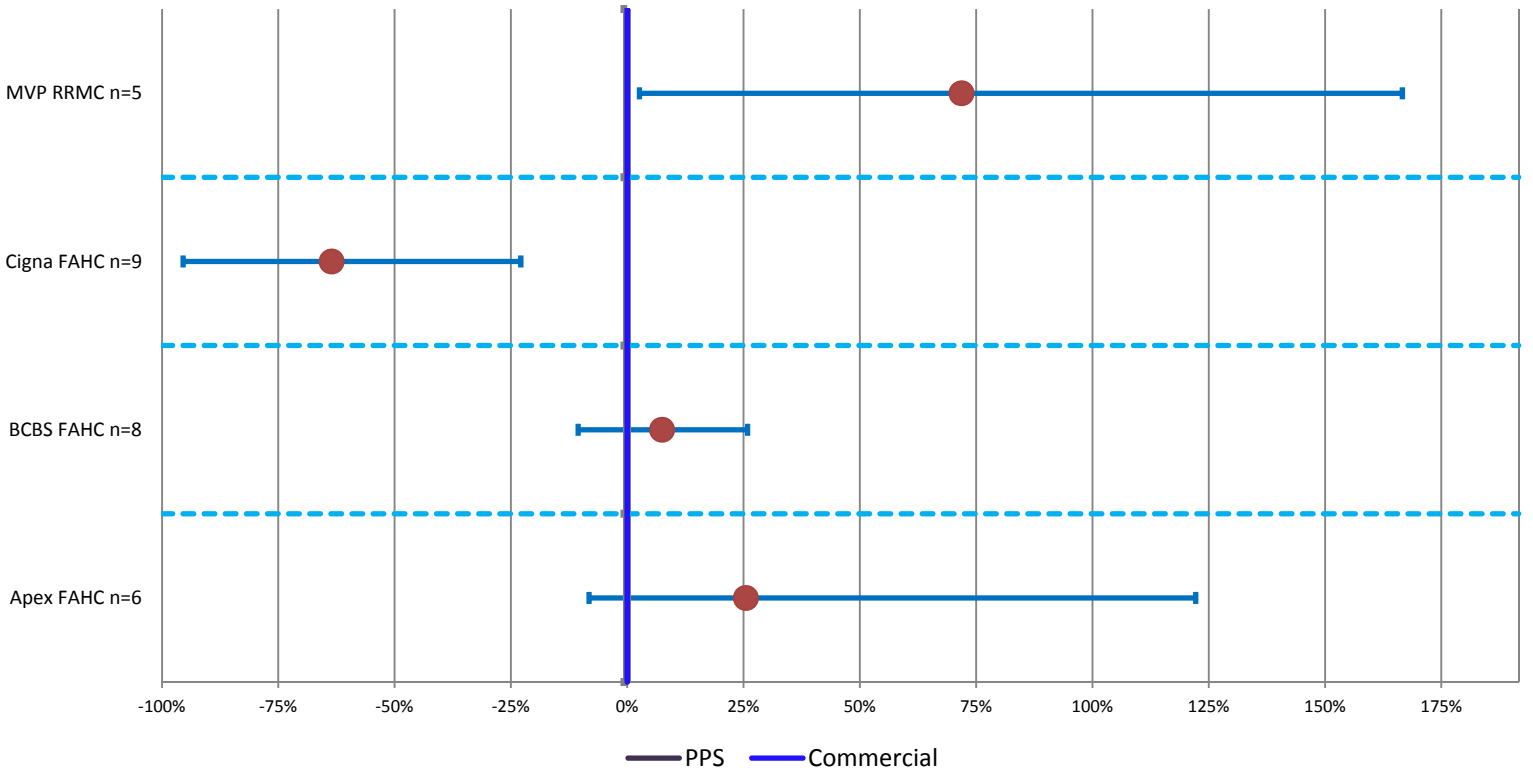
FY2012 Hospital Inpatient DRG 794 - NEONATE W OTHER SIGNIFICANT PROBLEMS Charge Variation



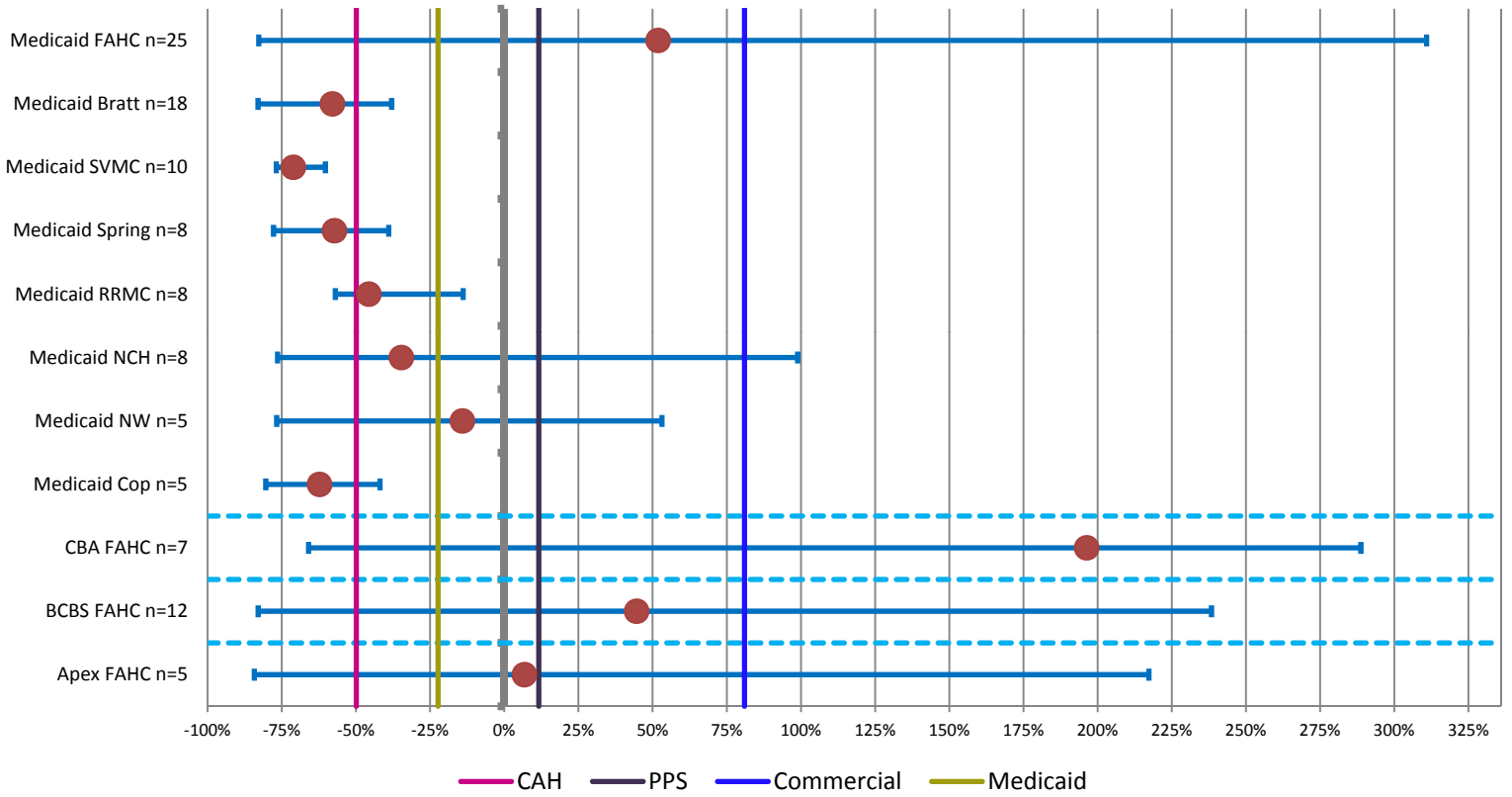
**FY2012 Hospital Inpatient DRG 544 - PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O
CC/MCC Charge Variation**



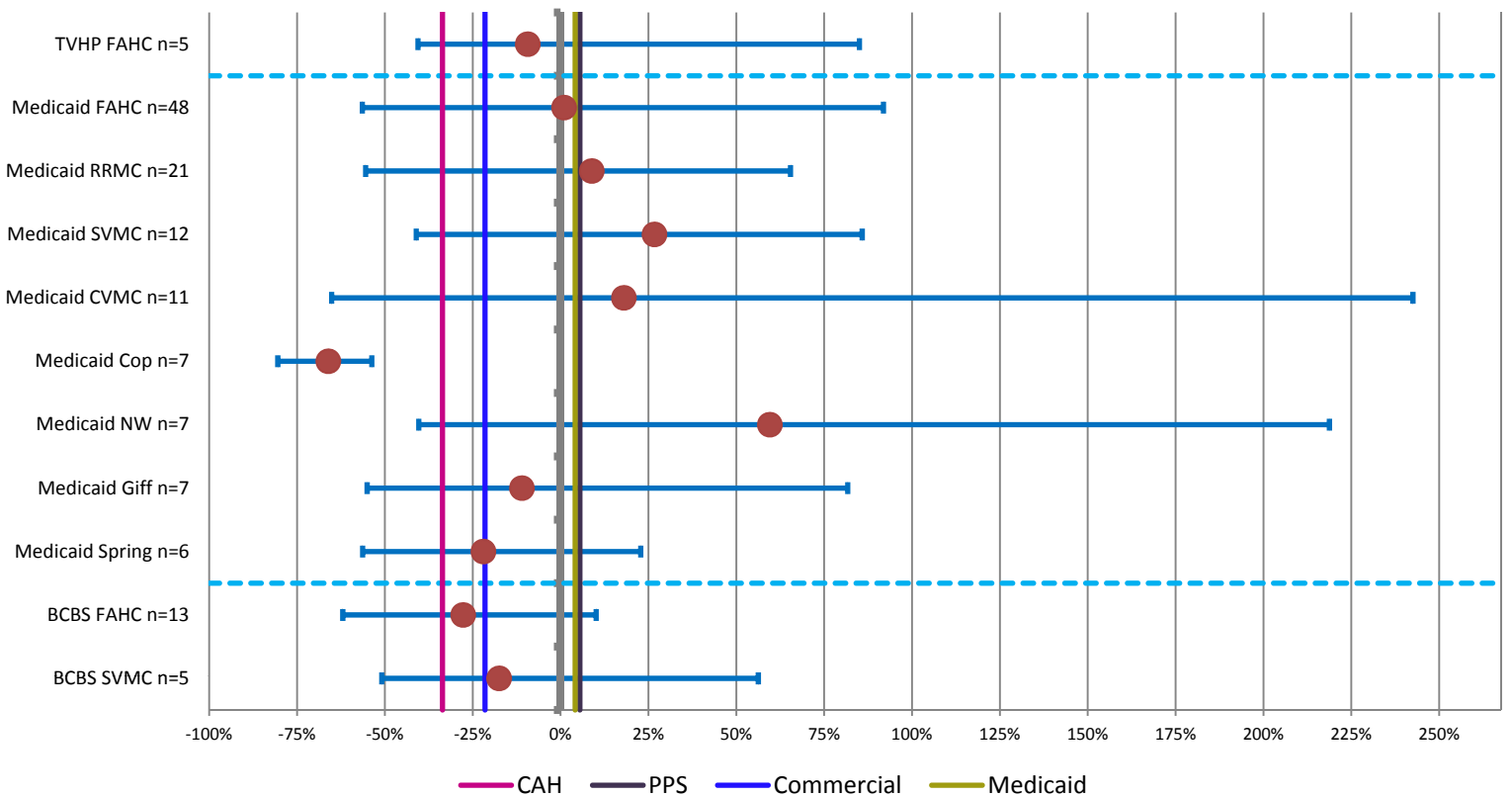
**FY2012 Hospital Inpatient DRG 462 - BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O
MCC Charge Variation**



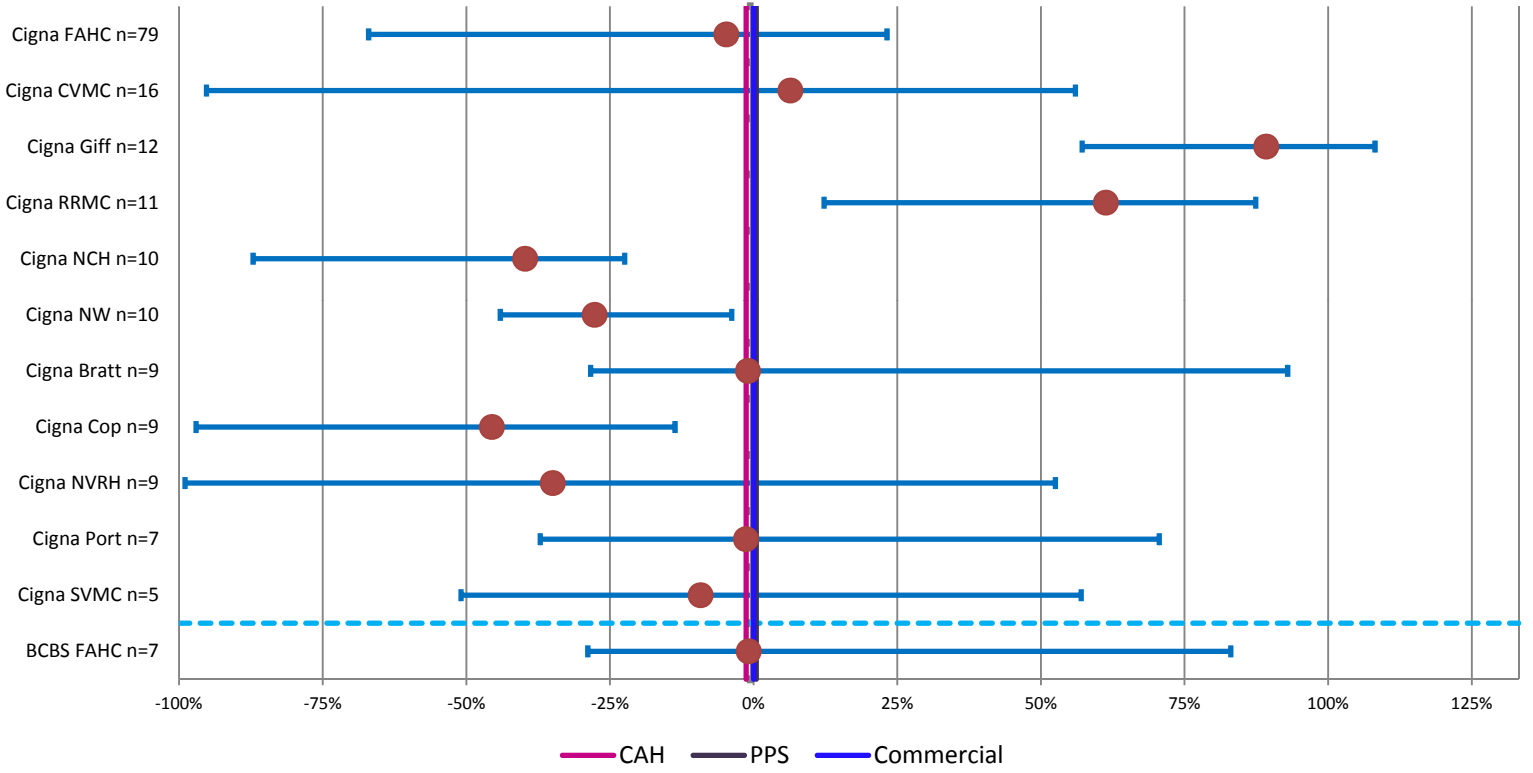
FY2012 Hospital Inpatient DRG 792 - PREMATURETY W/O MAJOR PROBLEMS Charge Variation



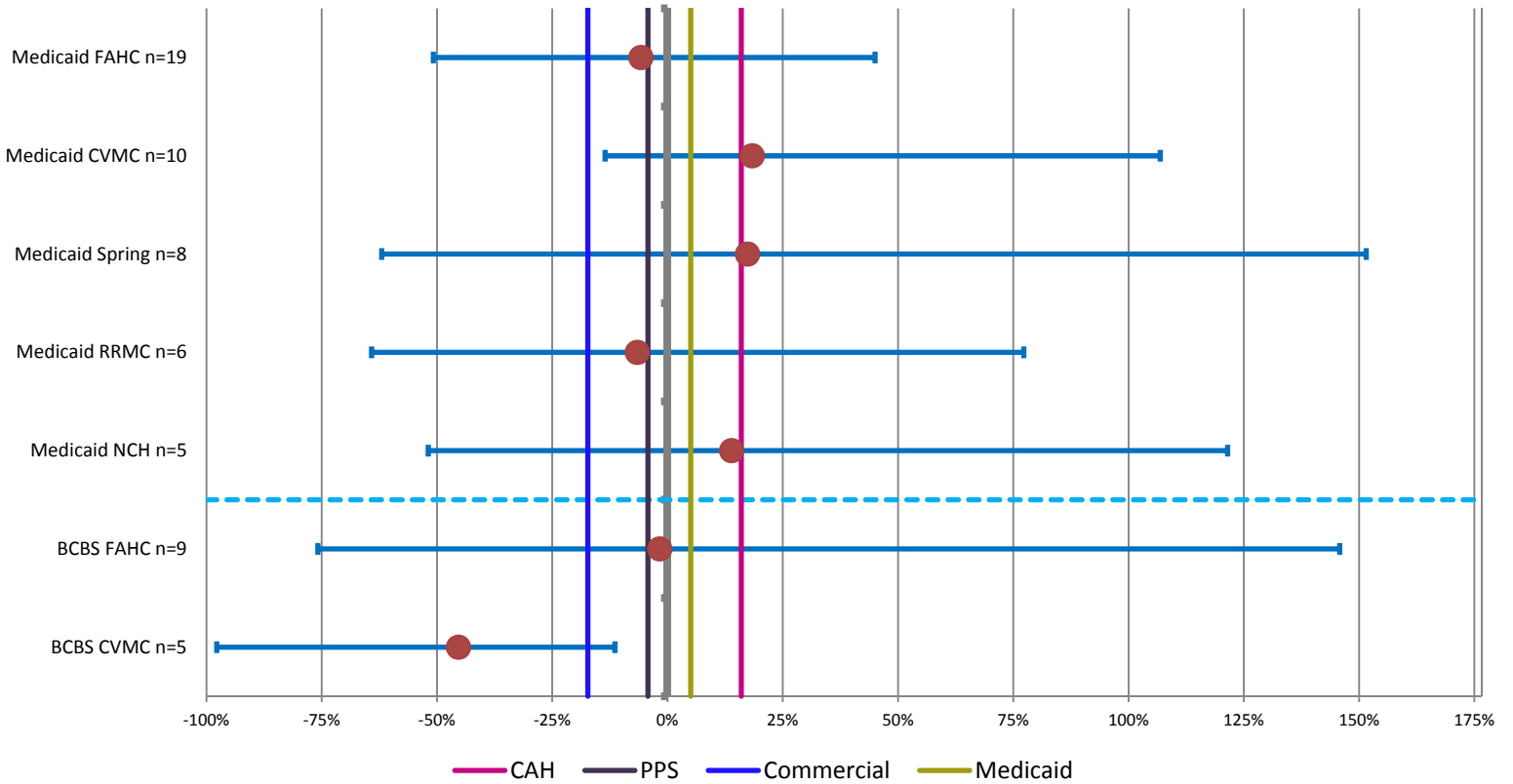
FY2012 Hospital Inpatient DRG 603 - CELLULITIS W/O MCC Charge Variation



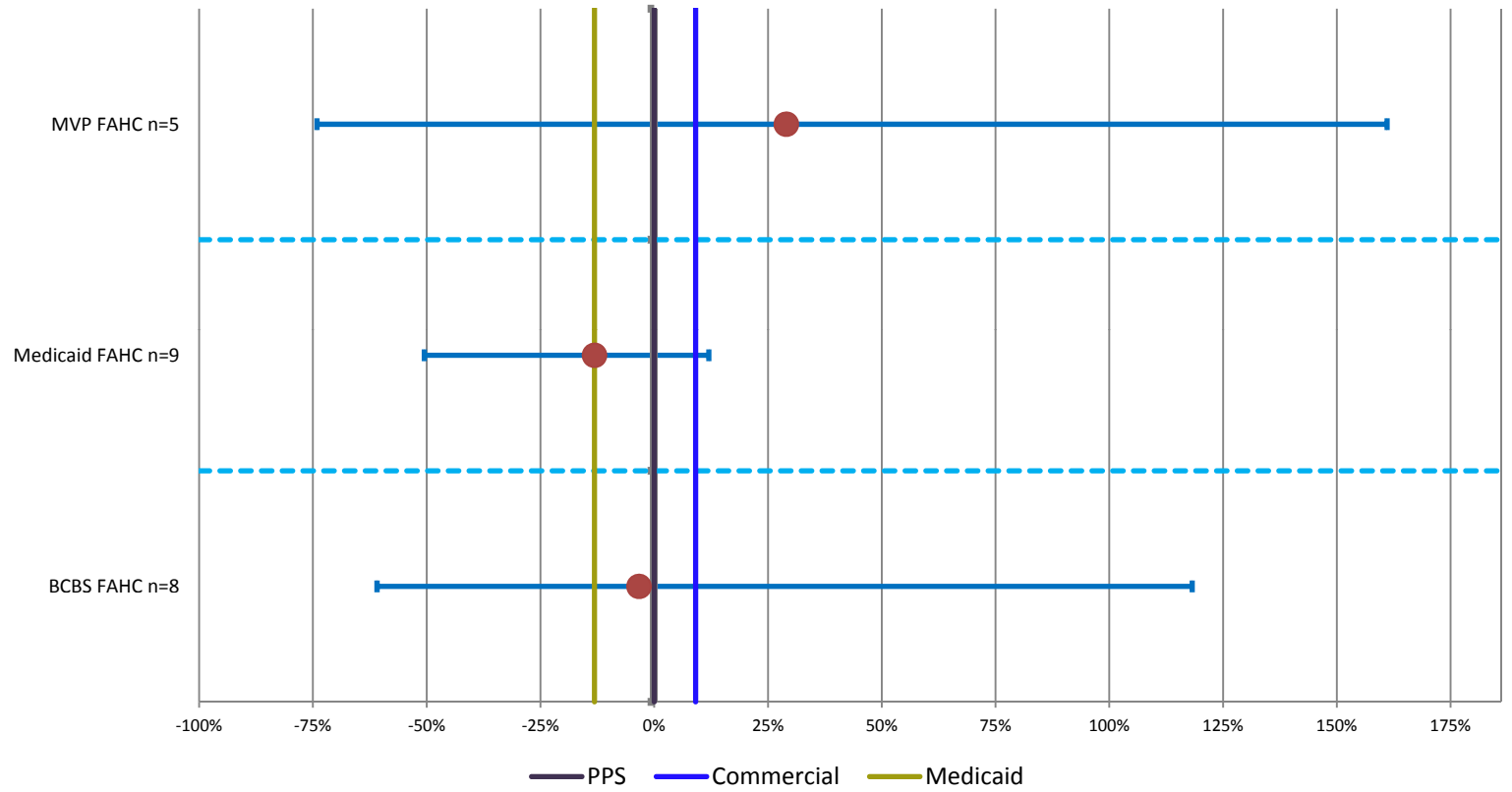
FY2012 Hospital Inpatient DRG 373 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC Charge Variation



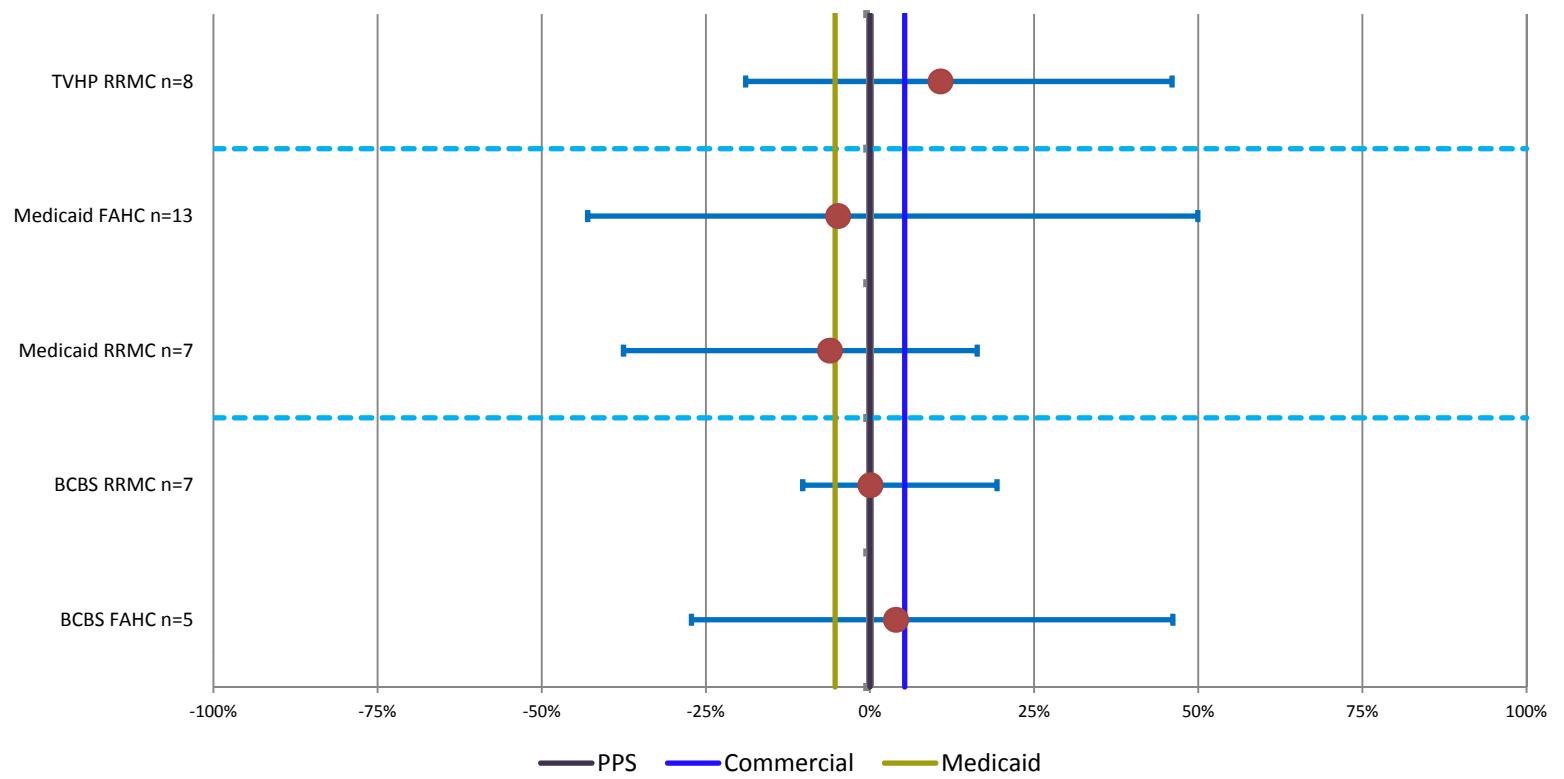
FY2012 Hospital Inpatient DRG 194 - SIMPLE PNEUMONIA & PLEURISY W CC Charge Variation



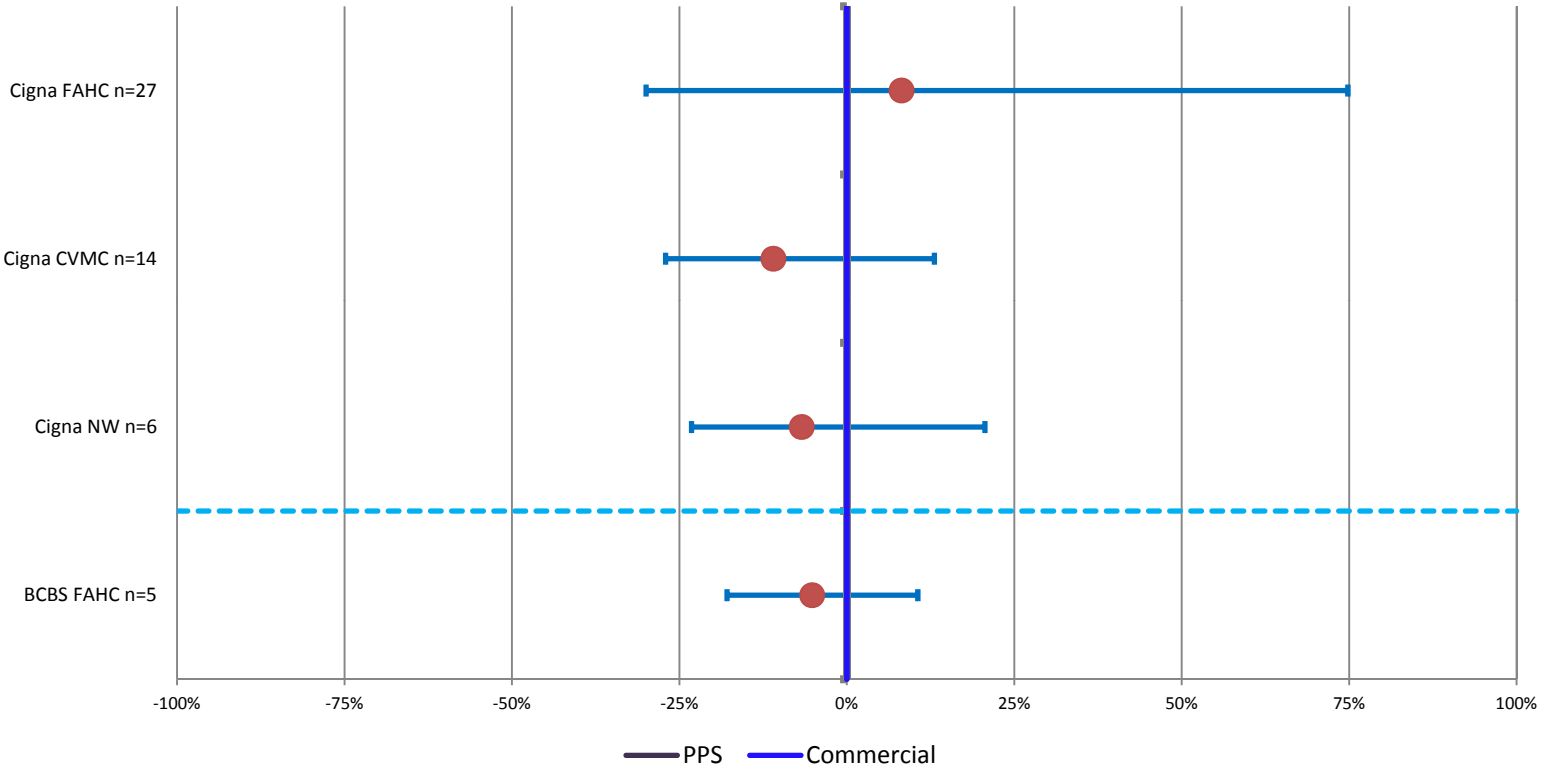
FY2012 Hospital Inpatient DRG 330 - MAJOR SMALL & LARGE BOWEL PROCEDURES W CC Charge Variation



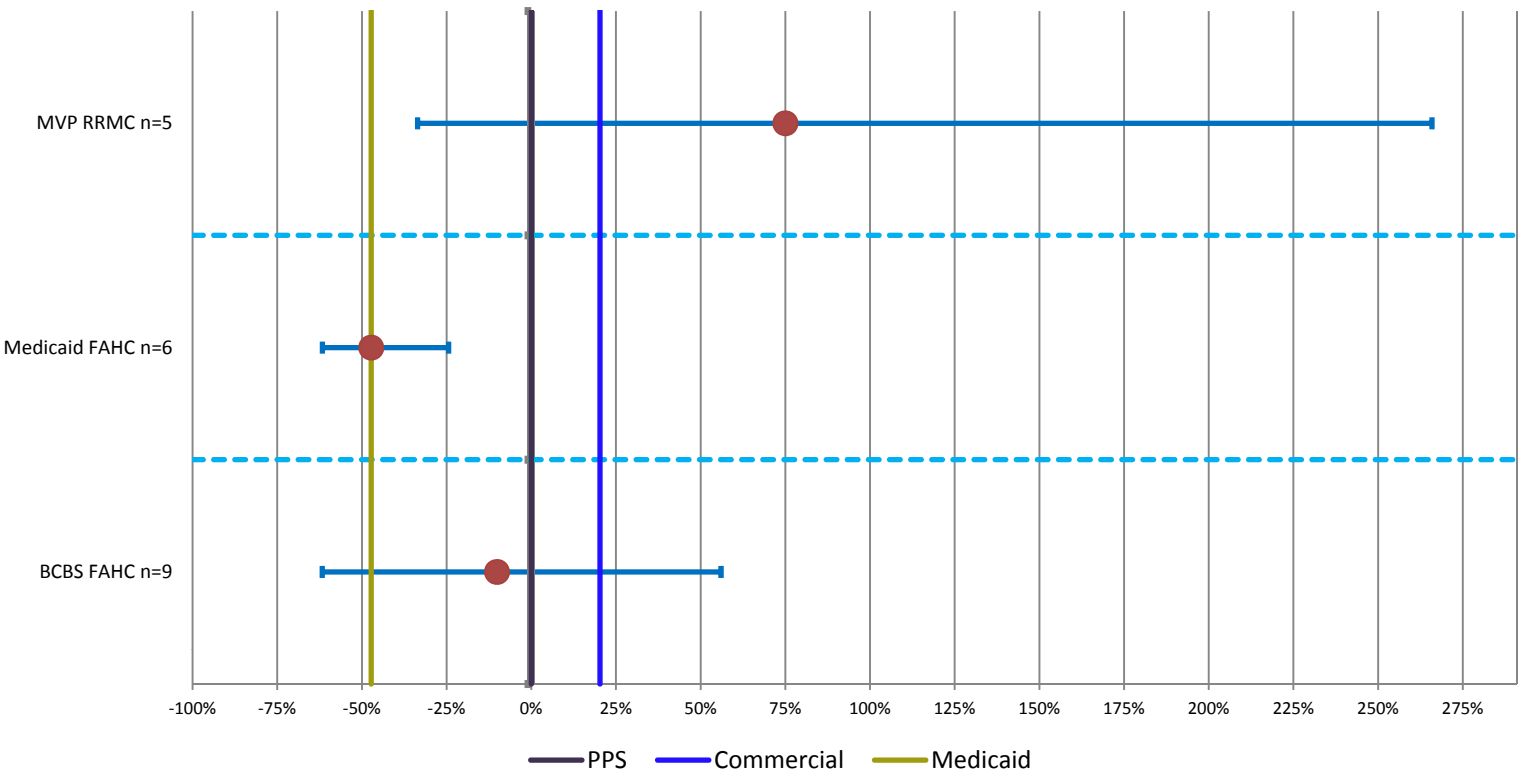
FY2012 Hospital Inpatient DRG 743 - UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC Charge Variation



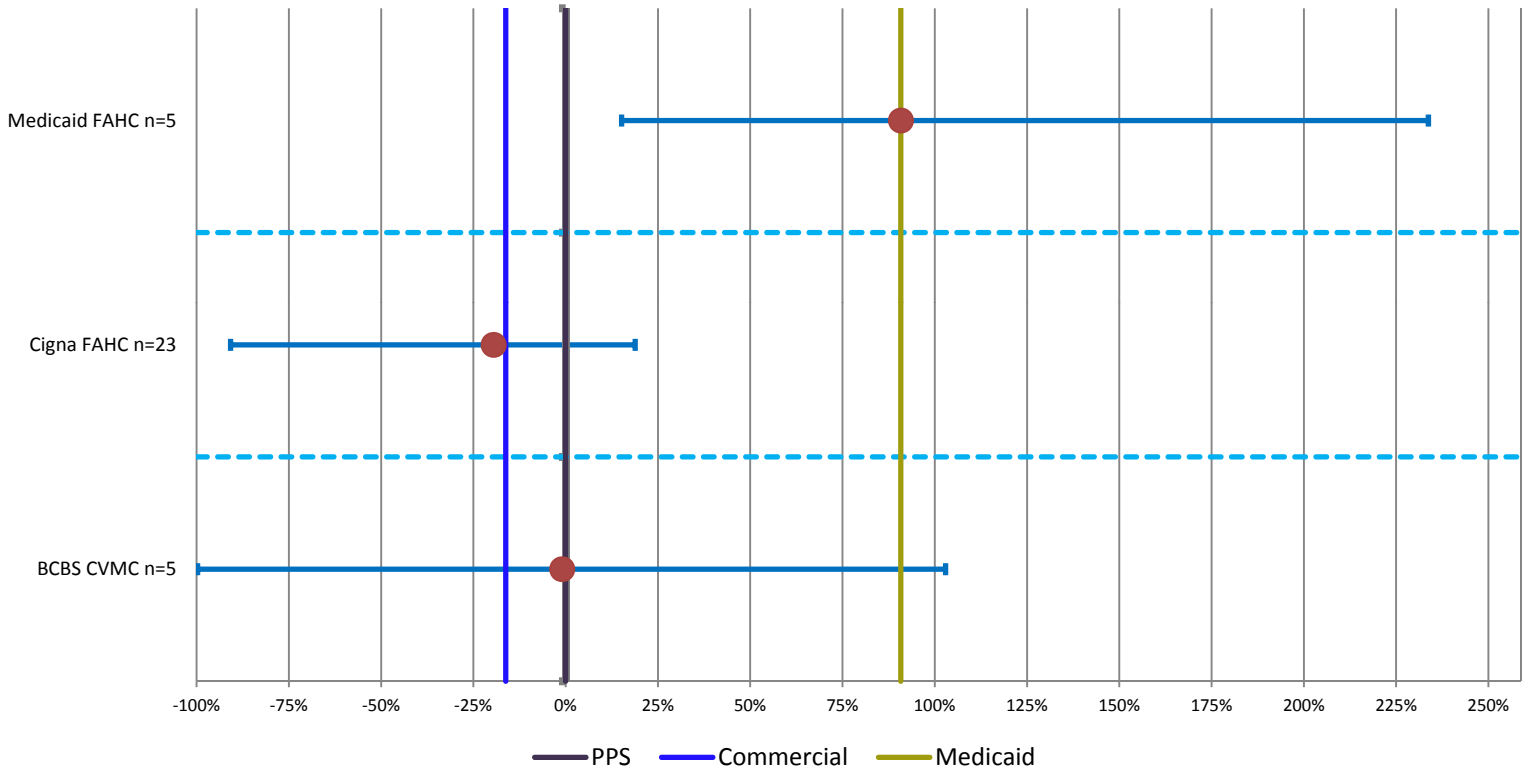
**FY2012 Hospital Inpatient DRG 371 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC
Charge Variation**



**FY2012 Hospital Inpatient DRG 331 - MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC Charge
Variation**

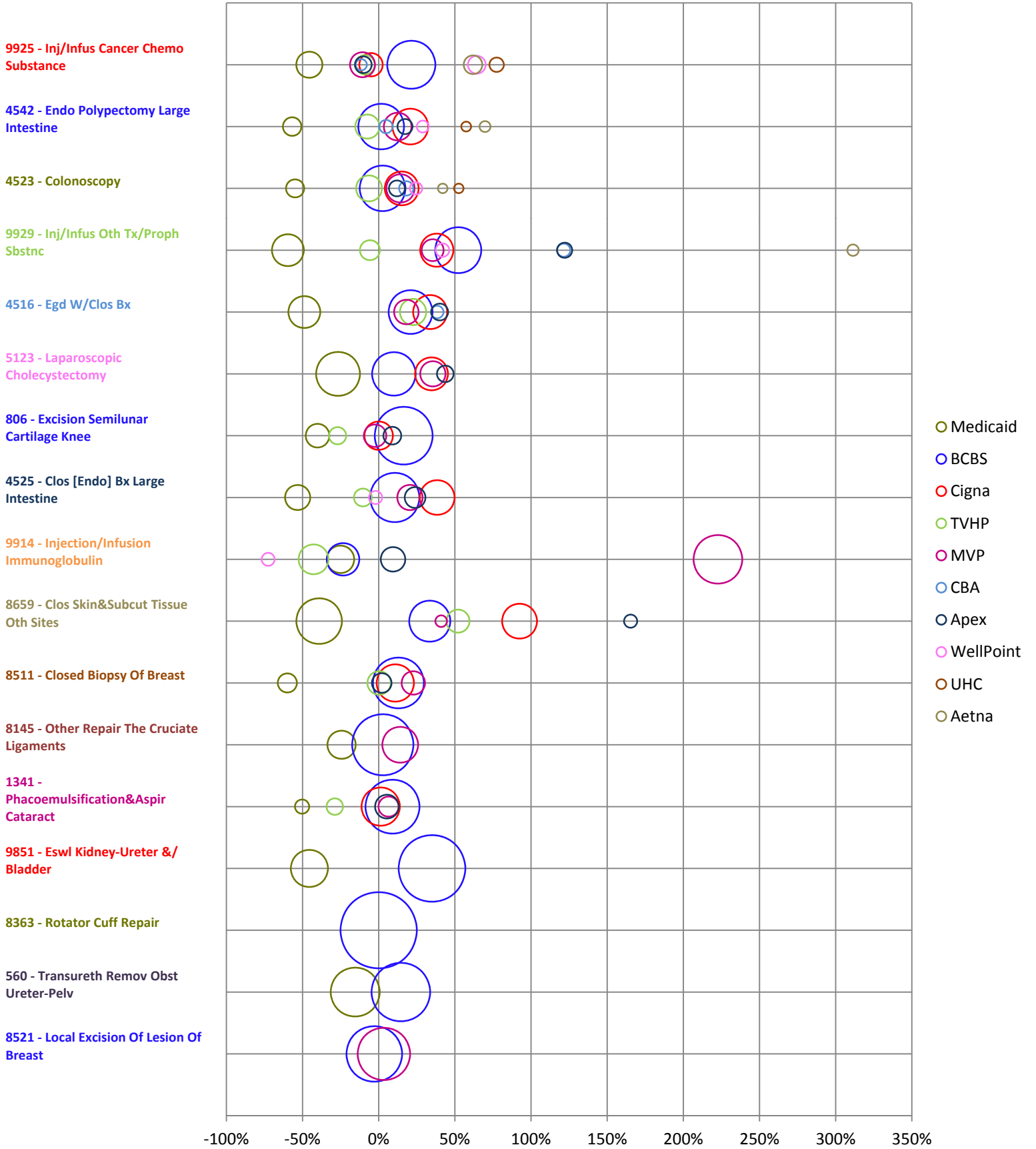


**FY2012 Hospital Inpatient DRG 372 - MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC
Charge Variation**

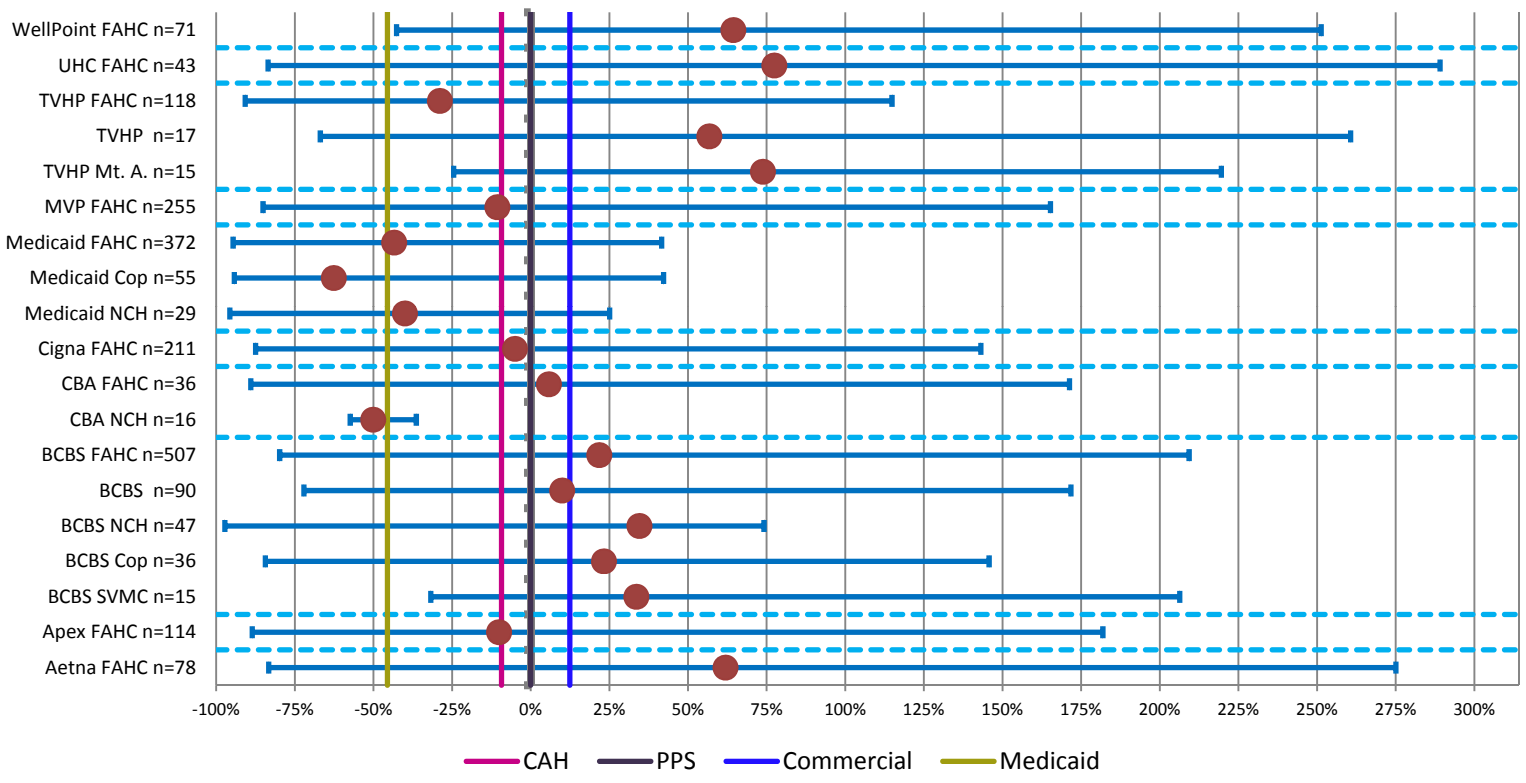


FY2012 Hospital Outpatient ICD-9 Procedure Allowed Payment Amount Variation

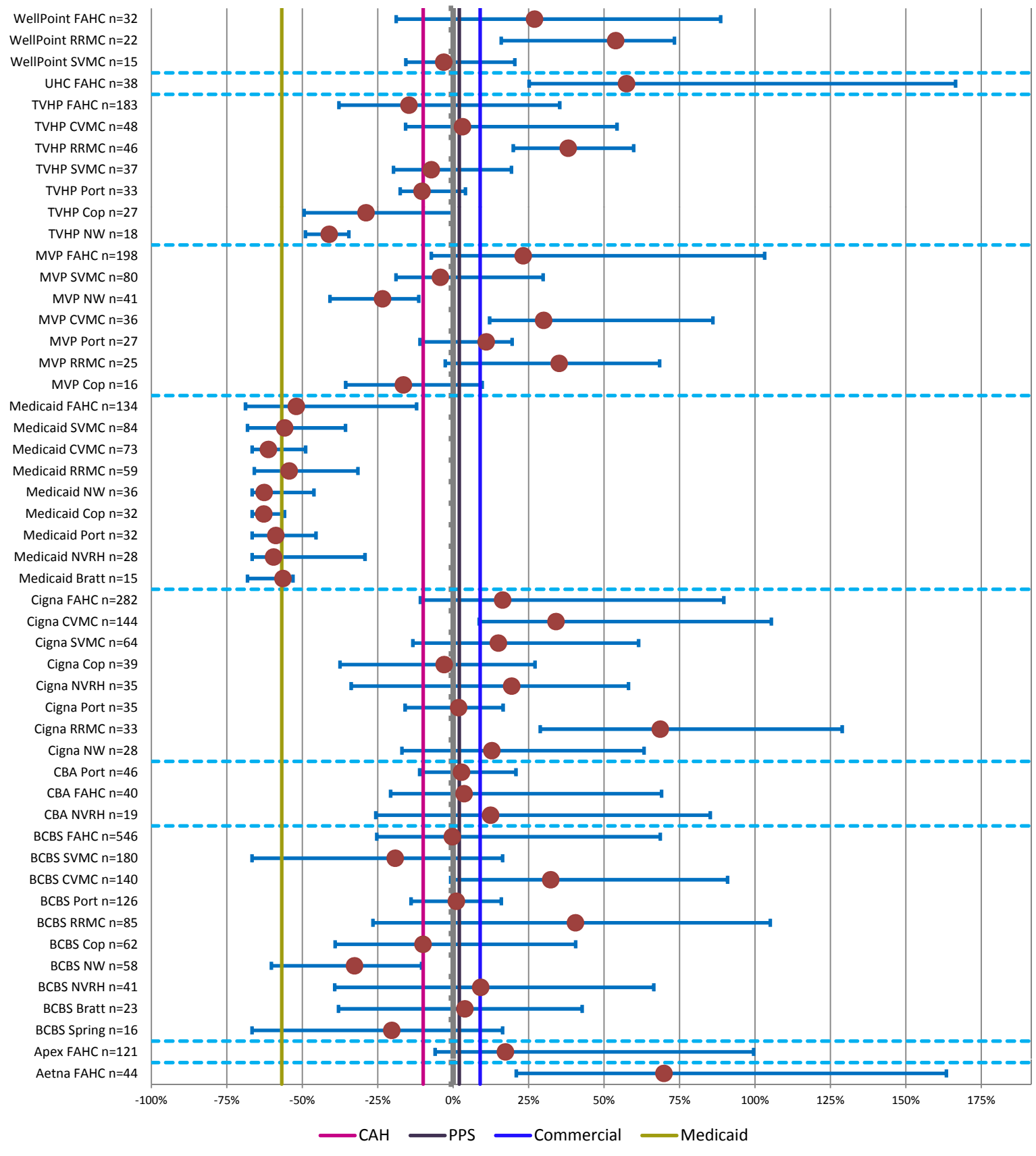
FY2012 Hospital Outpatient ICD-9 Procedure Allowed Payment Amount Variation (Min 15 Visits)



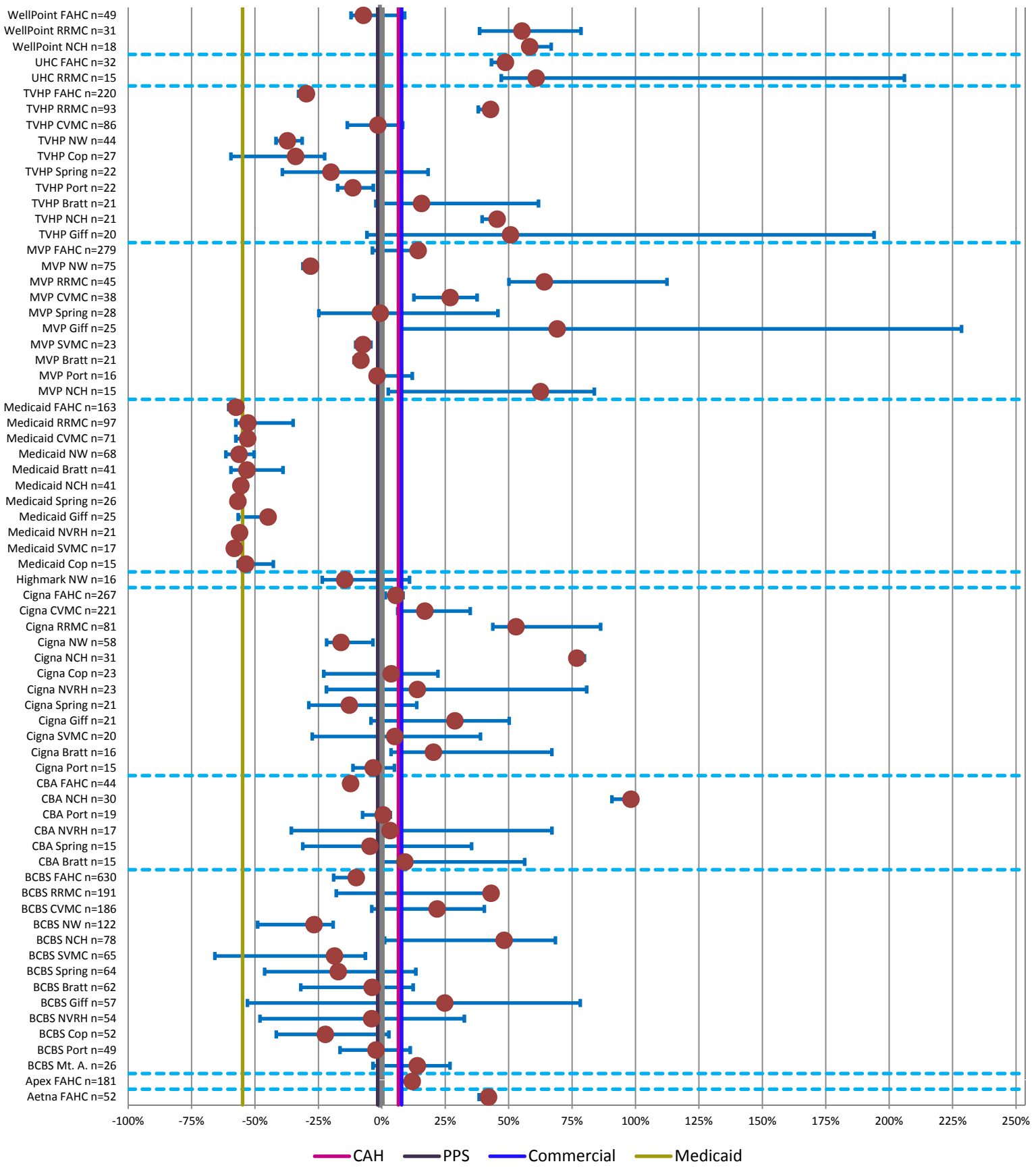
FY2012 Hospital Outpatient ICD-9 Procedure 9925 - INJ/INFUS CANCER CHEMO SUBSTANCE Allowed Payment Amount Variation



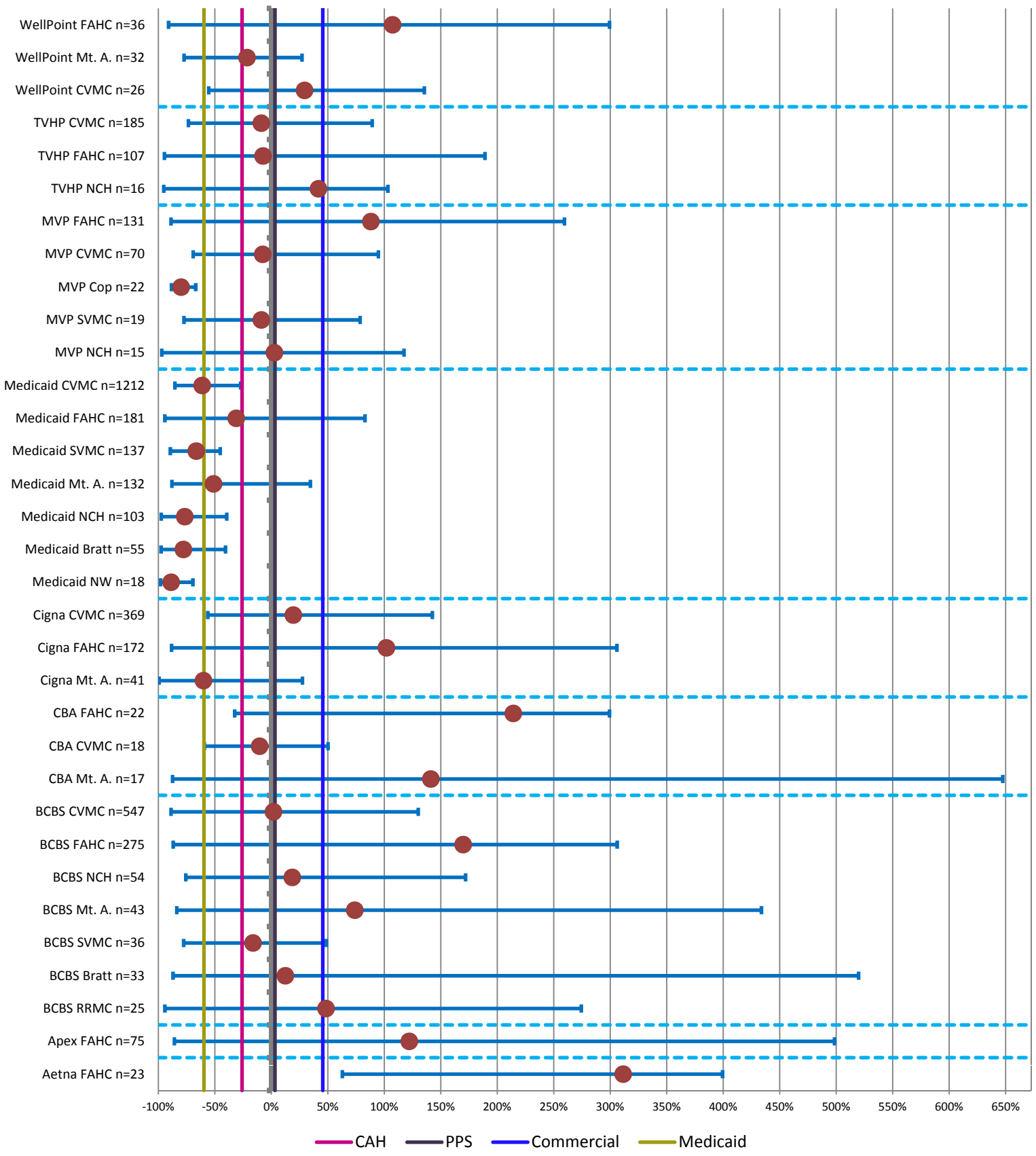
FY2012 Hospital Outpatient ICD-9 Procedure 4542 - ENDO POLYPECTOMY LARGE INTESTINE Allowed Payment Amount Variation



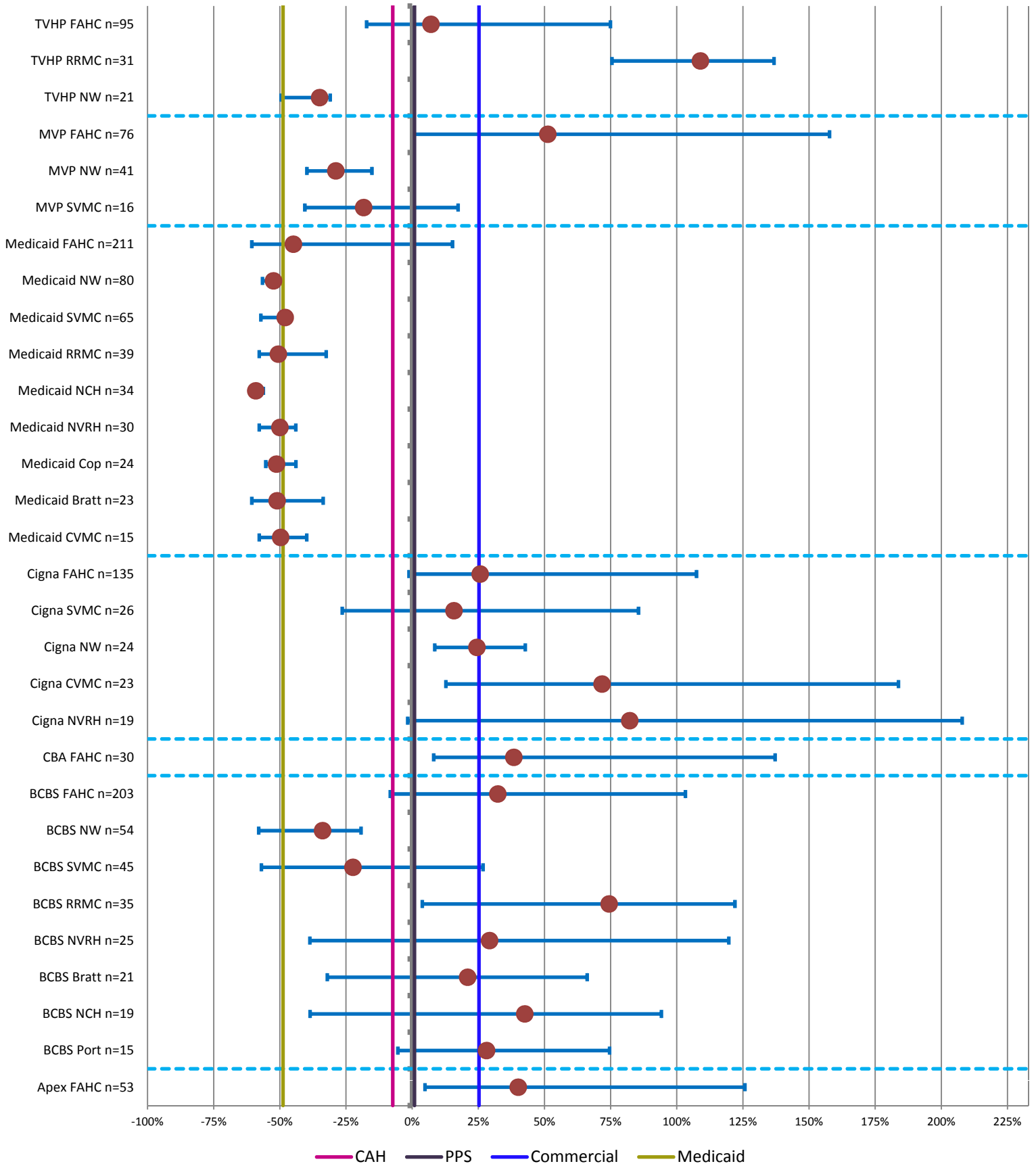
FY2012 Hospital Outpatient ICD-9 Procedure 4523 - COLONOSCOPY Allowed Payment Amount Variation



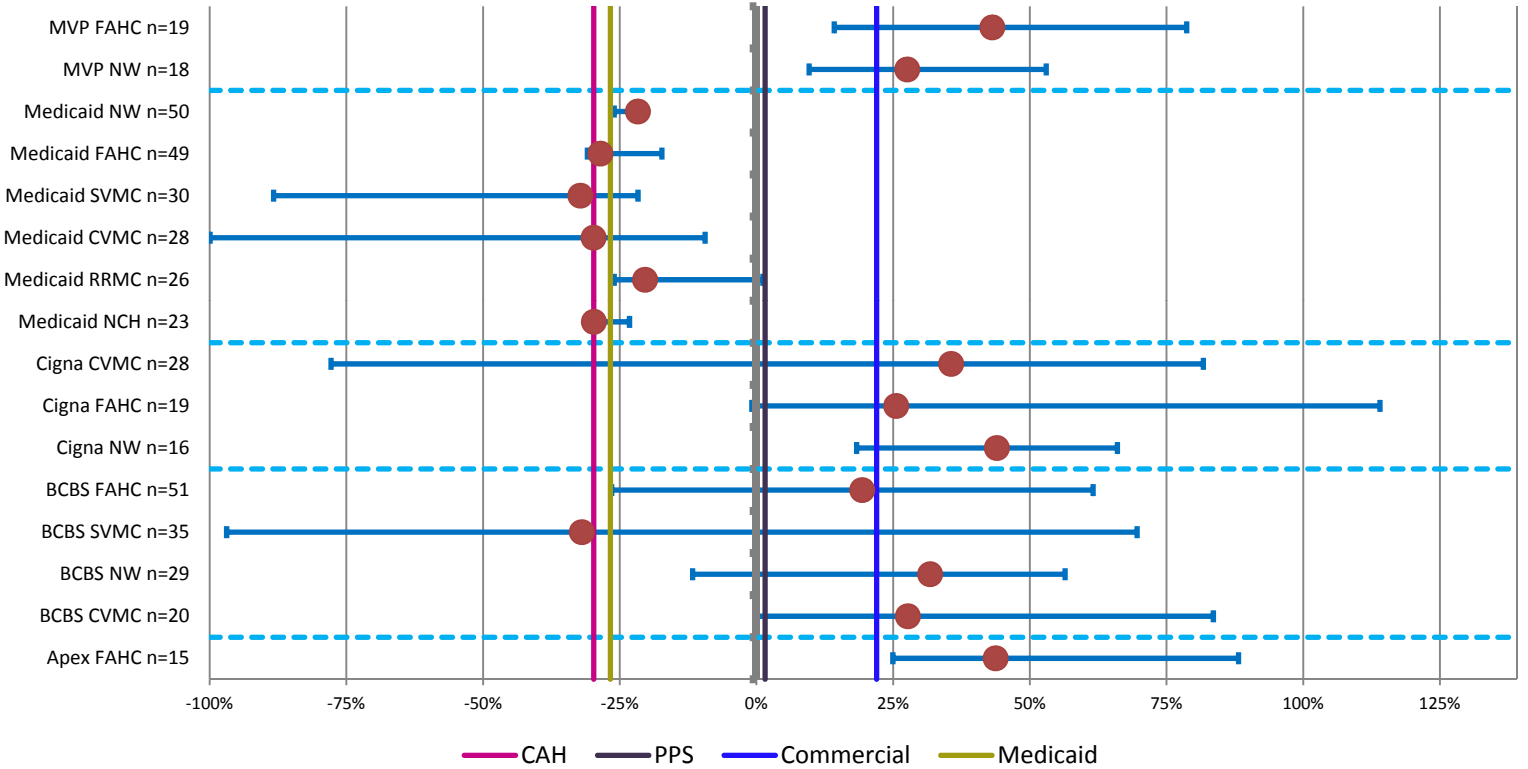
FY2012 Hospital Outpatient ICD-9 Procedure 9929 - INJ/INFUS OTH TX/PROPH SBTNC Allowed Payment Amount Variation



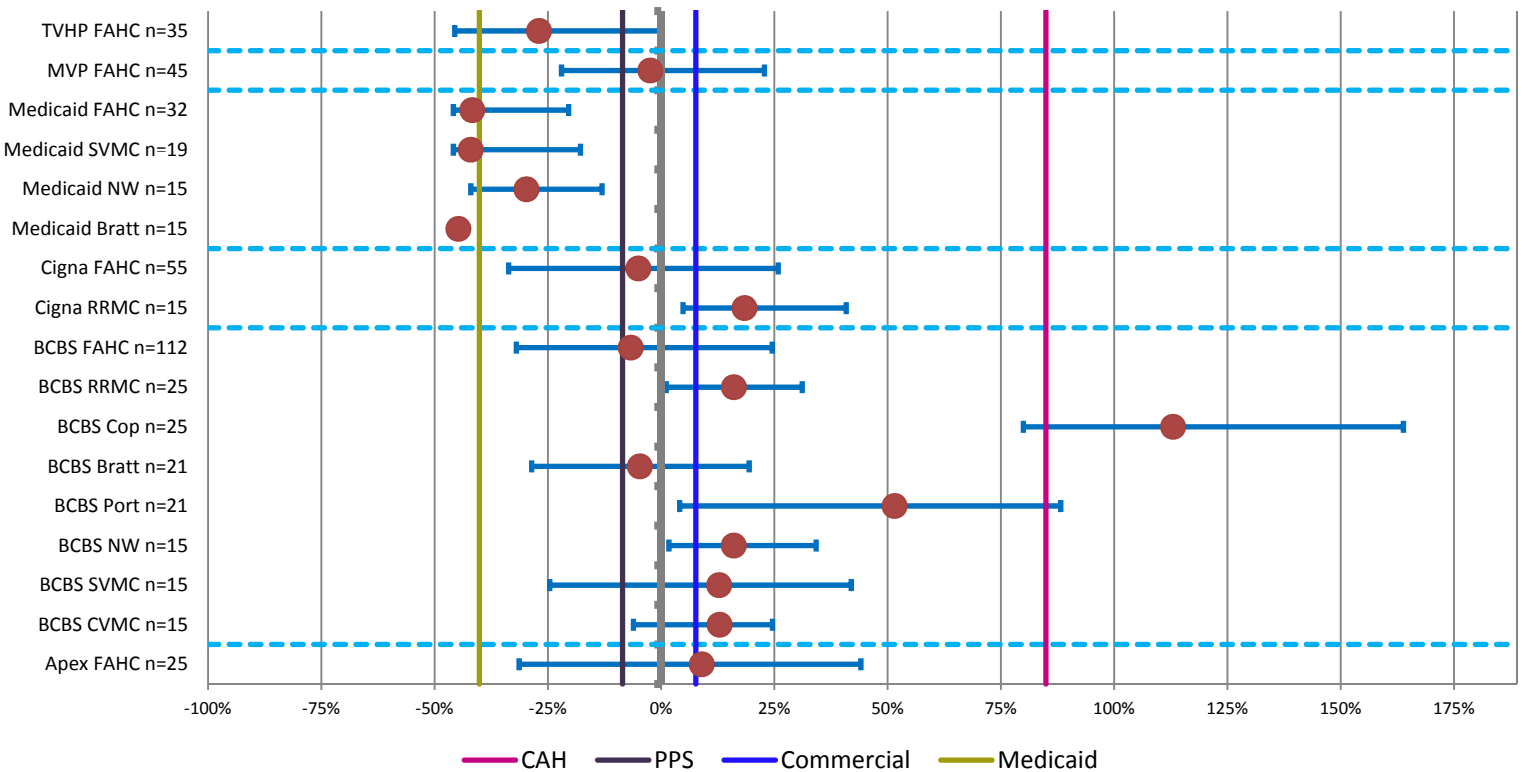
FY2012 Hospital Outpatient ICD-9 Procedure 4516 - EGD W/CLOS BX Allowed Payment Amount Variation



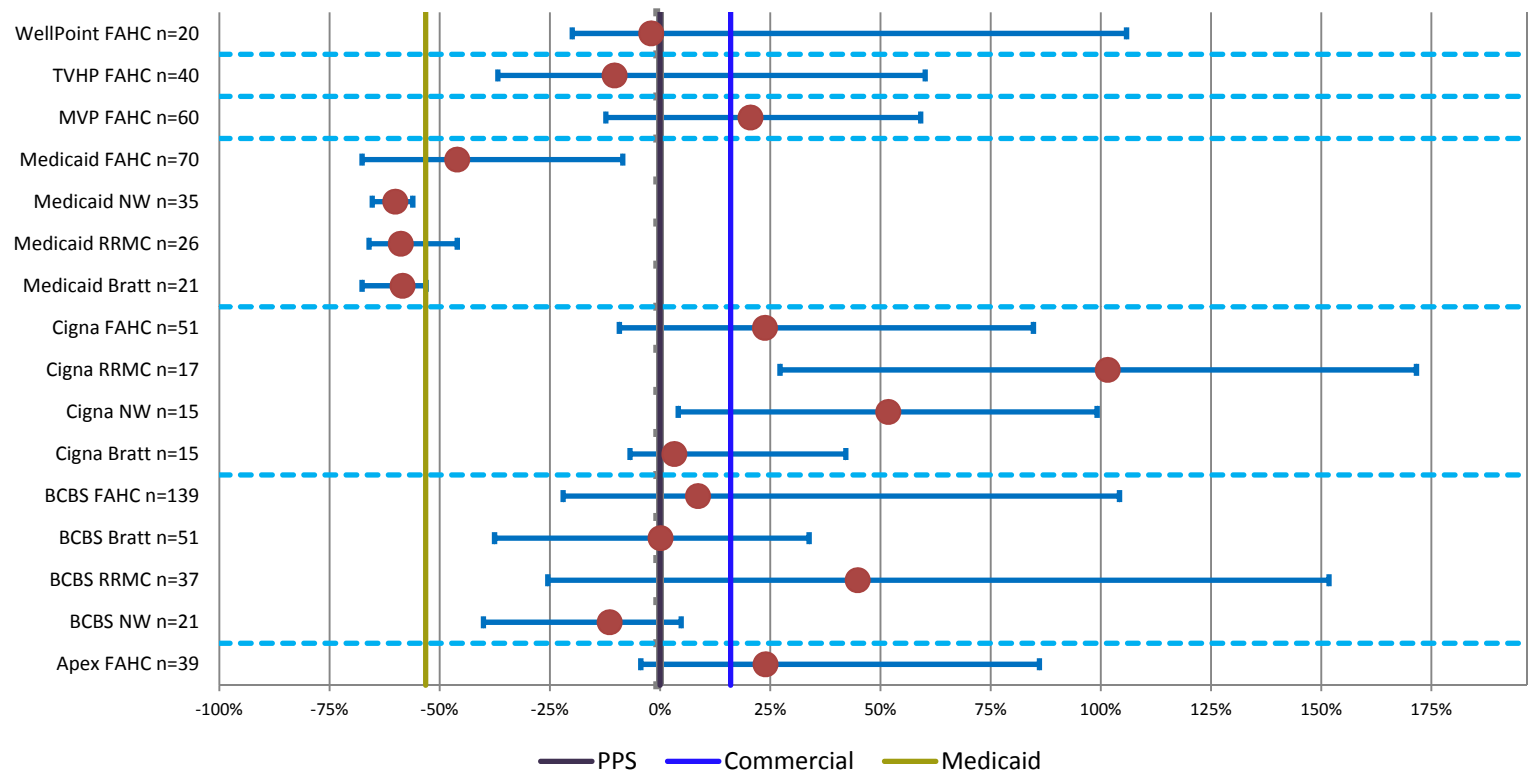
FY2012 Hospital Outpatient ICD-9 Procedure 5123 - LAPAROSCOPIC CHOLECYSTECTOMY Allowed Payment Amount Variation



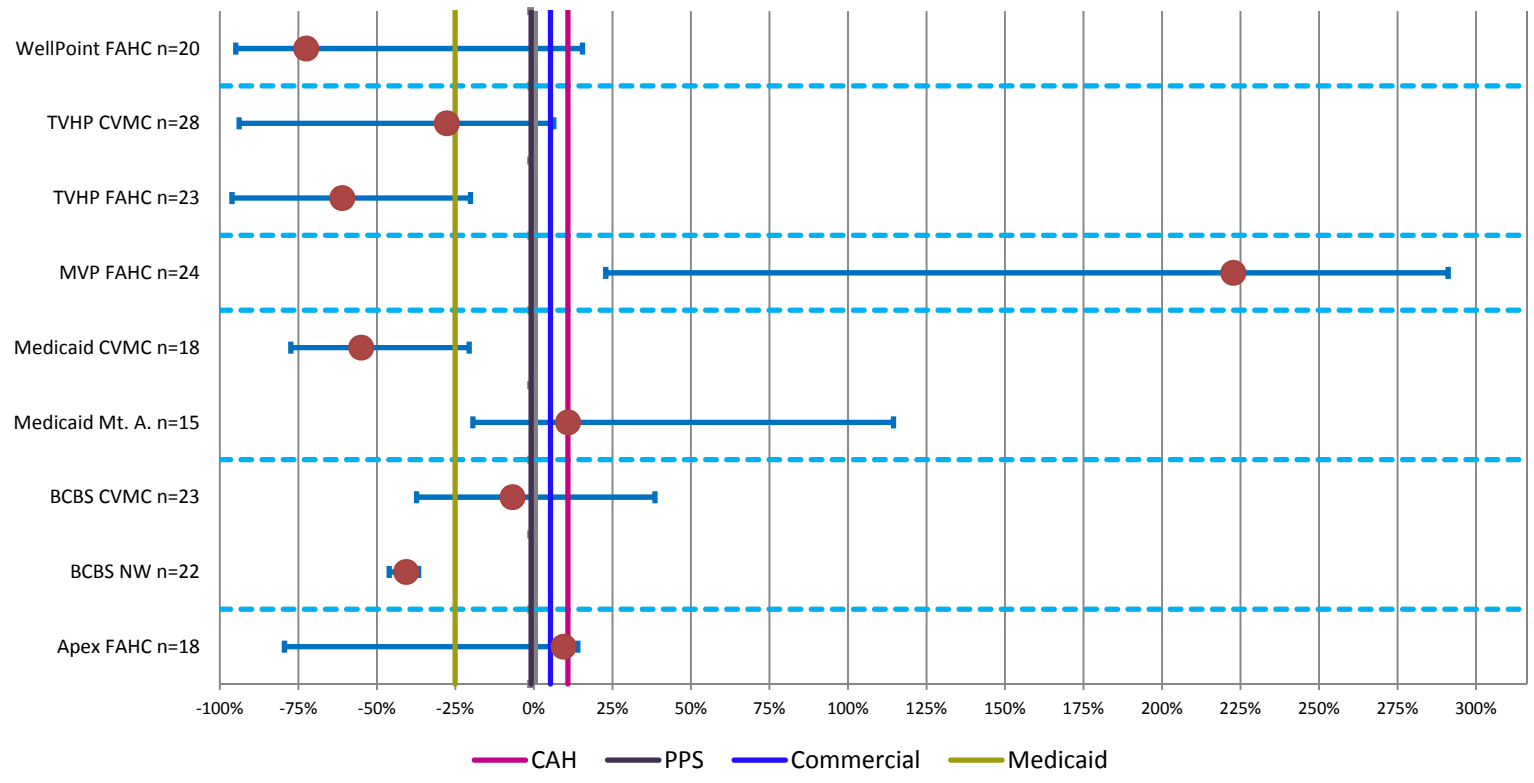
FY2012 Hospital Outpatient ICD-9 Procedure 806 - EXCISION SEMILUNAR CARTILAGE KNEE Allowed Payment Amount Variation



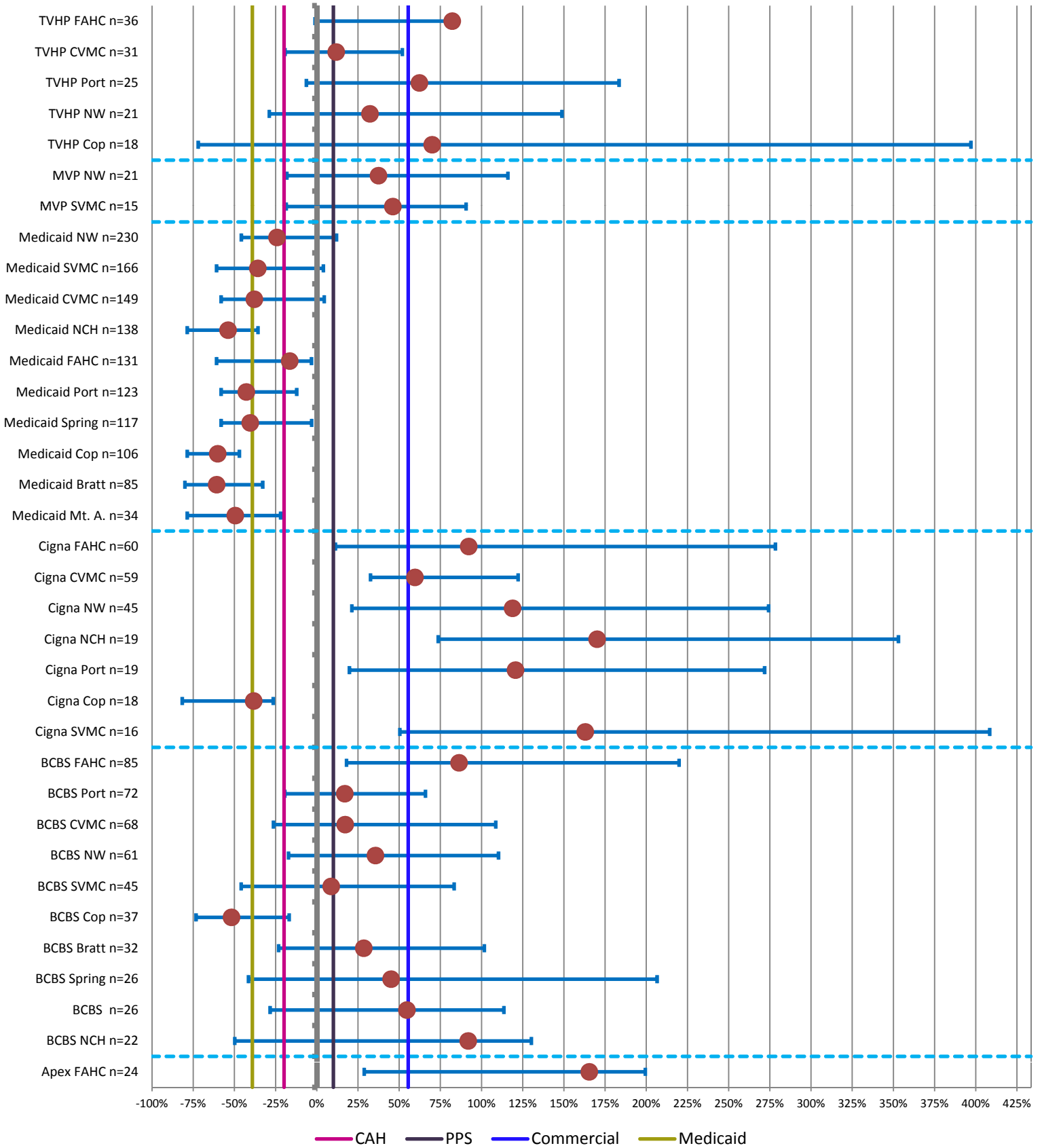
FY2012 Hospital Outpatient ICD-9 Procedure 4525 - CLOS [ENDO] BX LARGE INTESTINE Allowed Payment Amount Variation



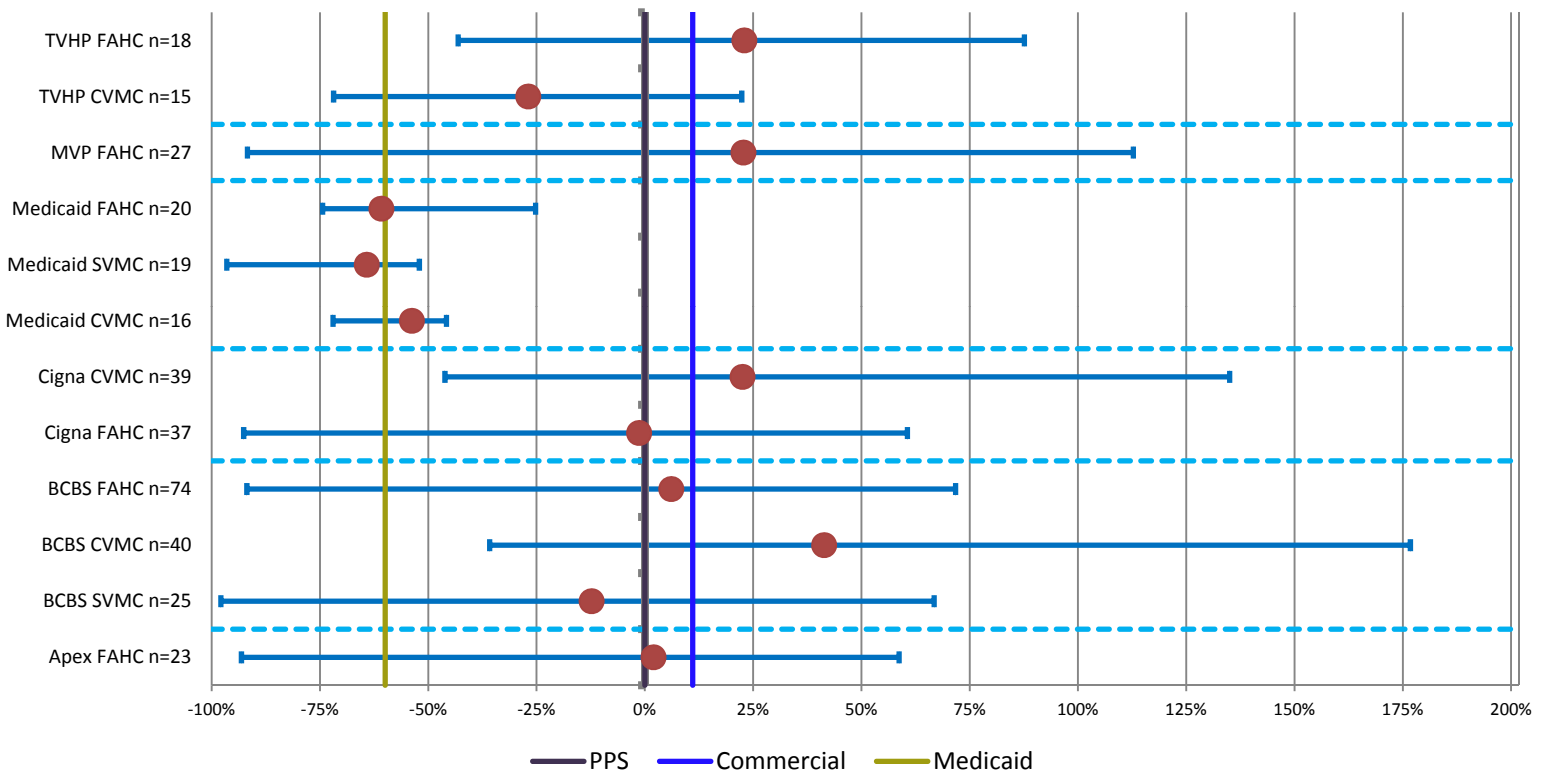
FY2012 Hospital Outpatient ICD-9 Procedure 9914 - INJECTION/INFUSION IMMUNOGLOBULIN Allowed Payment Amount Variation



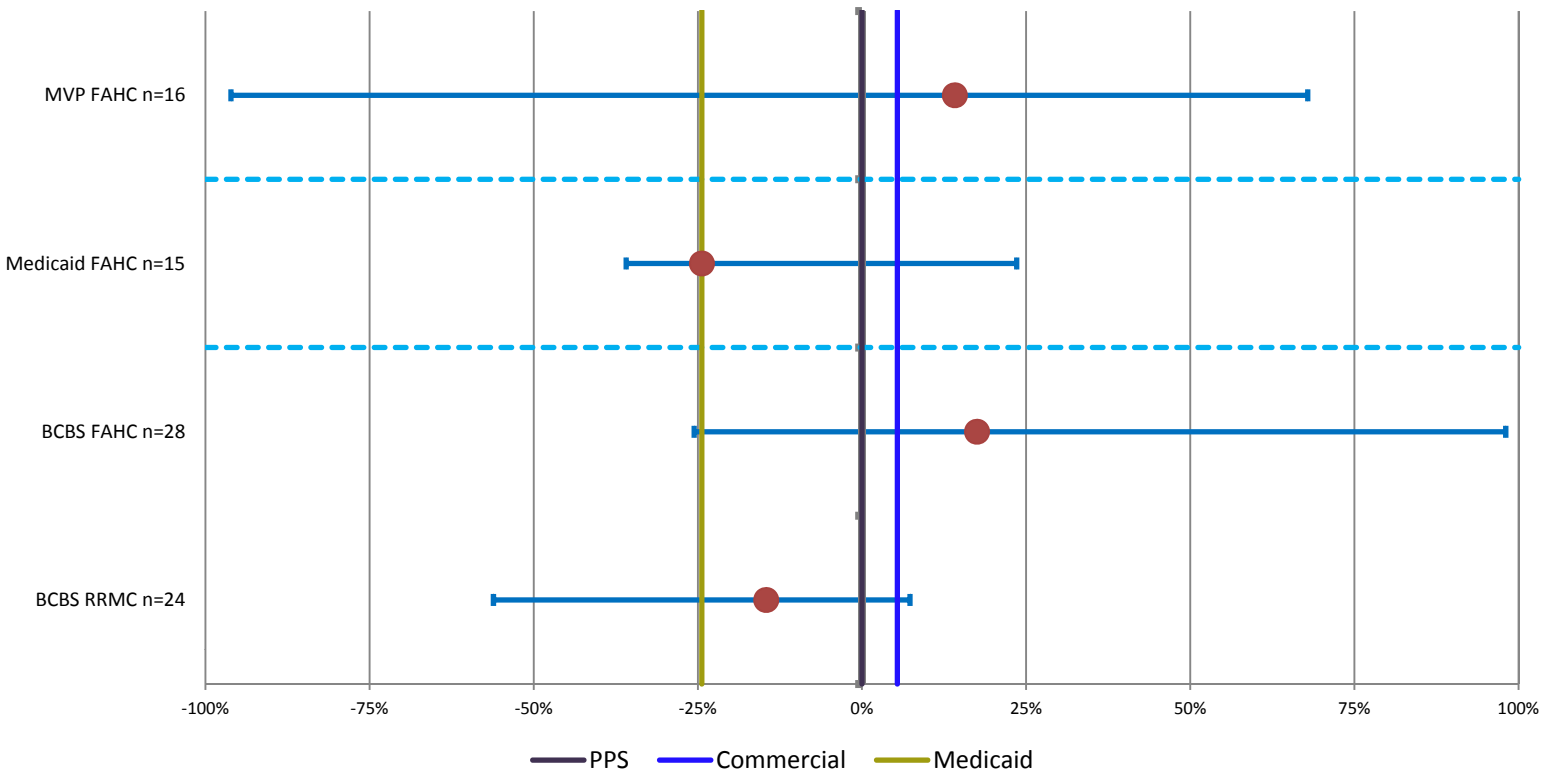
FY2012 Hospital Outpatient ICD-9 Procedure 8659 - CLOS SKIN&SUBCUT TISSUE OTH SITES Allowed Payment Amount Variation



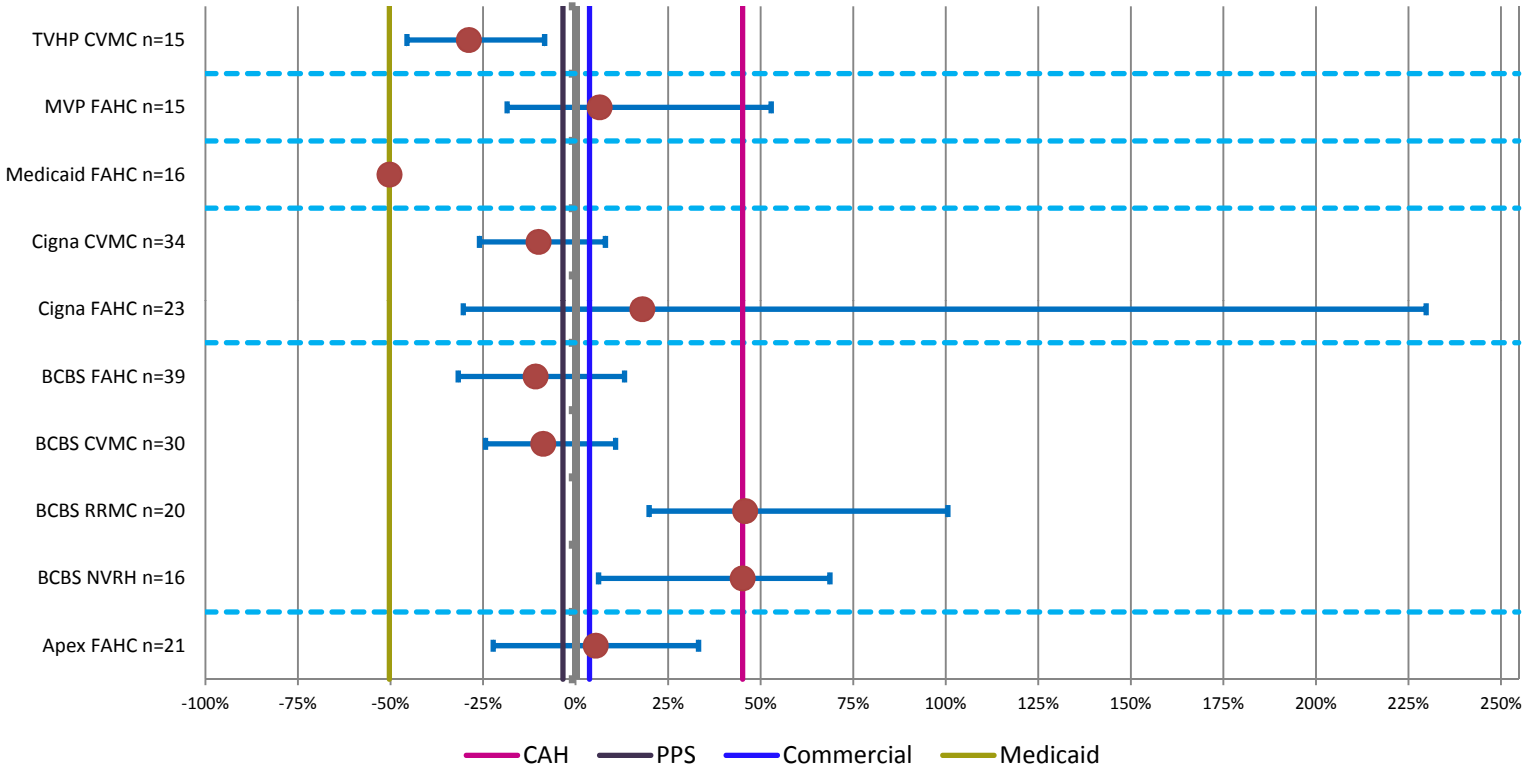
FY2012 Hospital Outpatient ICD-9 Procedure 8511 - CLOSED BIOPSY OF BREAST Allowed Payment Amount Variation



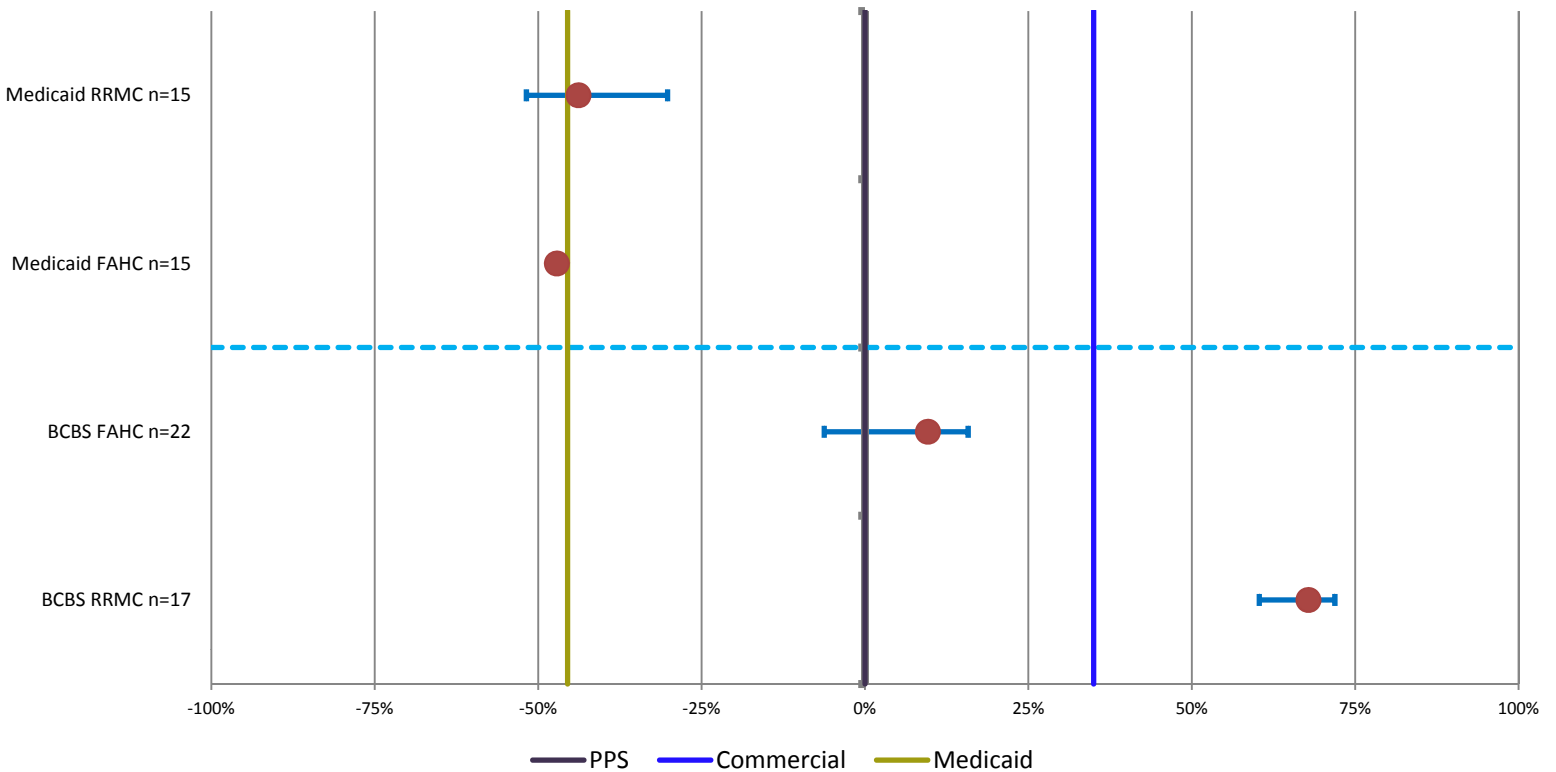
FY2012 Hospital Outpatient ICD-9 Procedure 8145 - OTHER REPAIR THE CRUCIATE LIGAMENTS Allowed Payment Amount Variation



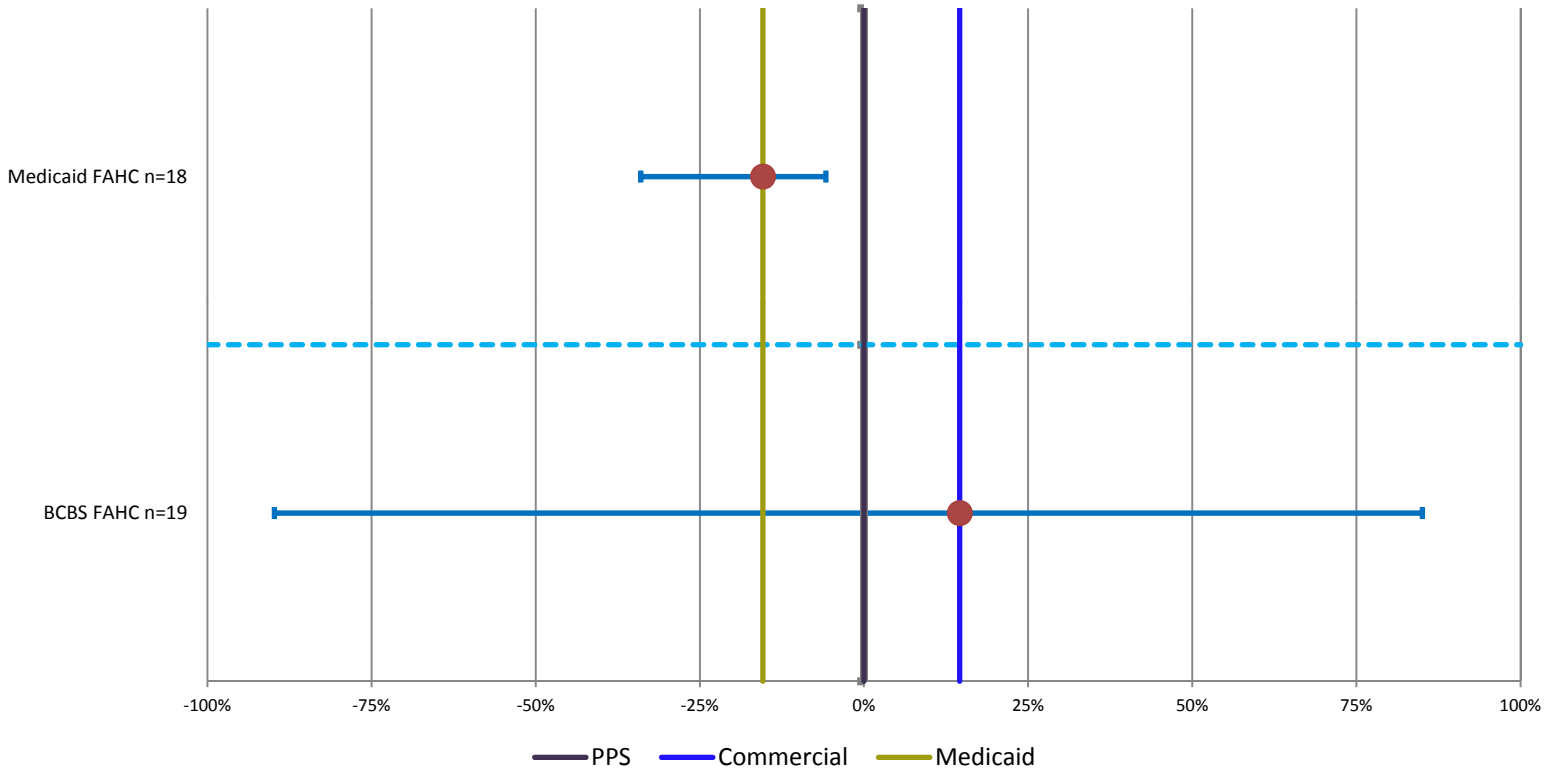
FY2012 Hospital Outpatient ICD-9 Procedure 1341 - PHACOEMULSIFICATION&ASPIR CATARACT Allowed Payment Amount Variation



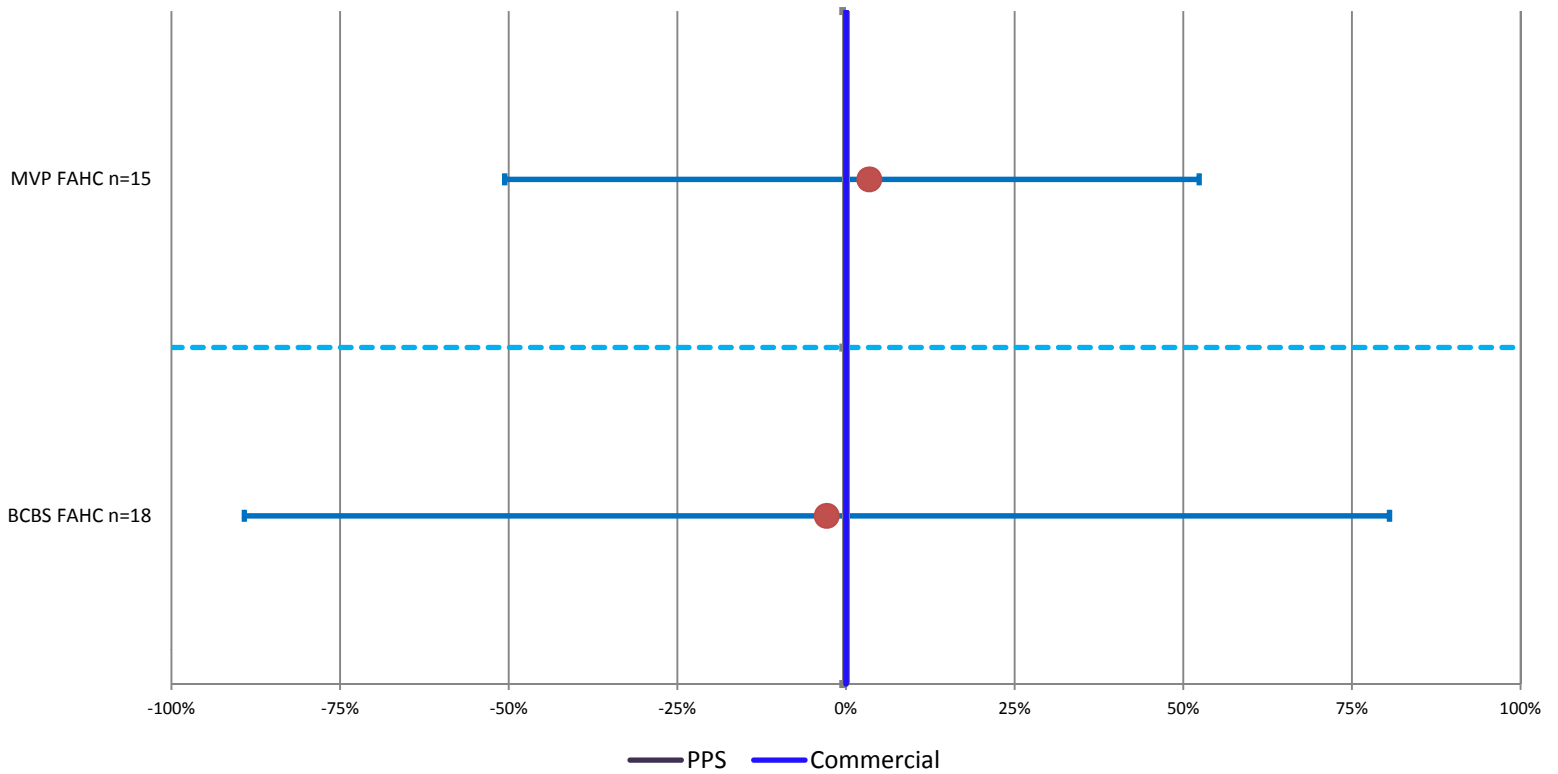
FY2012 Hospital Outpatient ICD-9 Procedure 9851 - ESWL KIDNEY-URETER &/ BLADDER Allowed Payment Amount Variation



FY2012 Hospital Outpatient ICD-9 Procedure 560 - TRANSURETH REMOV OBST URETER-PELV Allowed Payment Amount Variation

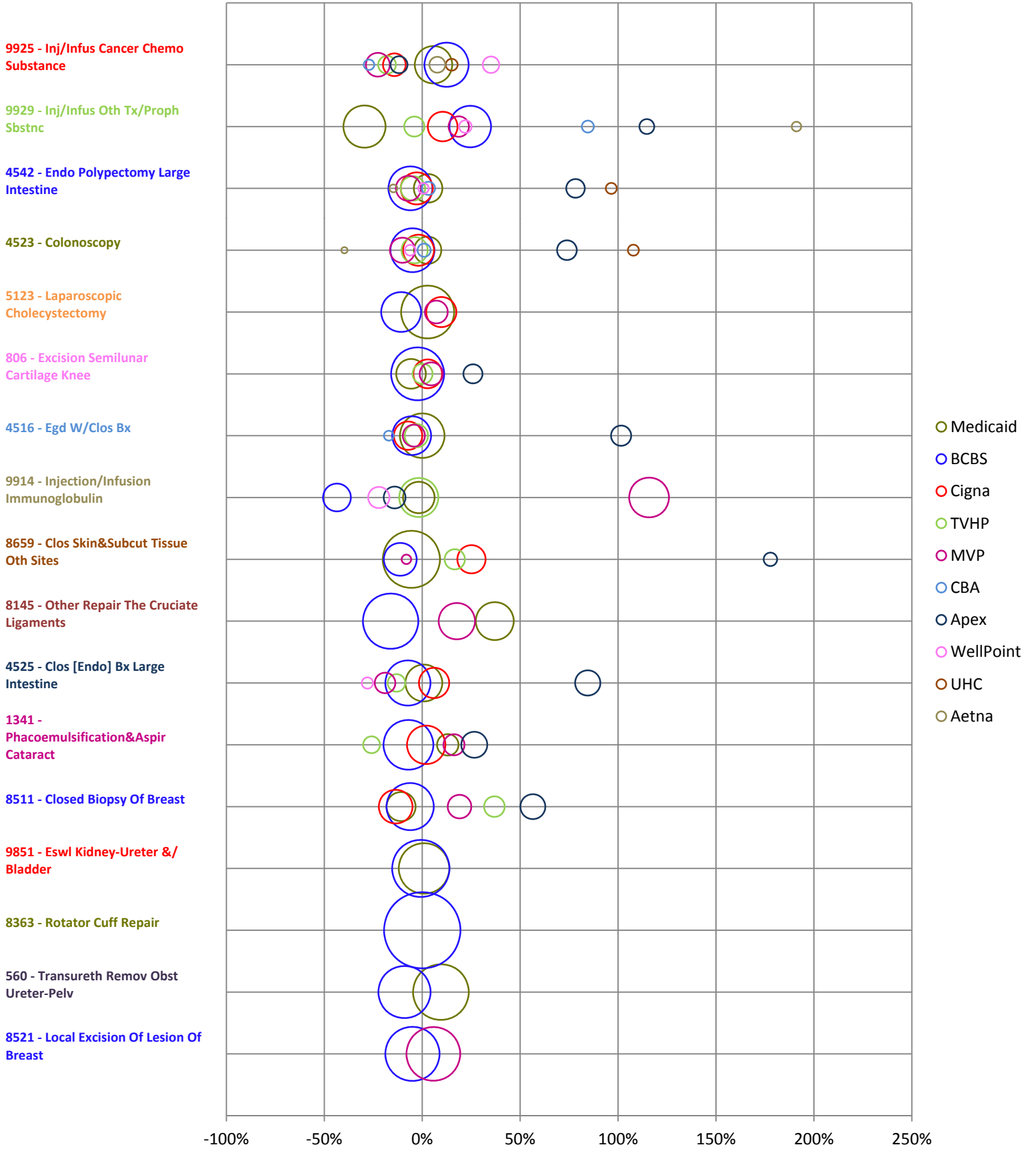


FY2012 Hospital Outpatient ICD-9 Procedure 8521 - LOCAL EXCISION OF LESION OF BREAST Allowed Payment Amount Variation

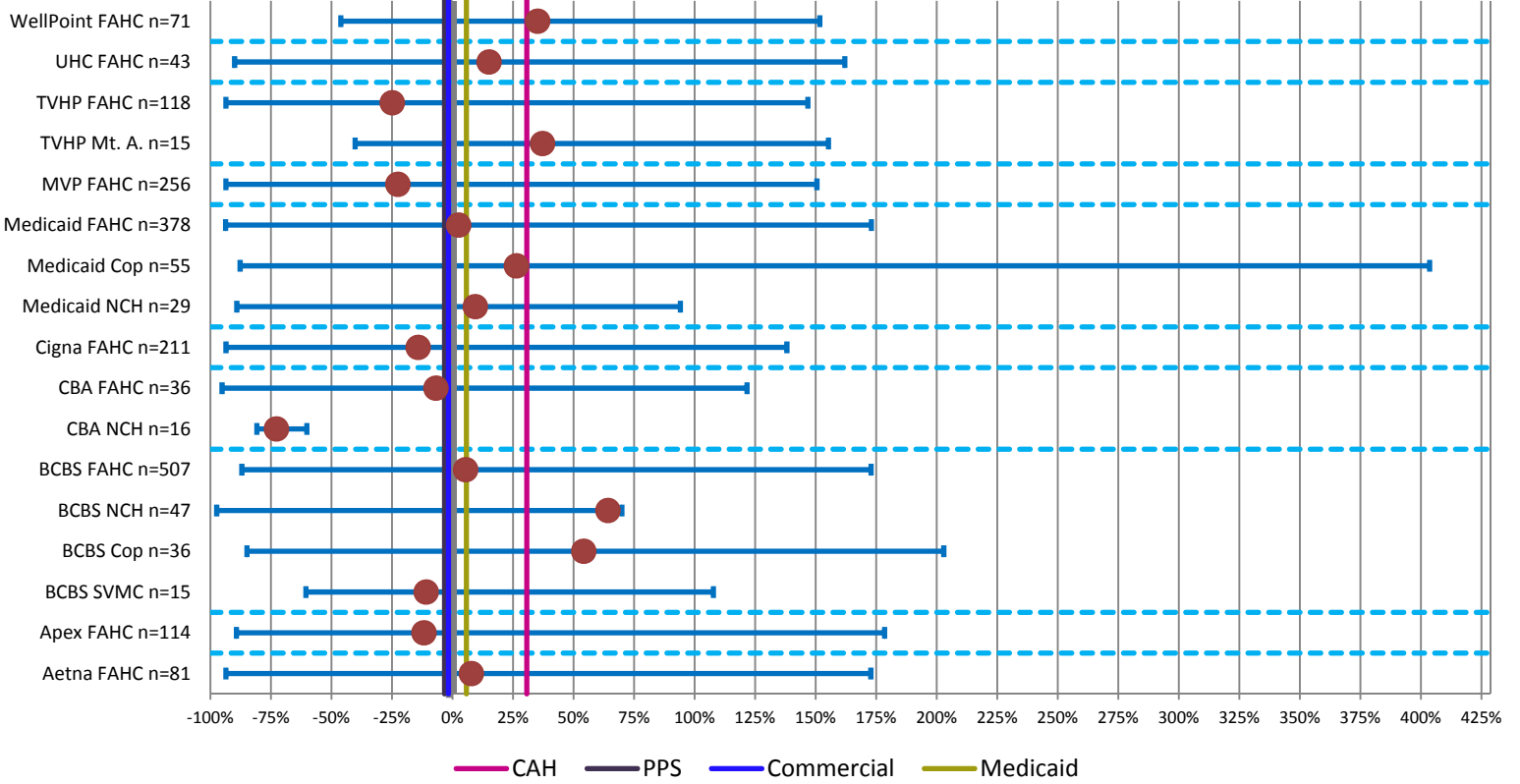


FY2012 Hospital Outpatient ICD-9 Procedure Cost Variation

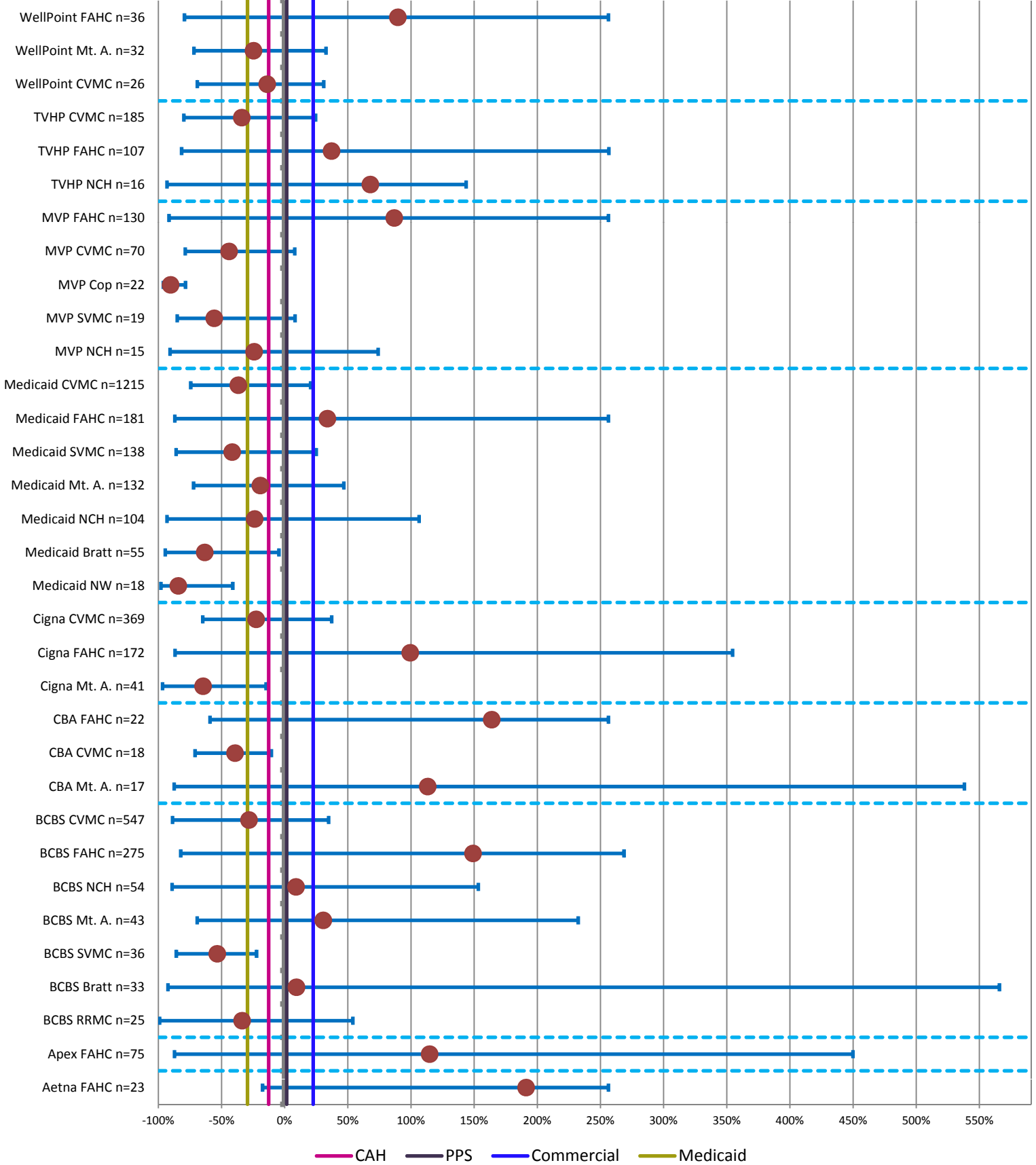
FY2012 Hospital Outpatient ICD-9 Procedure Cost Variation (Min 15 Visits)



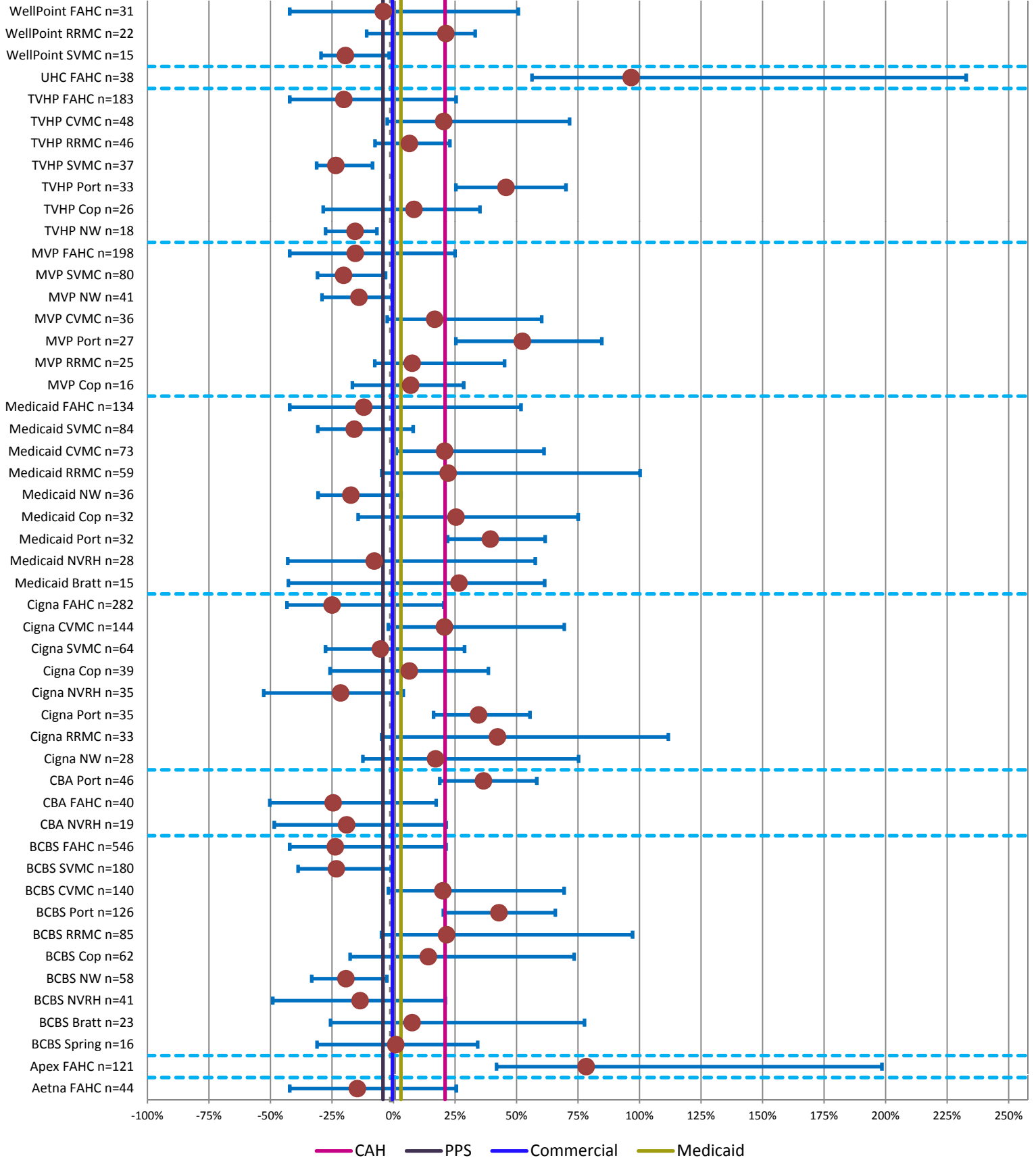
FY2012 Hospital Outpatient ICD-9 Procedure 9925 - INJ/INFUS CANCER CHEMO SUBSTANCE Cost Variation



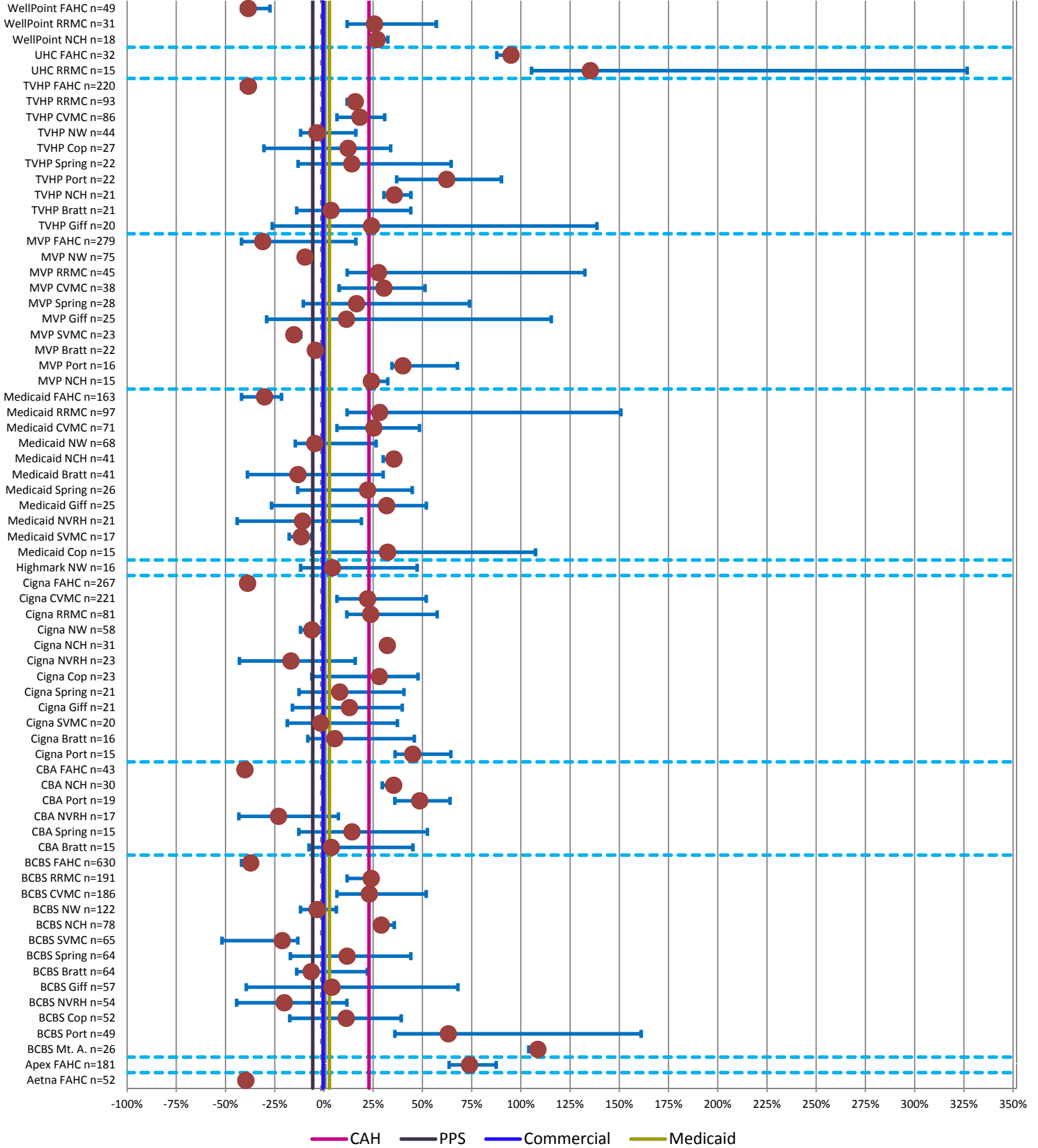
FY2012 Hospital Outpatient ICD-9 Procedure 9929 - INJ/INFUS OTH TX/PROPH SBSTNC Cost Variation



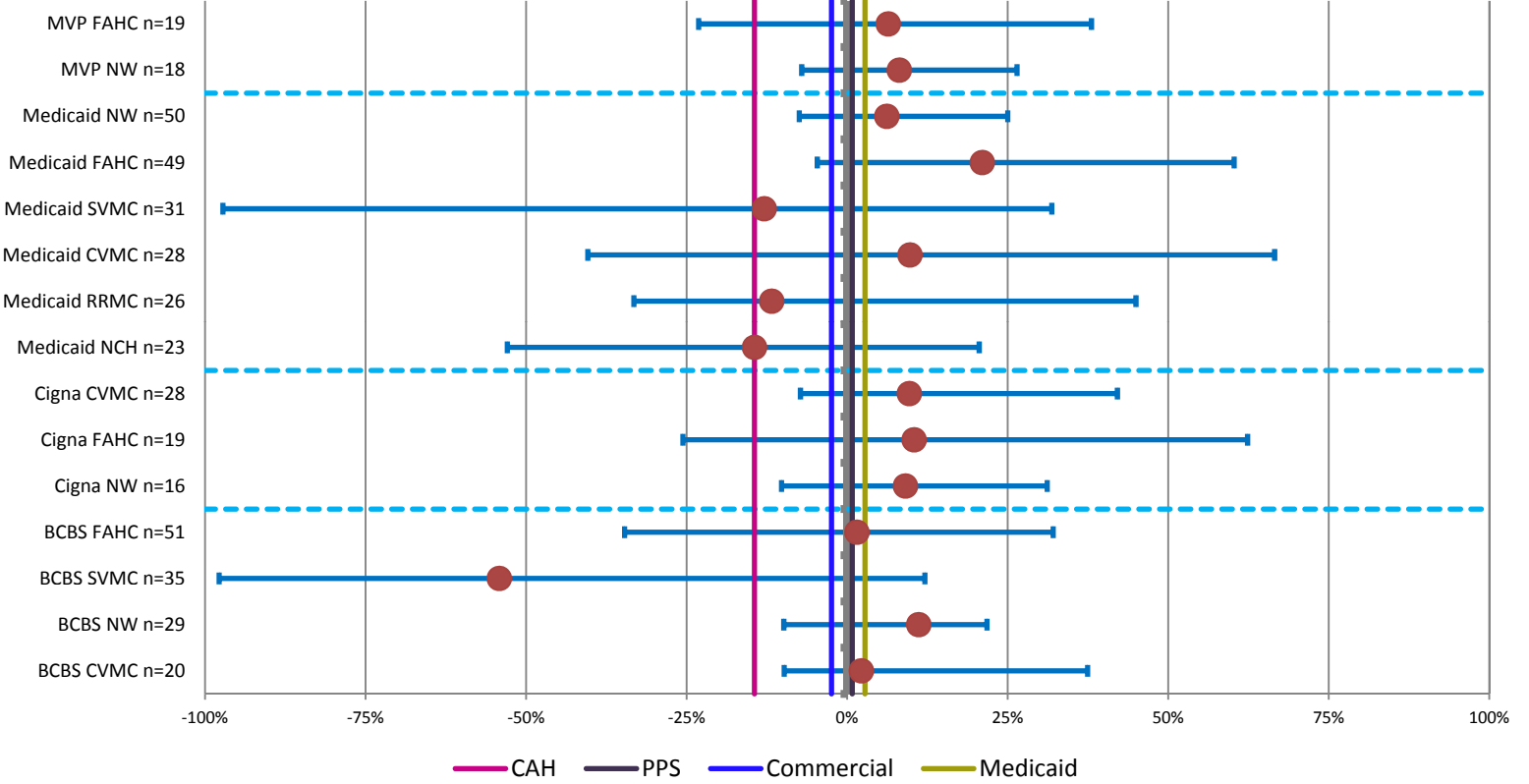
FY2012 Hospital Outpatient ICD-9 Procedure 4542 - ENDO POLYPECTOMY LARGE INTESTINE Cost Variation



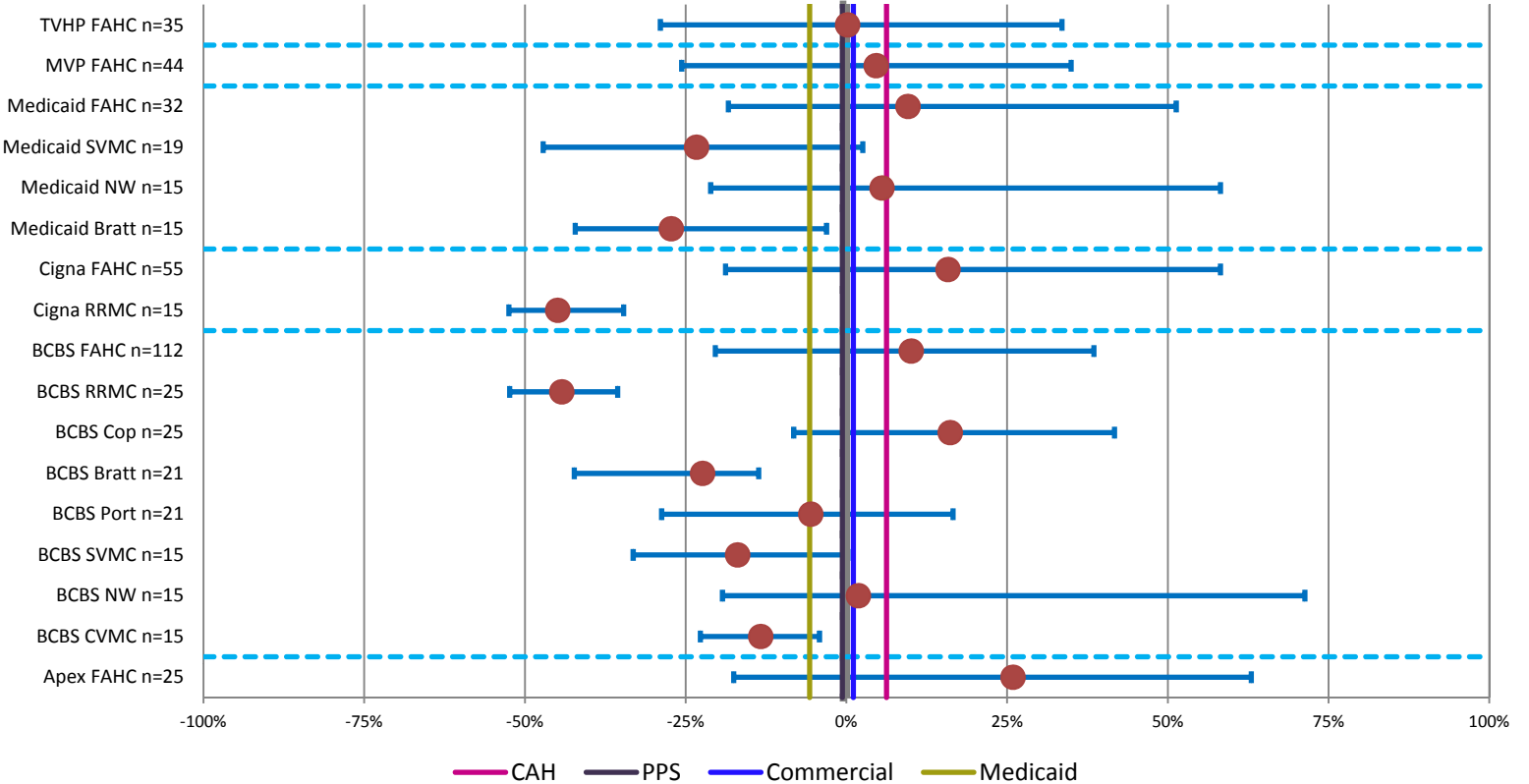
FY2012 Hospital Outpatient ICD-9 Procedure 4523 - COLONOSCOPY Cost Variation



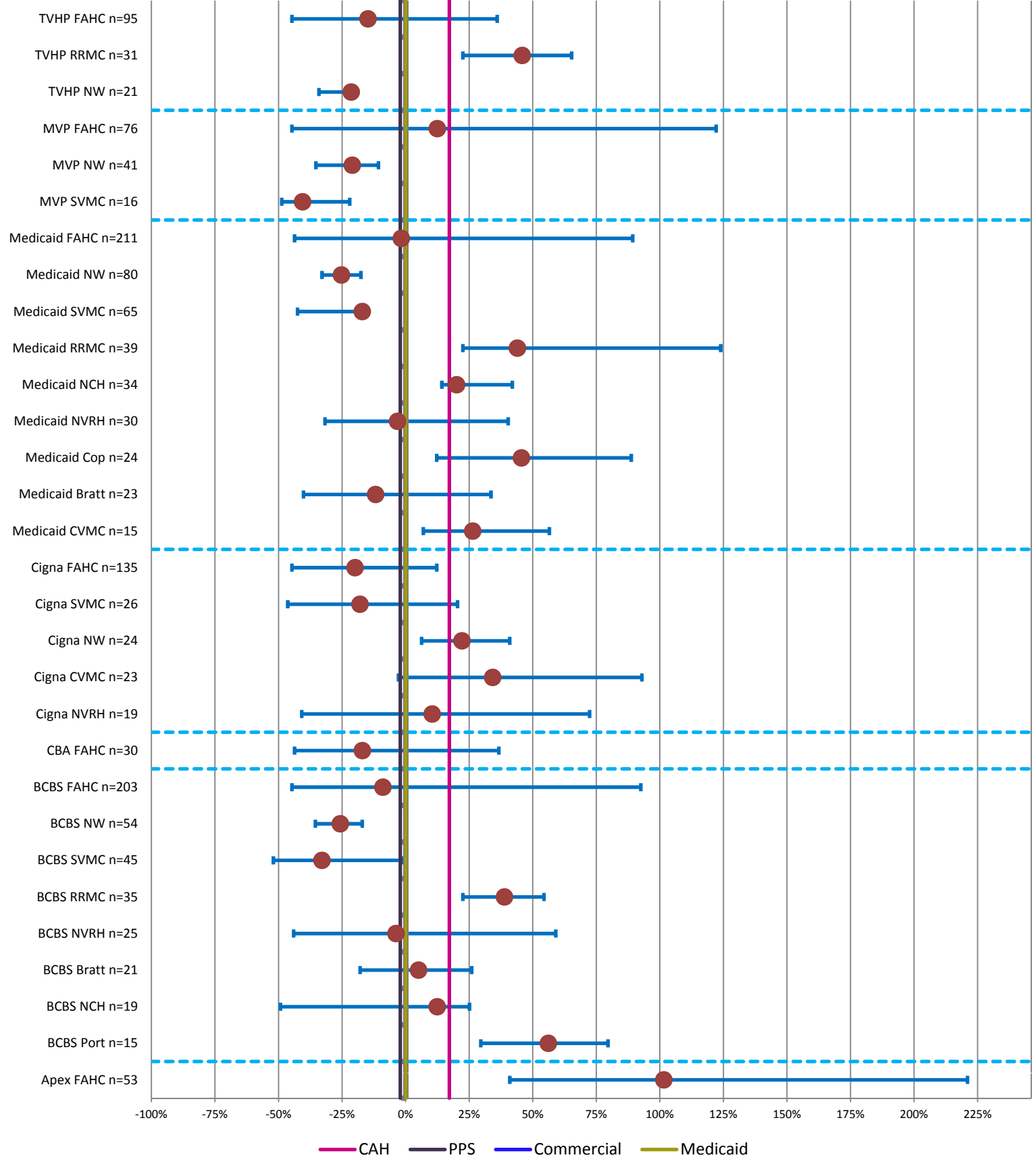
FY2012 Hospital Outpatient ICD-9 Procedure 5123 - LAPAROSCOPIC CHOLECYSTECTOMY Cost Variation



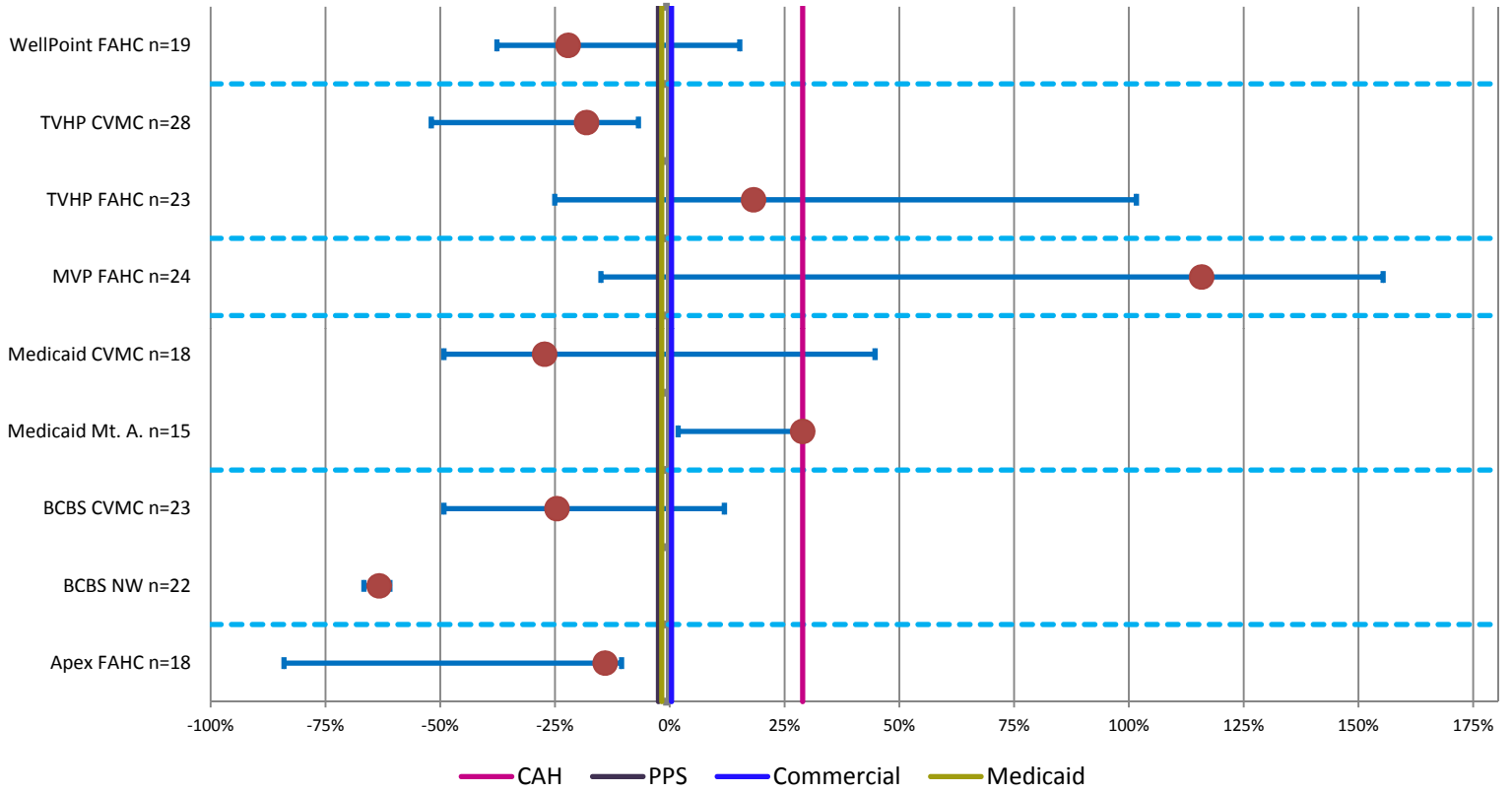
FY2012 Hospital Outpatient ICD-9 Procedure 806 - EXCISION SEMILUNAR CARTILAGE KNEE Cost Variation



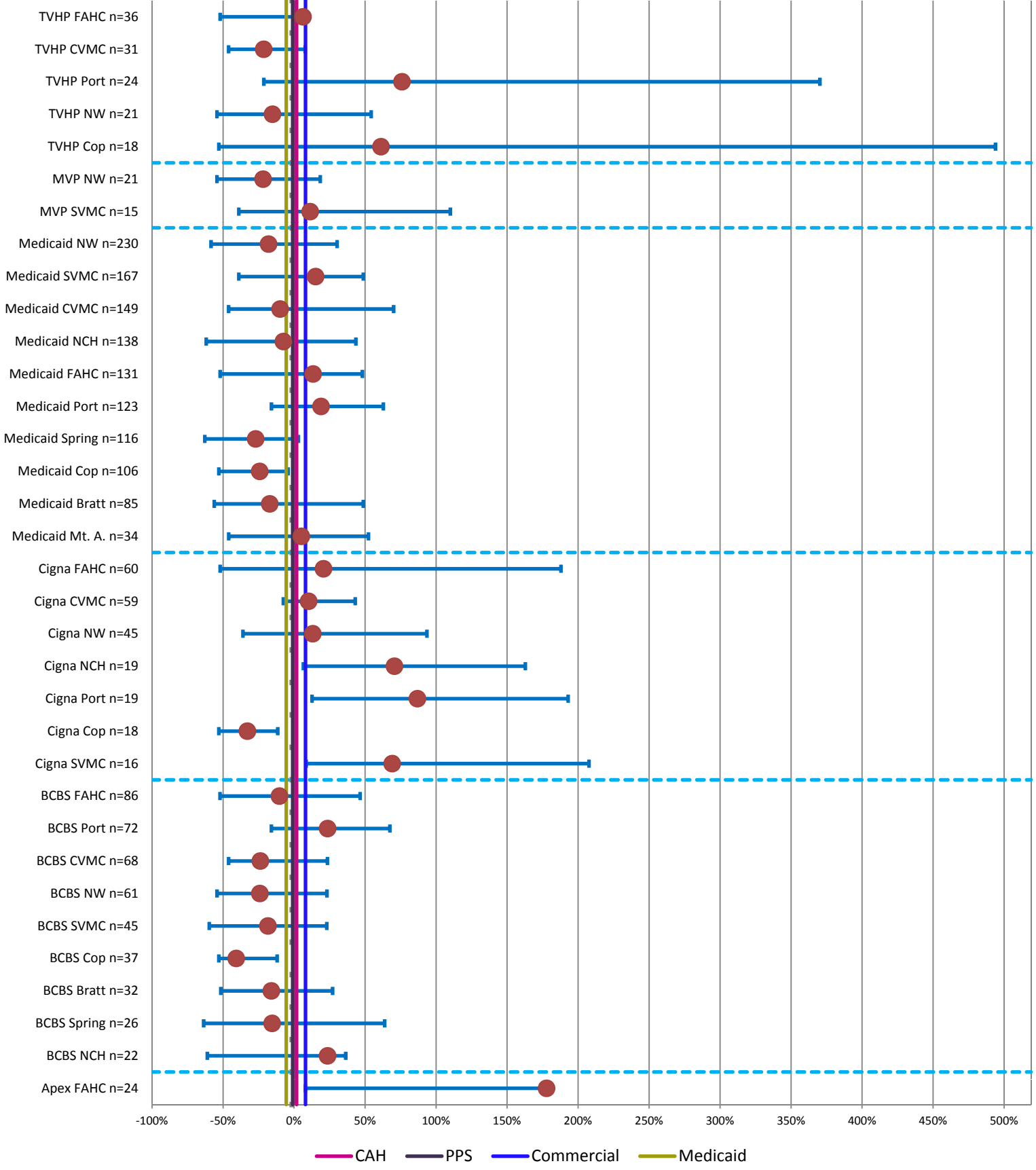
FY2012 Hospital Outpatient ICD-9 Procedure 4516 - EGD W/CLOS BX Cost Variation



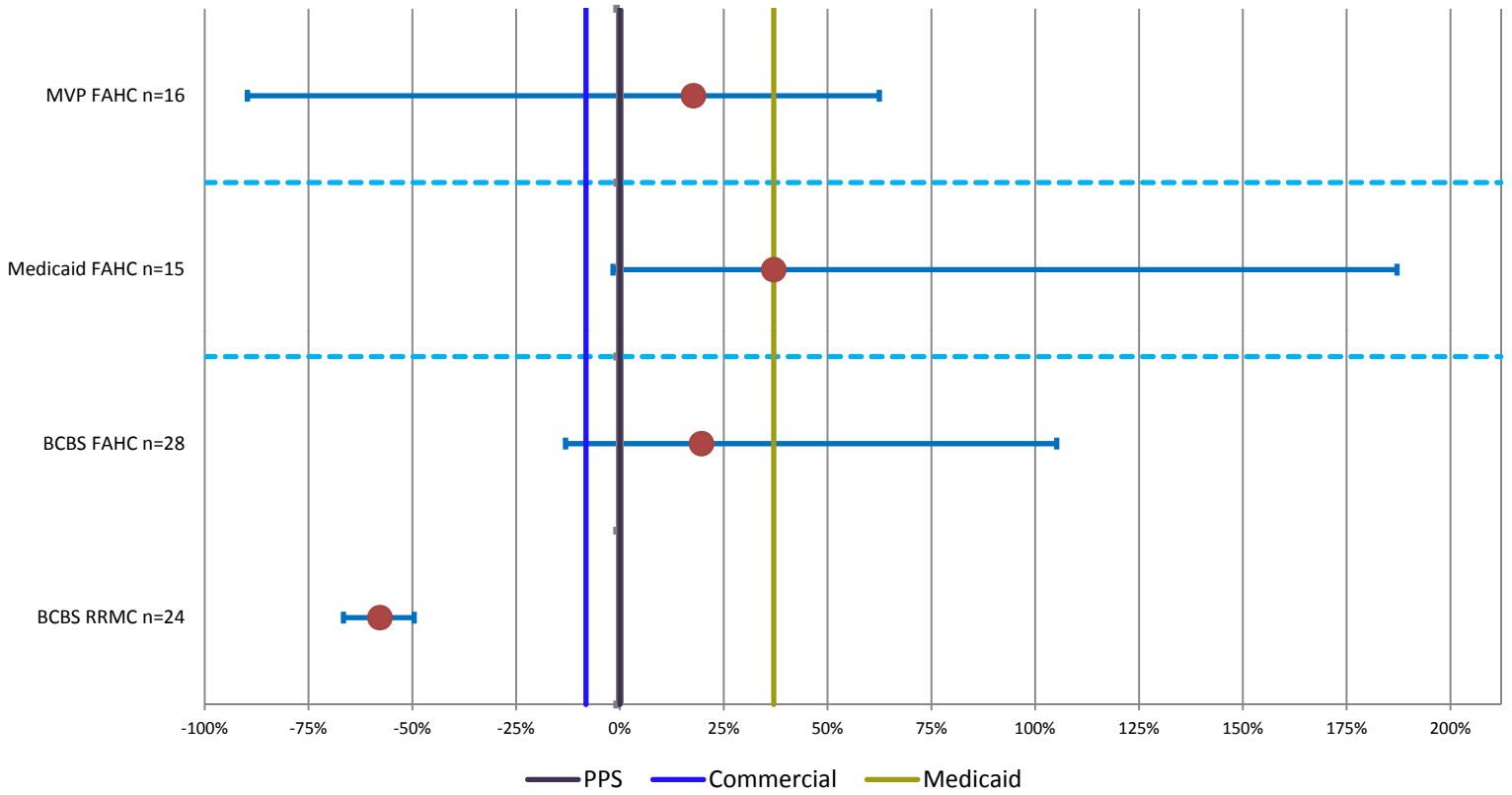
FY2012 Hospital Outpatient ICD-9 Procedure 9914 - INJECTION/INFUSION IMMUNOGLOBULIN Cost Variation



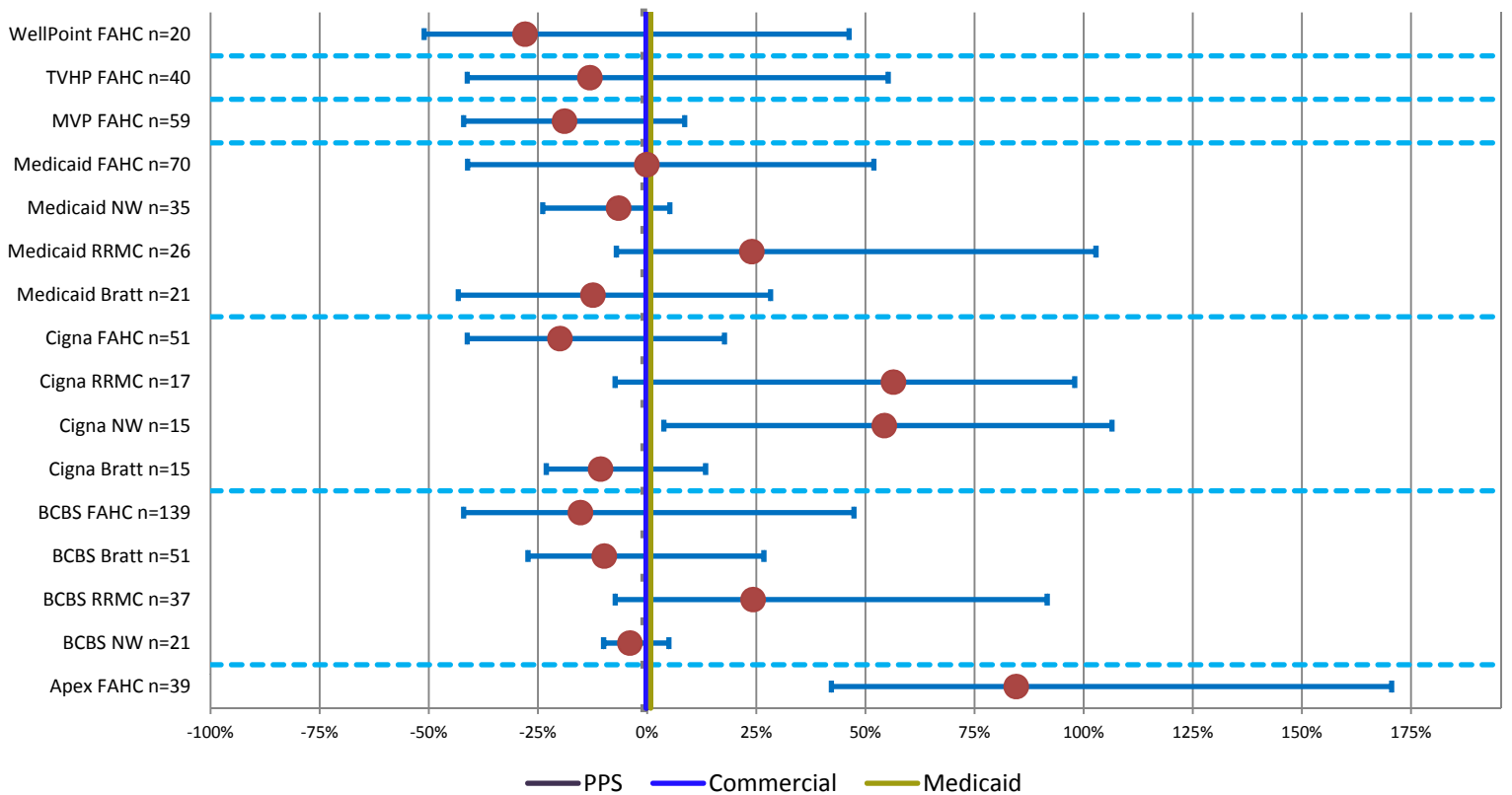
FY2012 Hospital Outpatient ICD-9 Procedure 8659 - CLOS SKIN&SUBCUT TISSUE OTH SITES Cost Variation



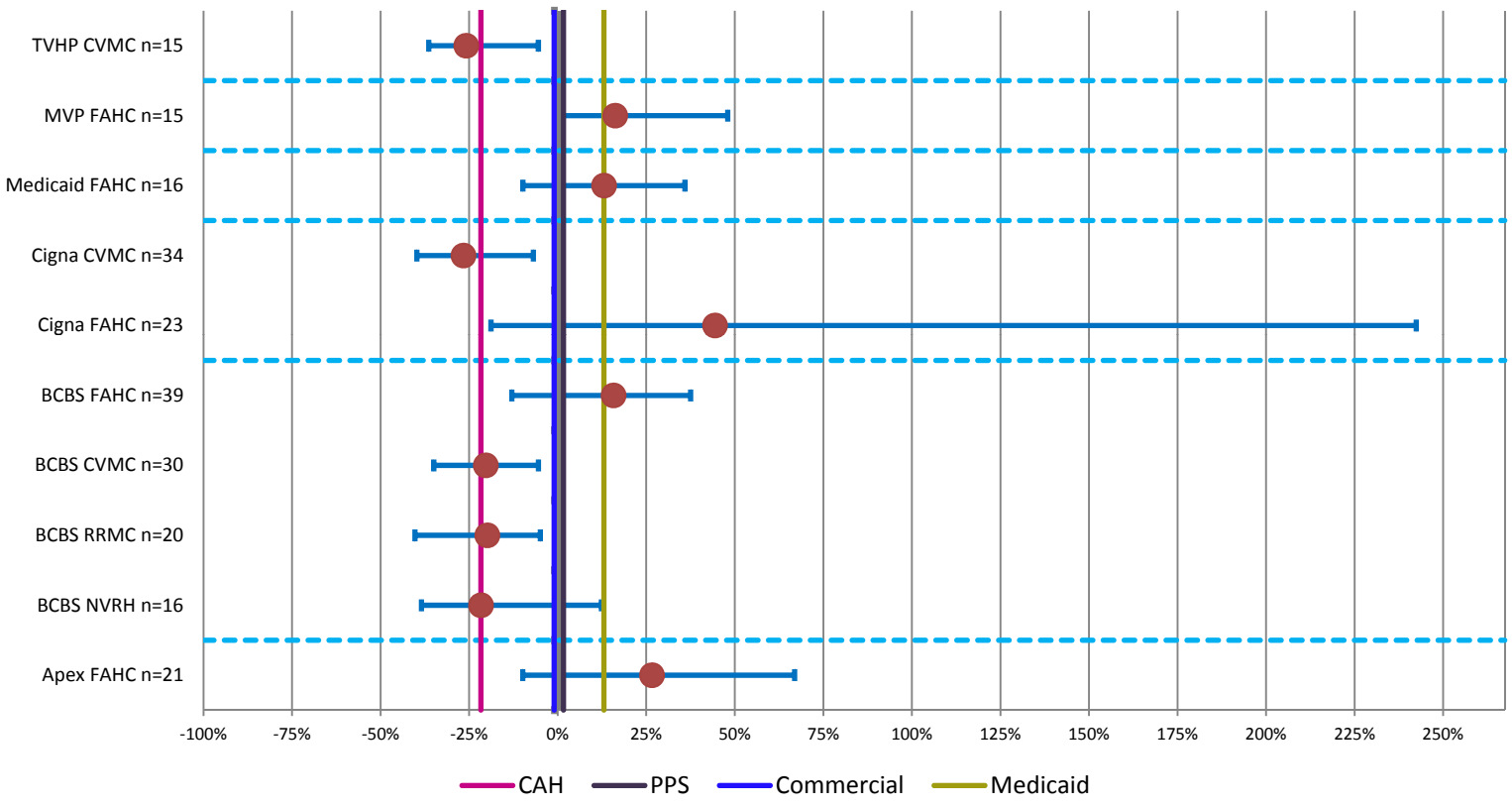
FY2012 Hospital Outpatient ICD-9 Procedure 8145 - OTHER REPAIR THE CRUCIATE LIGAMENTS Cost Variation



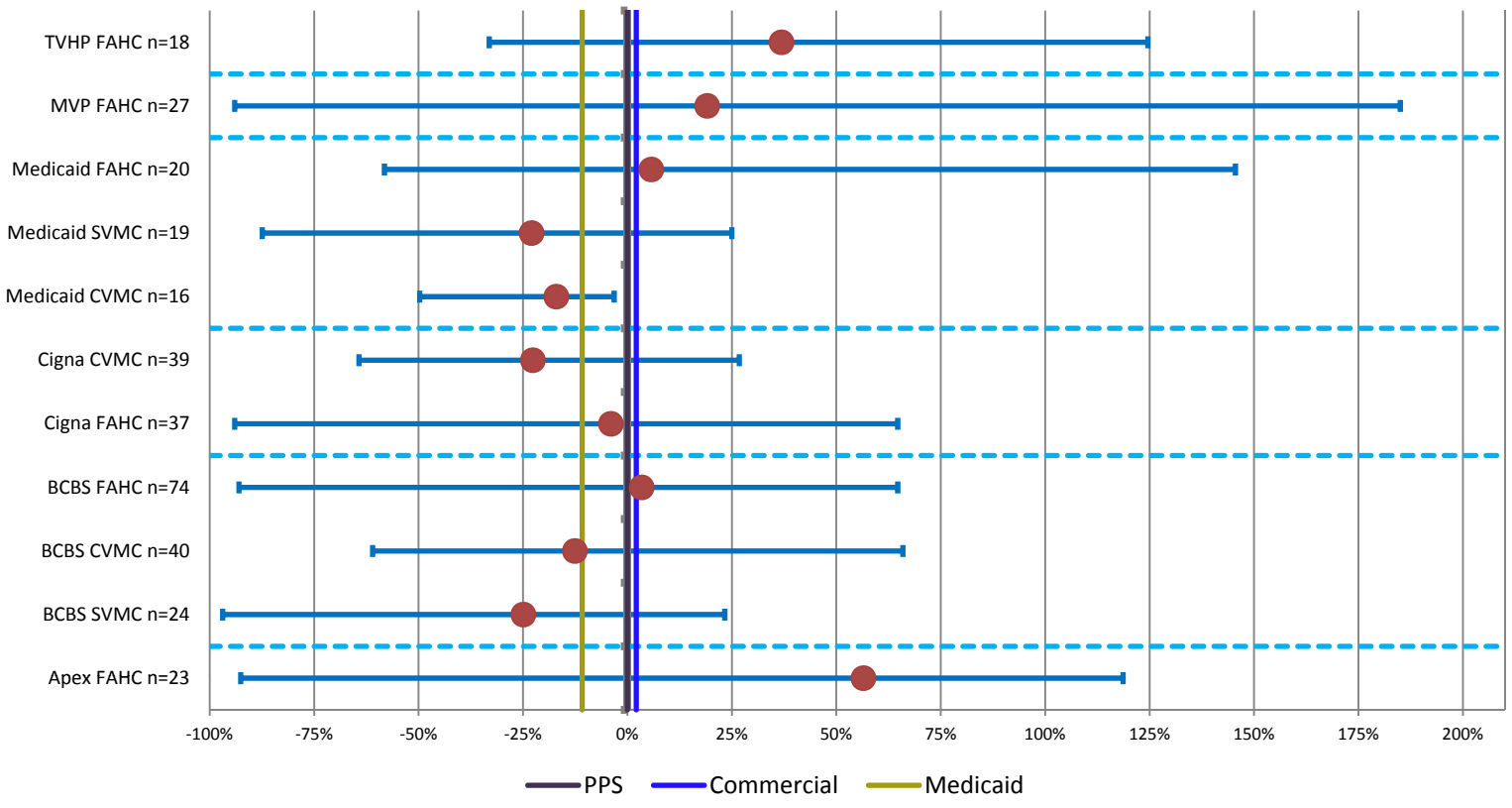
FY2012 Hospital Outpatient ICD-9 Procedure 4525 - CLOS [ENDO] BX LARGE INTESTINE Cost Variation



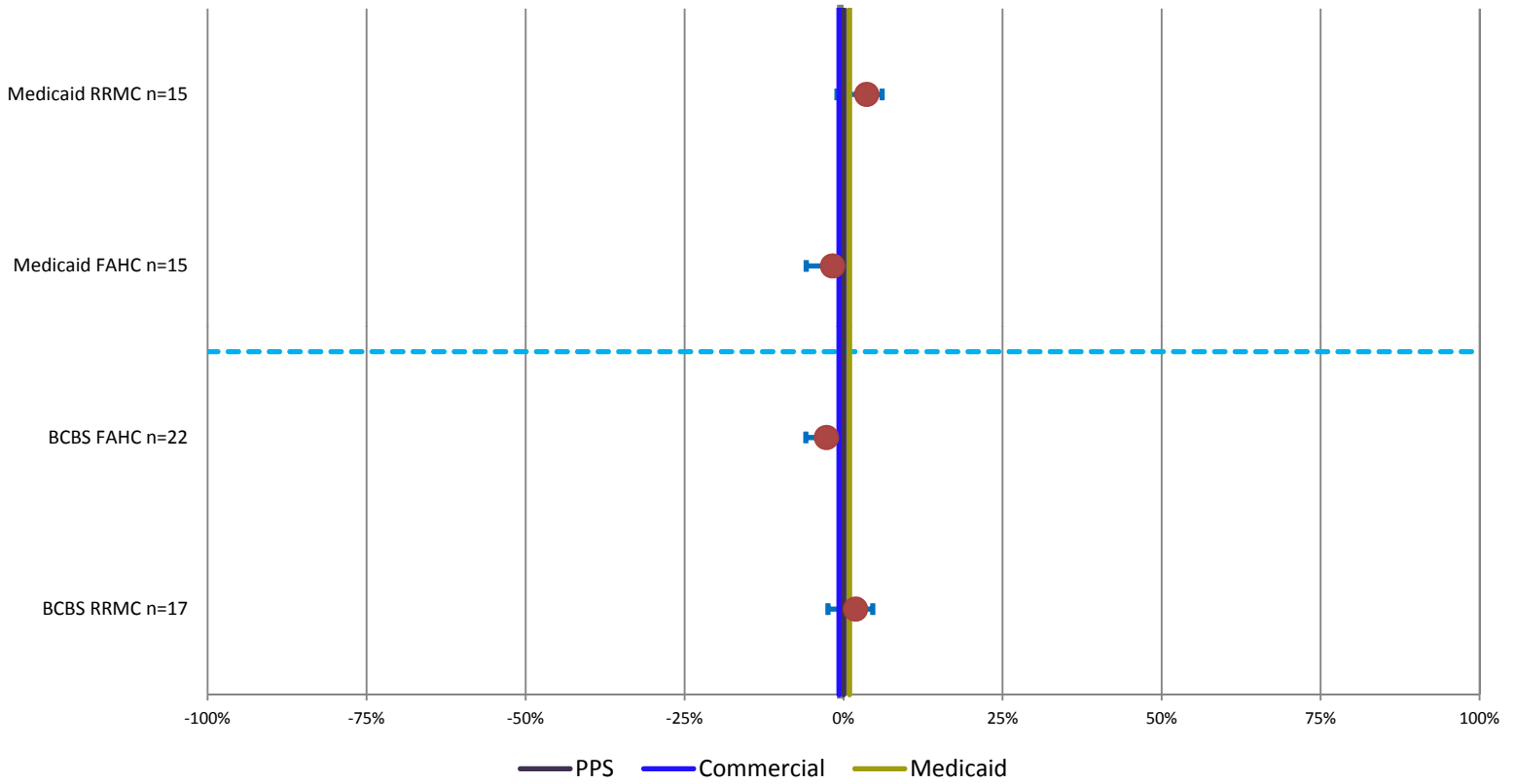
FY2012 Hospital Outpatient ICD-9 Procedure 1341 - PHACOEMULSIFICATION&ASPIR CATARACT Cost Variation



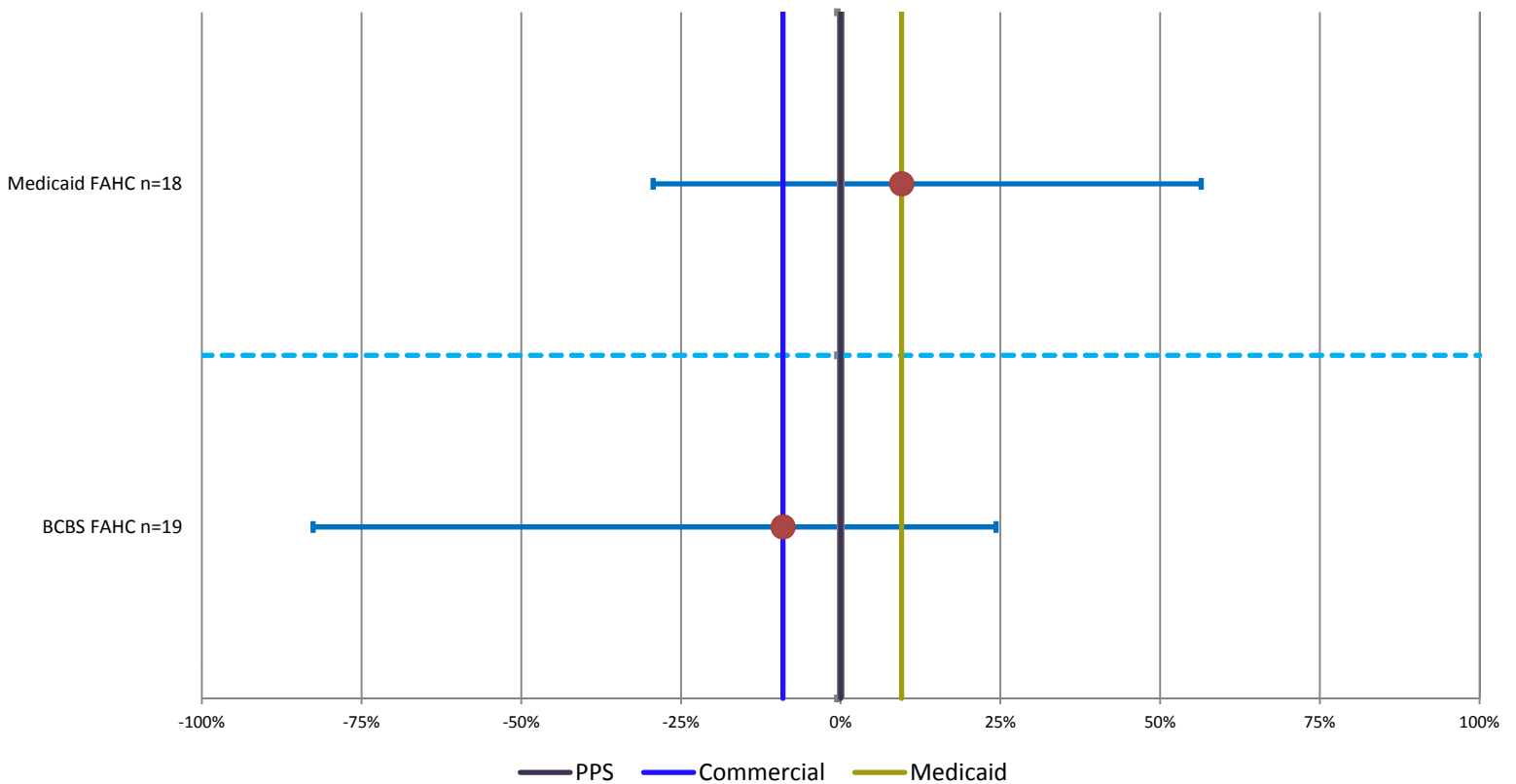
FY2012 Hospital Outpatient ICD-9 Procedure 8511 - CLOSED BIOPSY OF BREAST Cost Variation



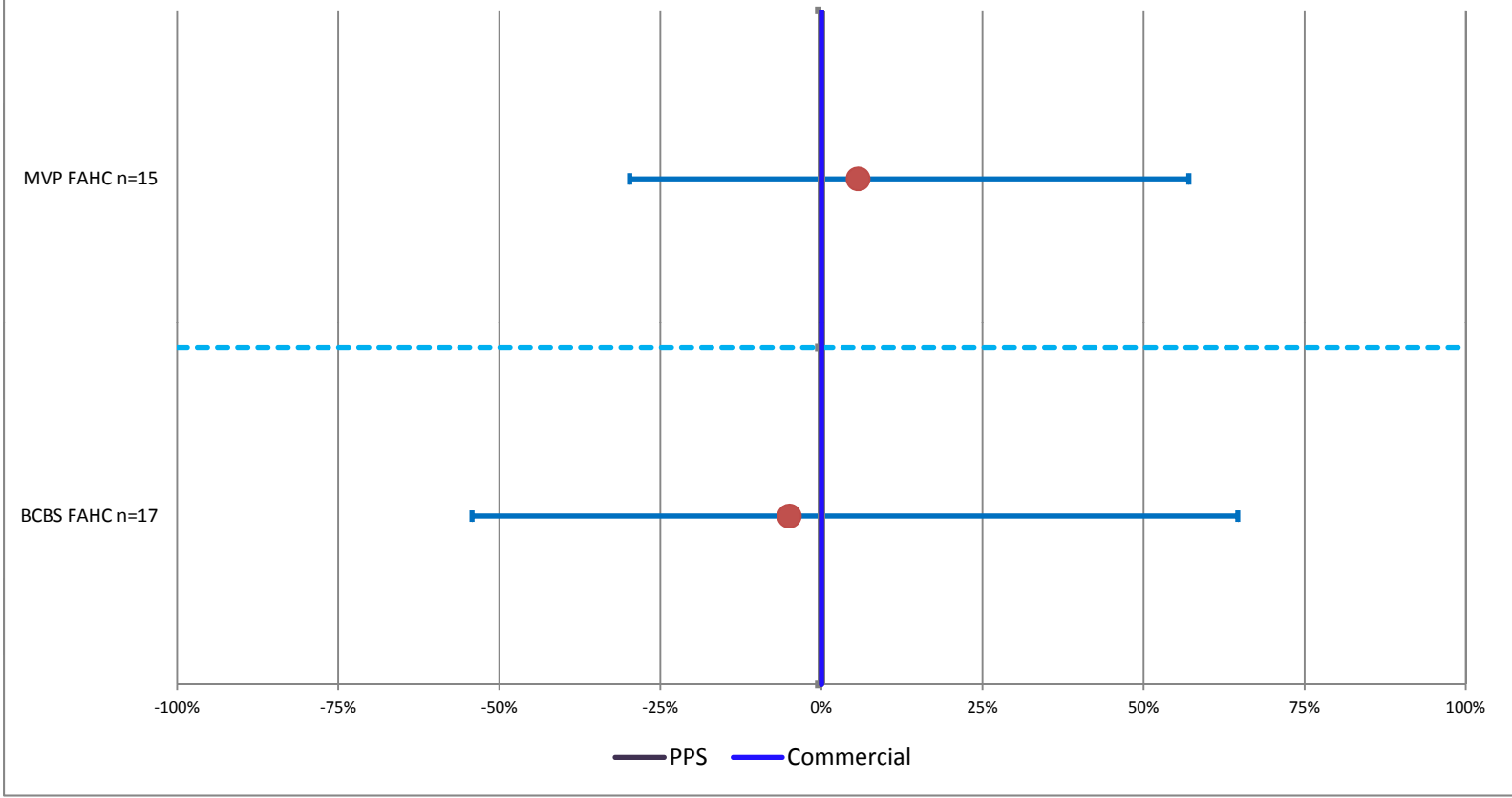
FY2012 Hospital Outpatient ICD-9 Procedure 9851 - ESWL KIDNEY-URETER &/ BLADDER Cost Variation



FY2012 Hospital Outpatient ICD-9 Procedure 560 - TRANSURETH REMOV OBST URETER-PELV Cost Variation

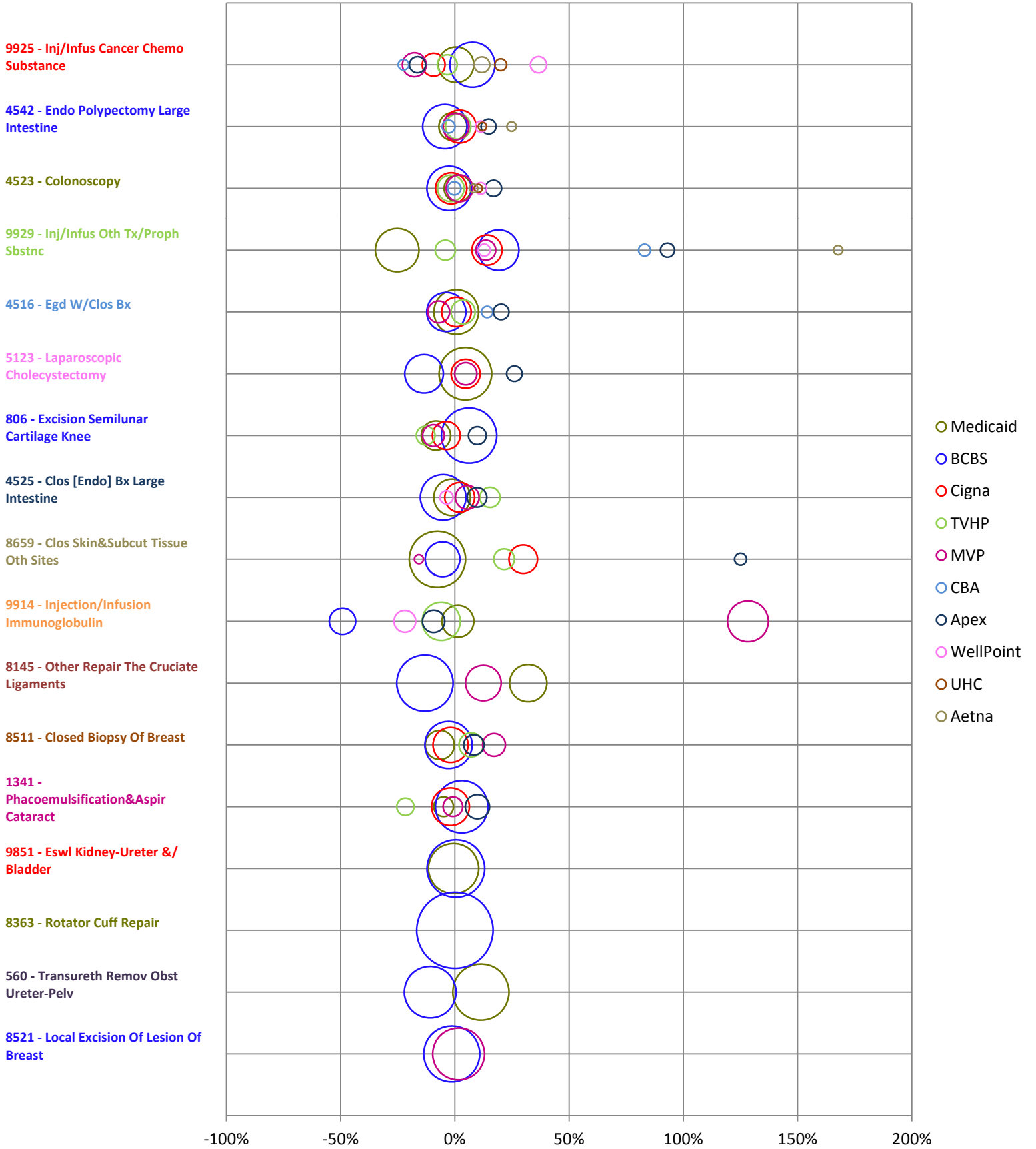


FY2012 Hospital Outpatient ICD-9 Procedure 8521 - LOCAL EXCISION OF LESION OF BREAST Cost Variation

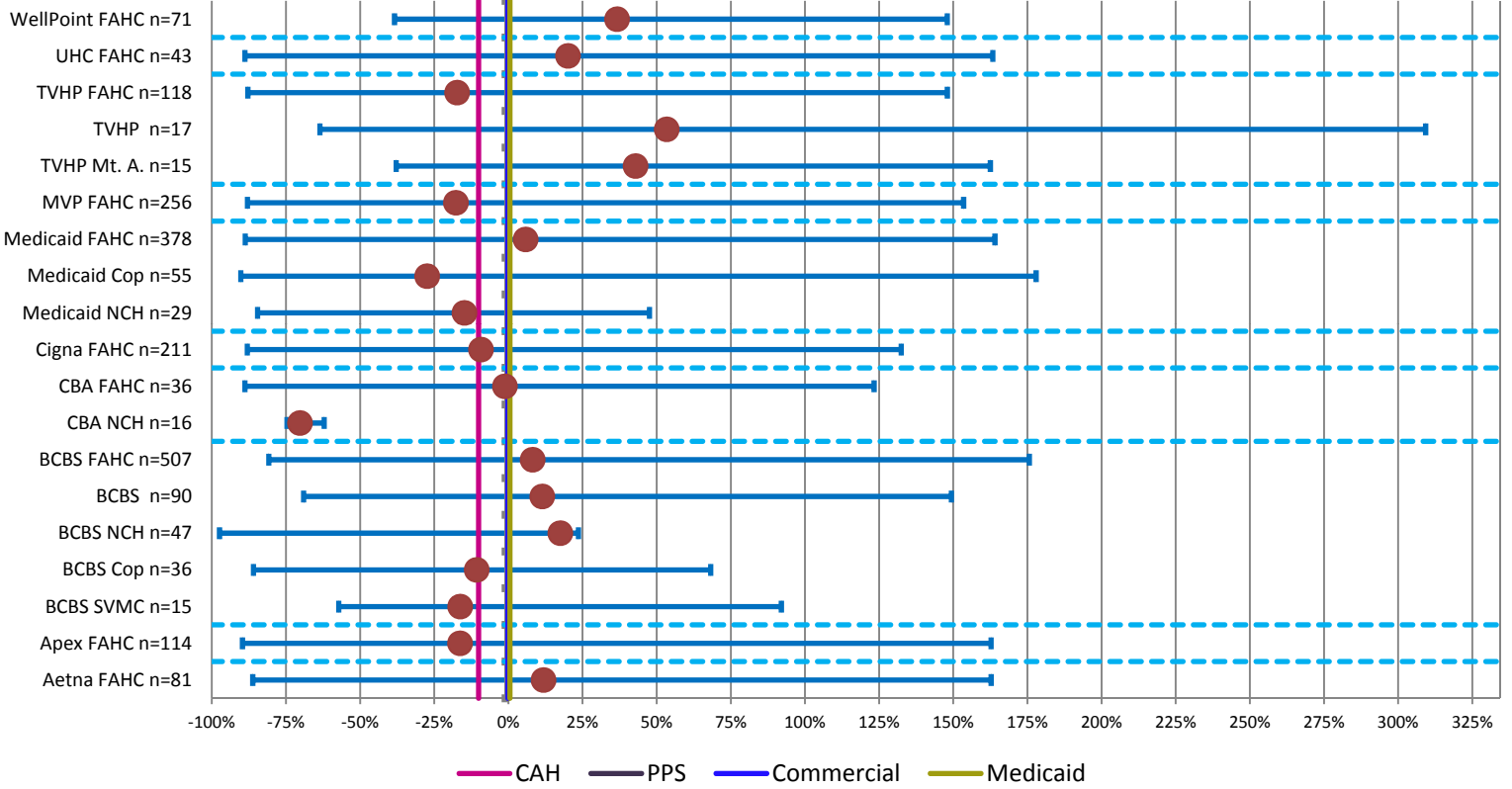


FY2012 Hospital Outpatient ICD-9 Procedure Charge Variation

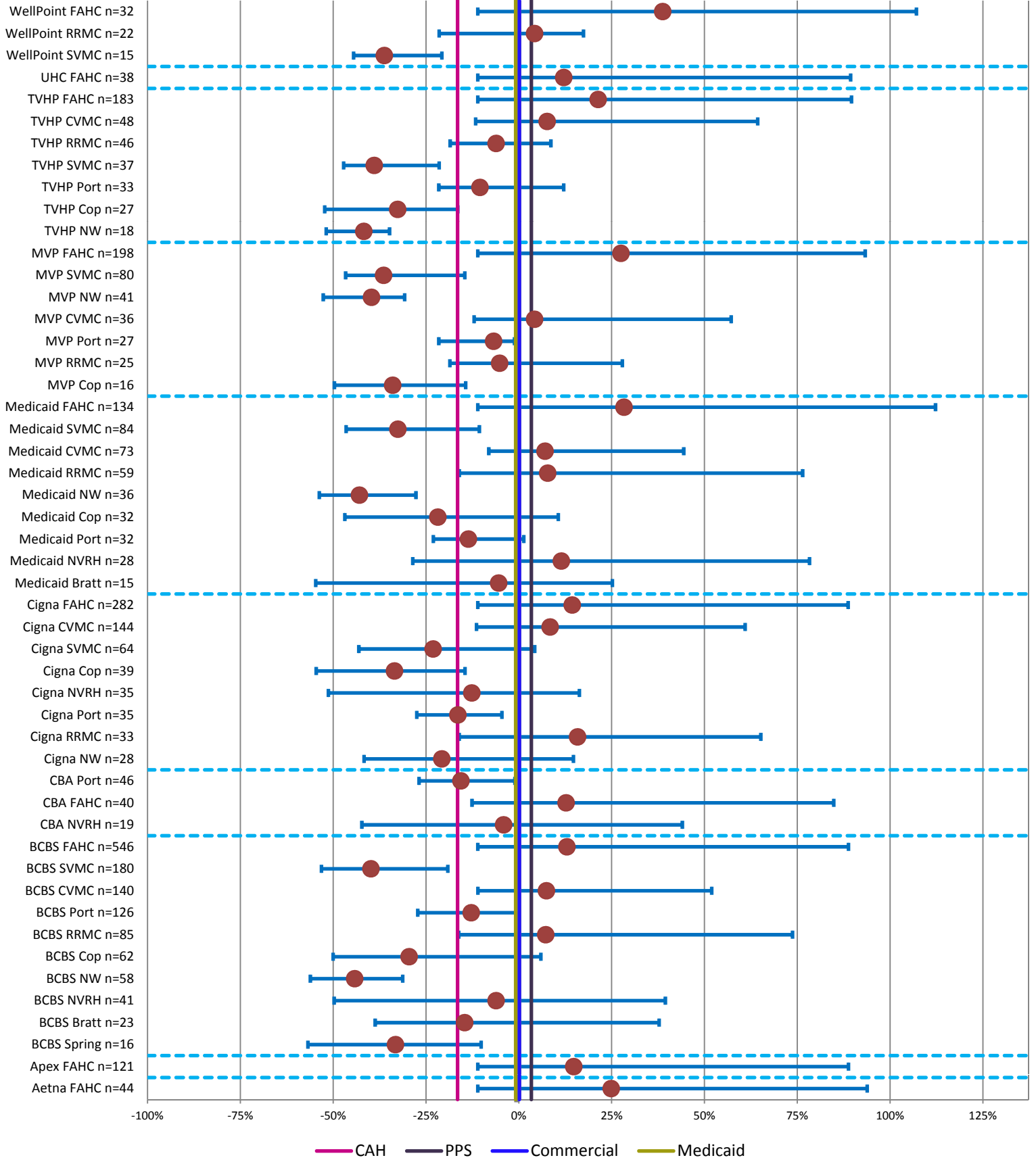
FY2012 Hospital Outpatient ICD-9 Procedure Charge Variation (Min 15 Visits)



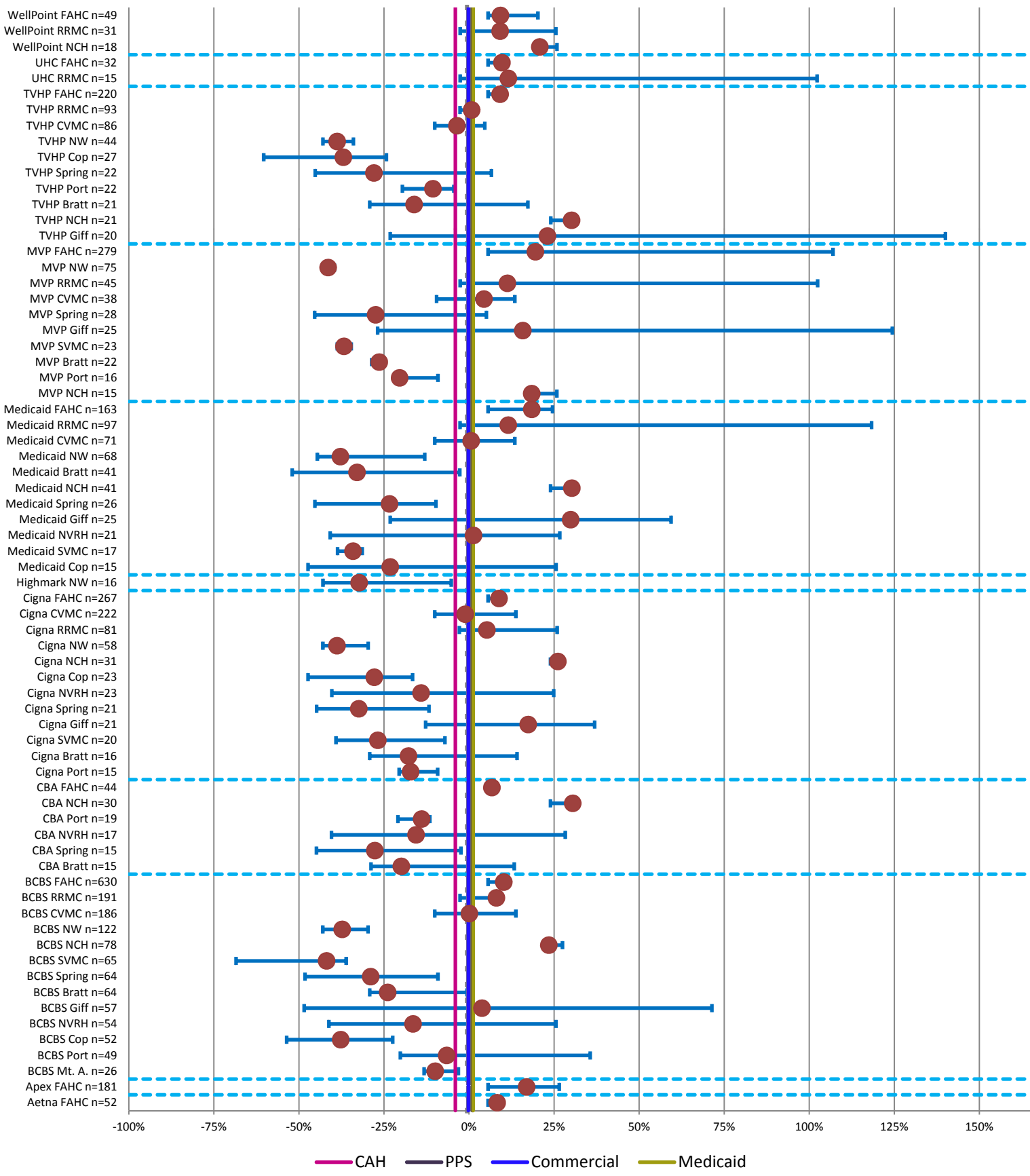
FY2012 Hospital Outpatient ICD-9 Procedure 9925 - INJ/INFUS CANCER CHEMO SUBSTANCE Charge Variation



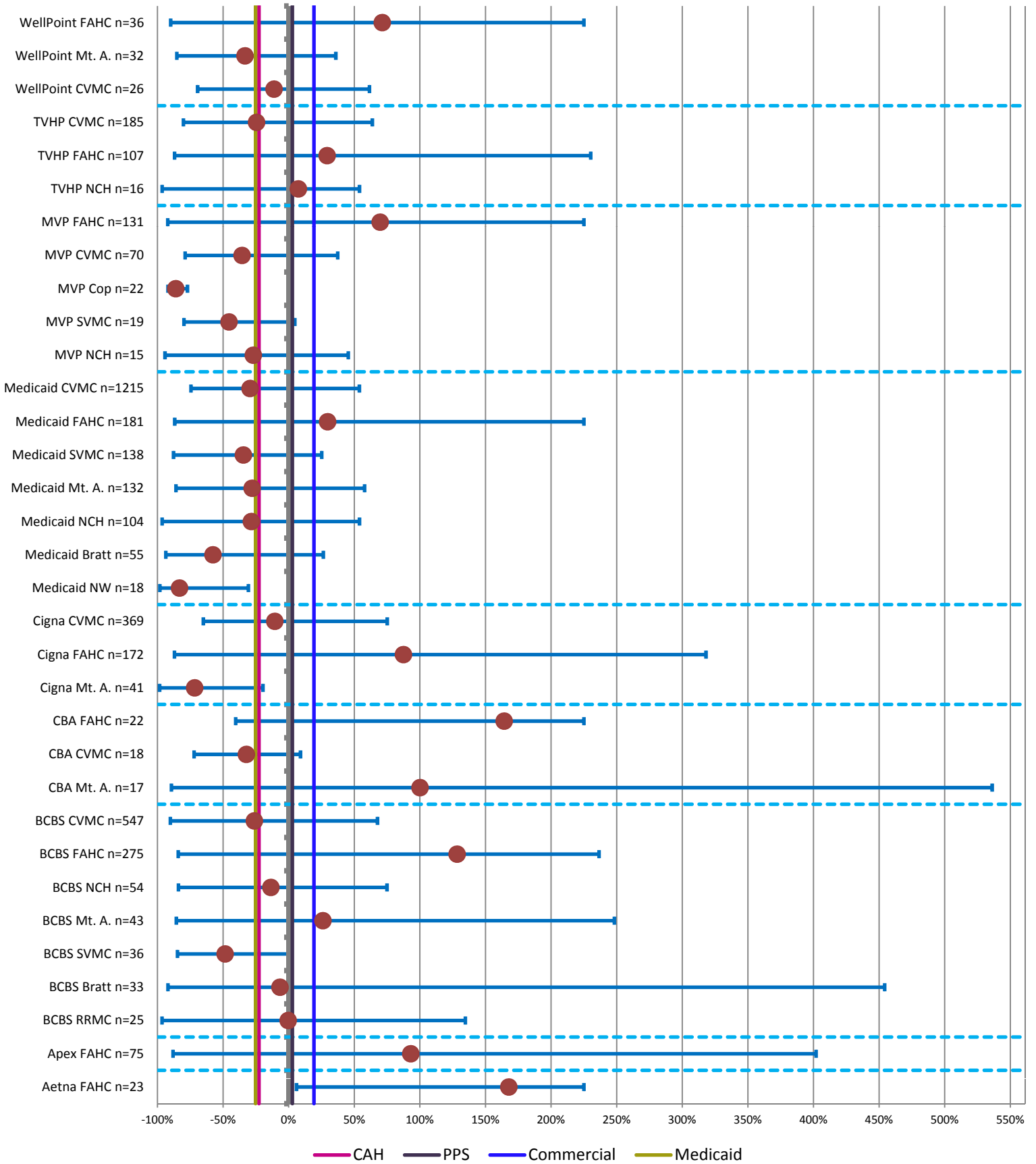
FY2012 Hospital Outpatient ICD-9 Procedure 4542 - ENDO POLYPECTOMY LARGE INTESTINE Charge Variation



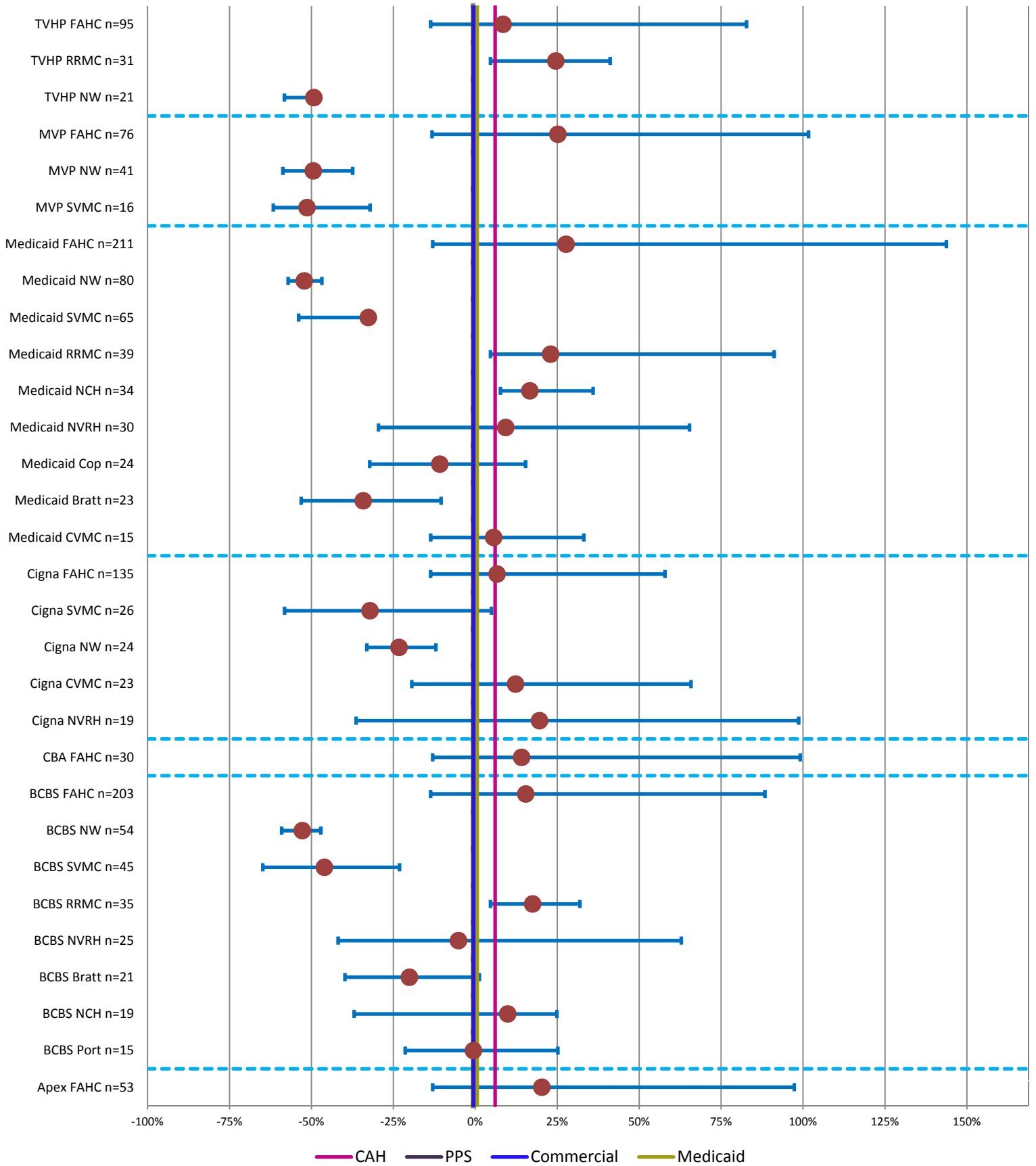
FY2012 Hospital Outpatient ICD-9 Procedure 4523 - COLONOSCOPY Charge Variation



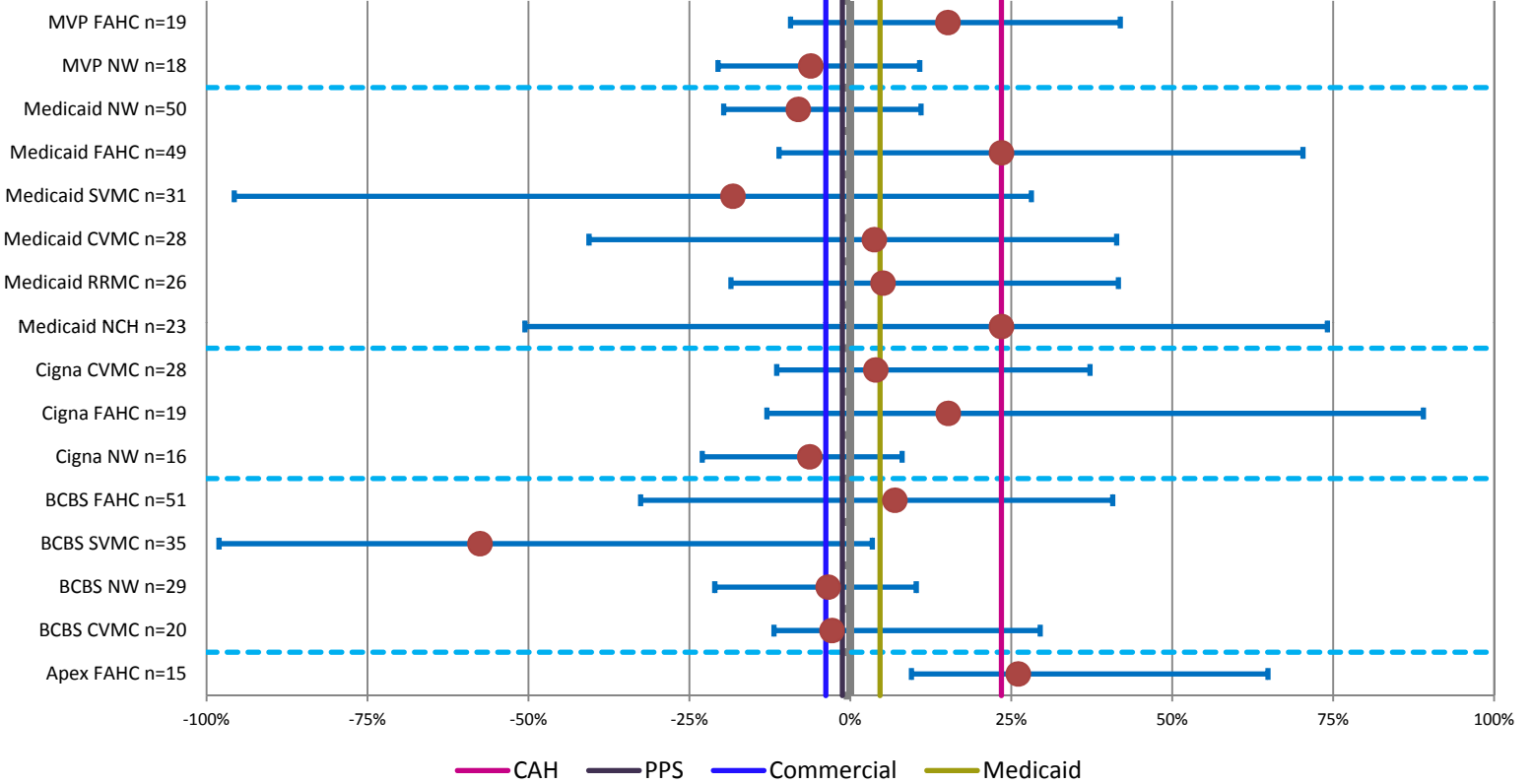
FY2012 Hospital Outpatient ICD-9 Procedure 9929 - INJ/INFUS OTH TX/PROPH SBSTNC Charge Variation



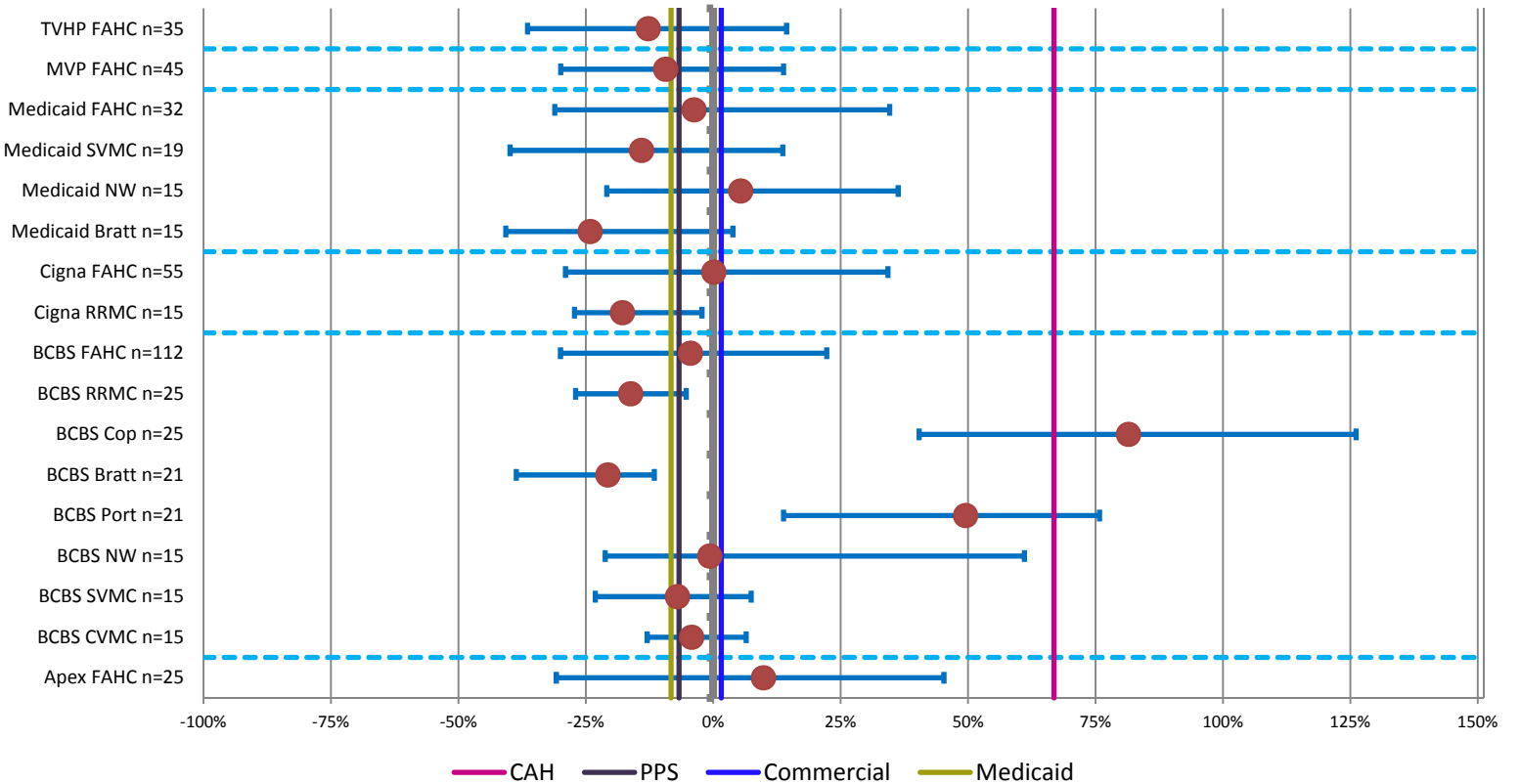
FY2012 Hospital Outpatient ICD-9 Procedure 4516 - EGD W/CLOS BX Charge Variation



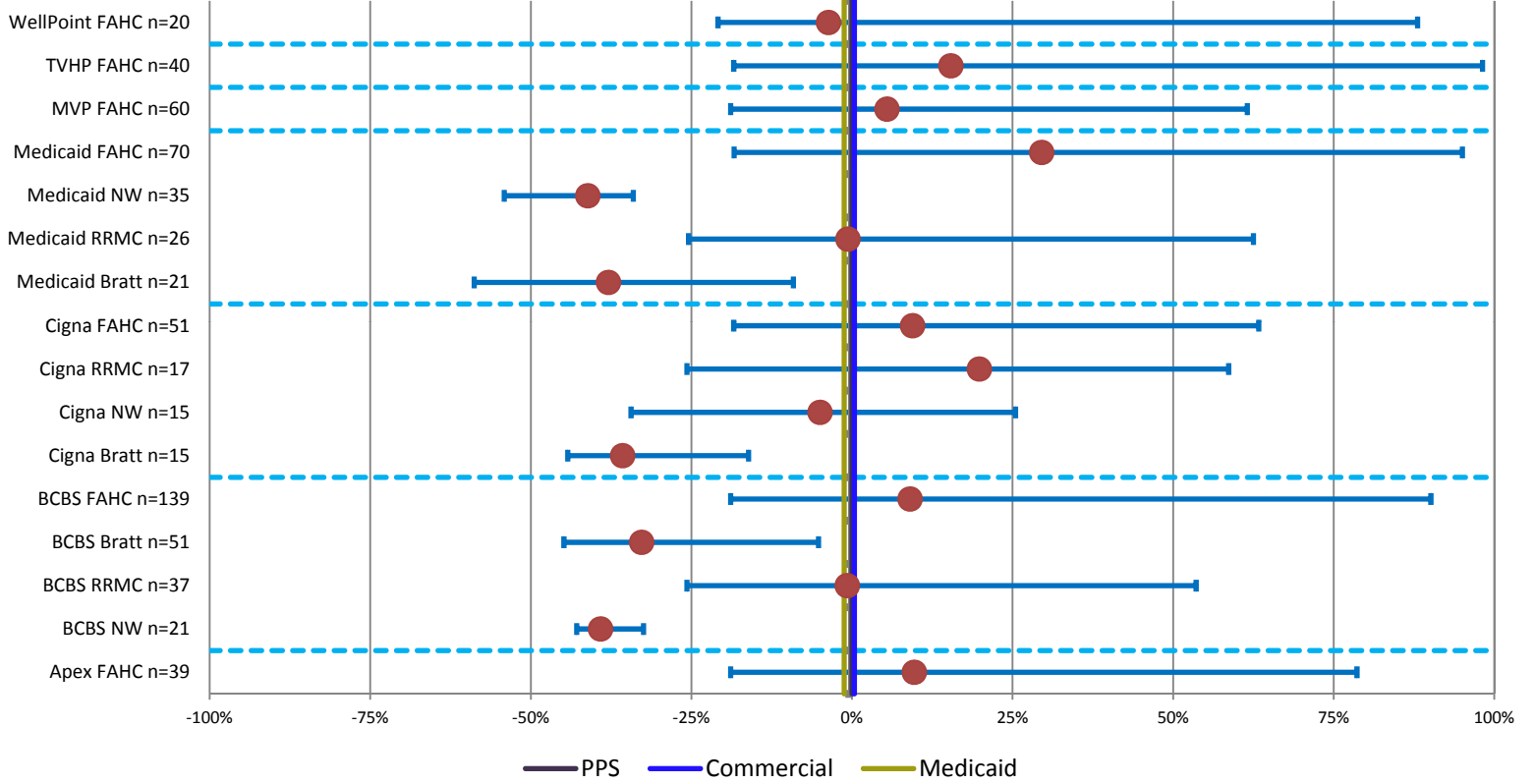
FY2012 Hospital Outpatient ICD-9 Procedure 5123 - LAPAROSCOPIC CHOLECYSTECTOMY Charge Variation



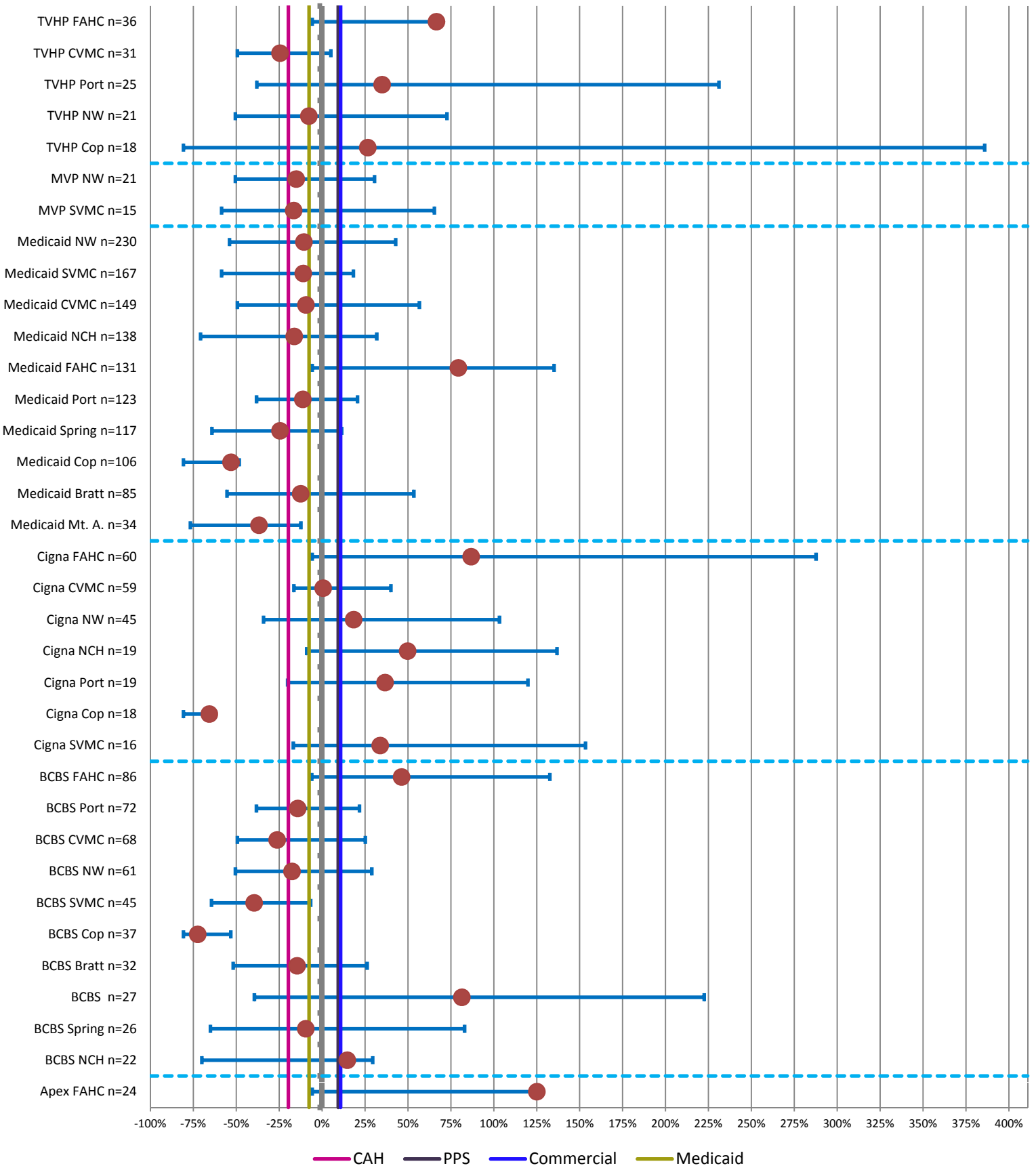
FY2012 Hospital Outpatient ICD-9 Procedure 806 - EXCISION SEMILUNAR CARTILAGE KNEE Charge Variation



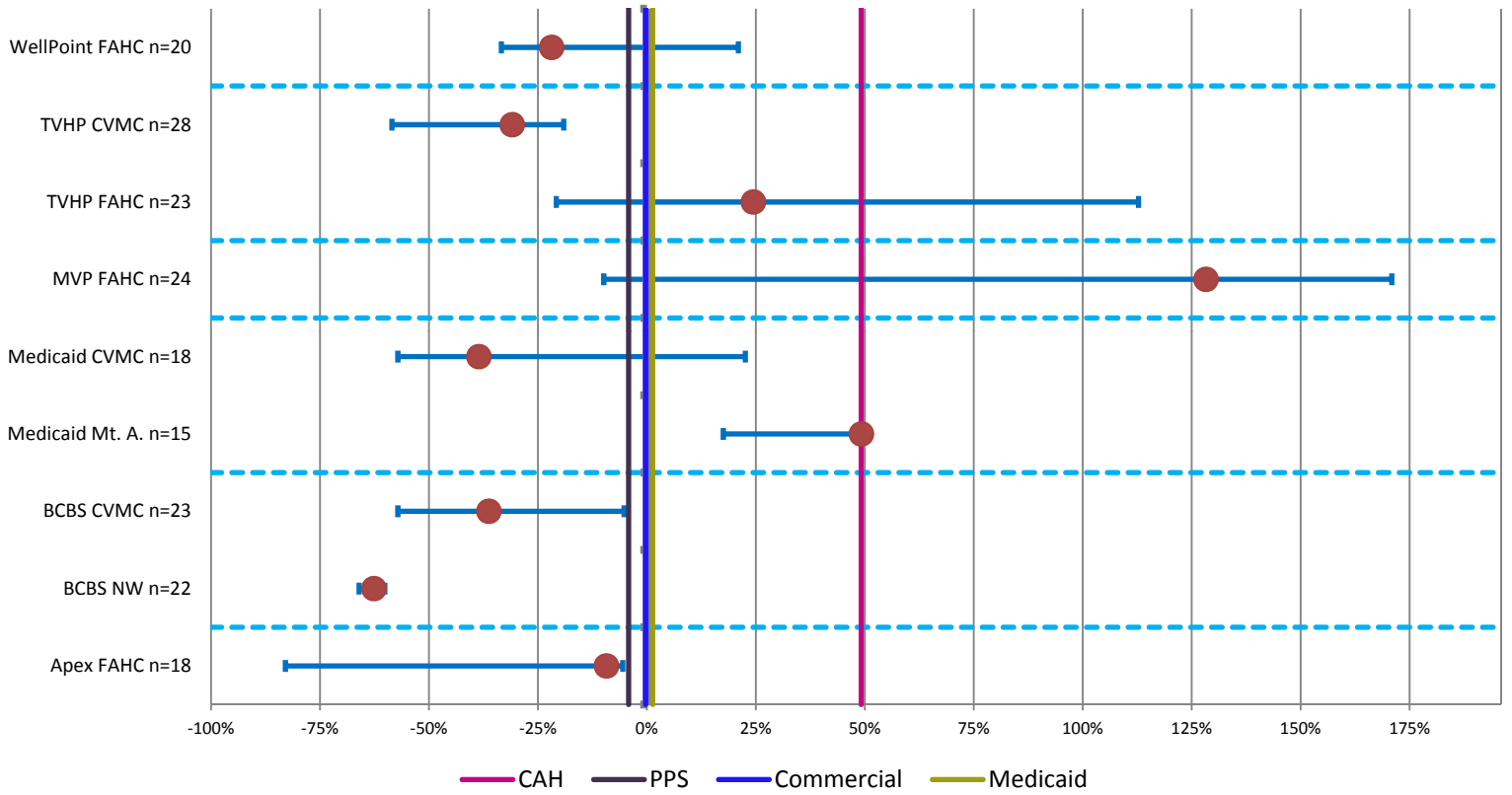
FY2012 Hospital Outpatient ICD-9 Procedure 4525 - CLOS [ENDO] BX LARGE INTESTINE Charge Variation



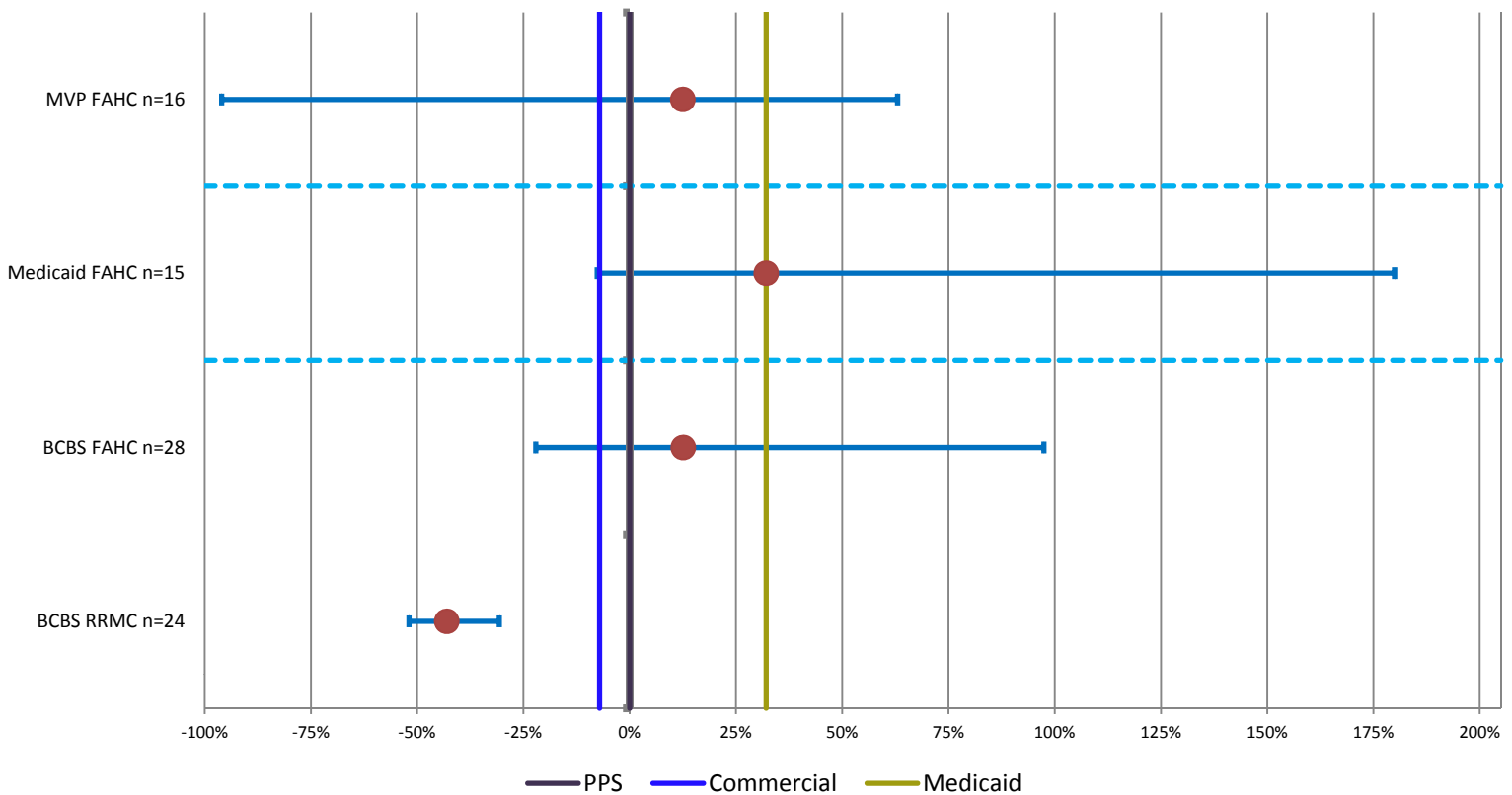
FY2012 Hospital Outpatient ICD-9 Procedure 8659 - CLOS SKIN&SUBCUT TISSUE OTH SITES Charge Variation



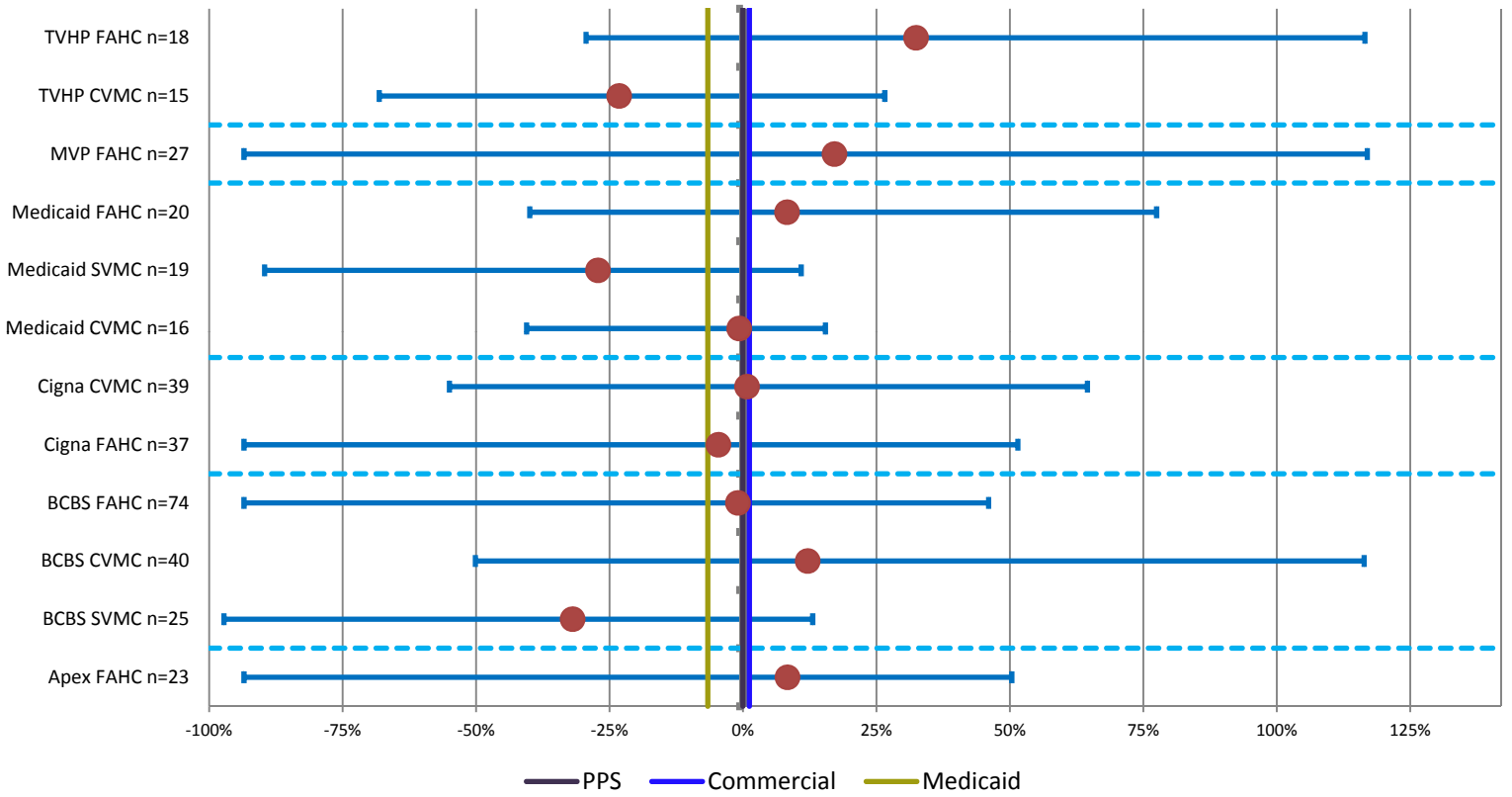
FY2012 Hospital Outpatient ICD-9 Procedure 9914 - INJECTION/INFUSION IMMUNOGLOBULIN Charge Variation



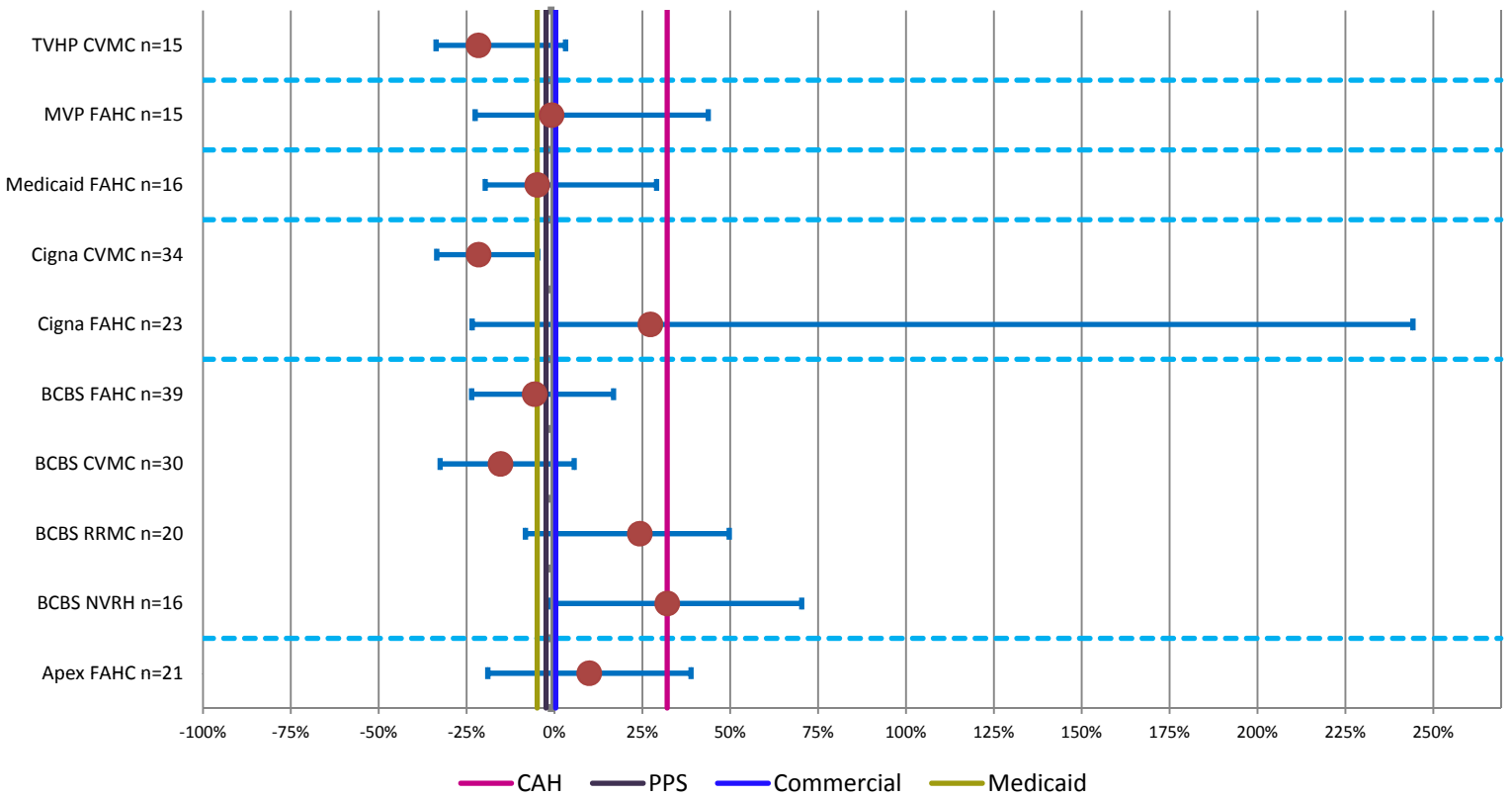
FY2012 Hospital Outpatient ICD-9 Procedure 8145 - OTHER REPAIR THE CRUCIATE LIGAMENTS Charge Variation



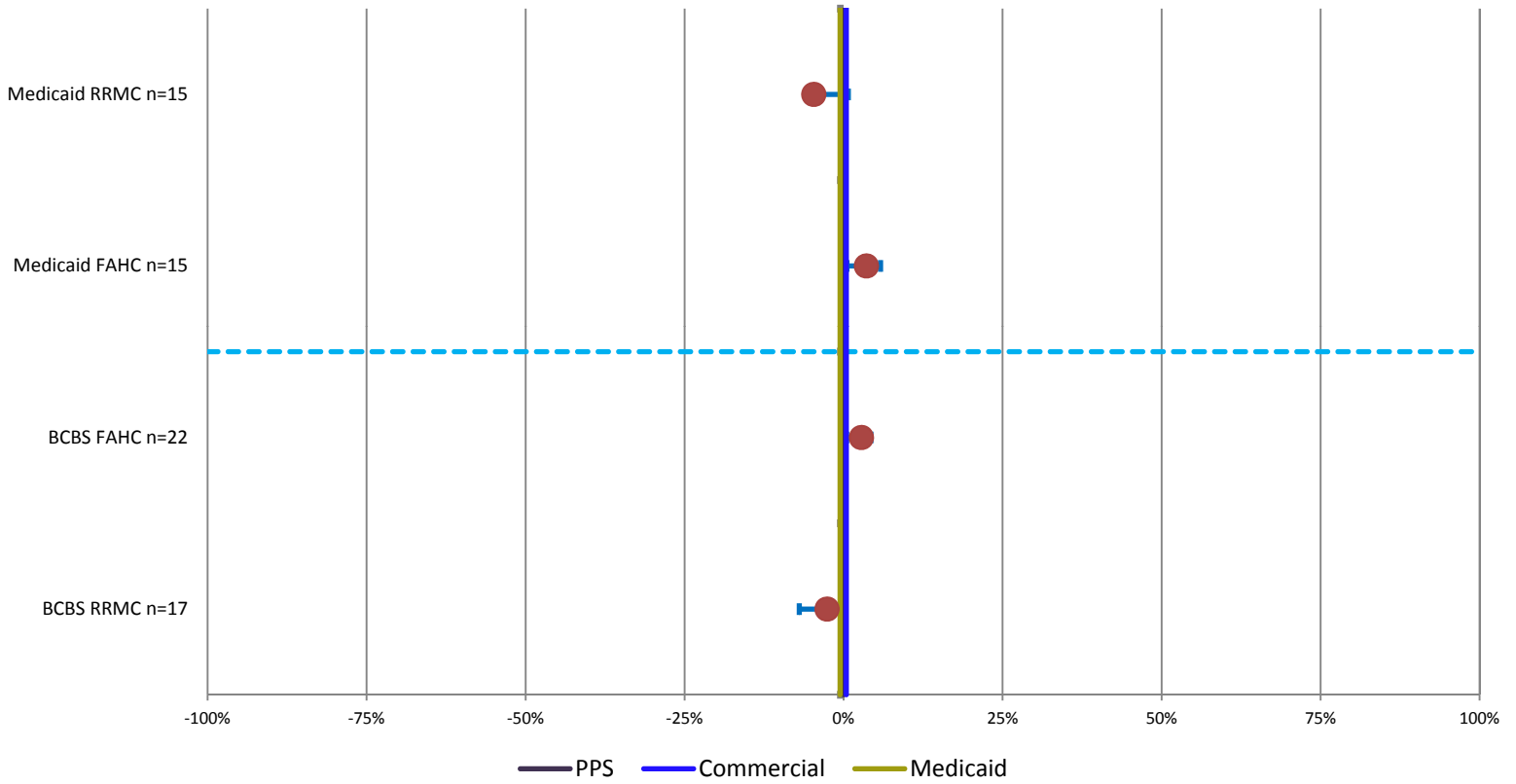
FY2012 Hospital Outpatient ICD-9 Procedure 8511 - CLOSED BIOPSY OF BREAST Charge Variation



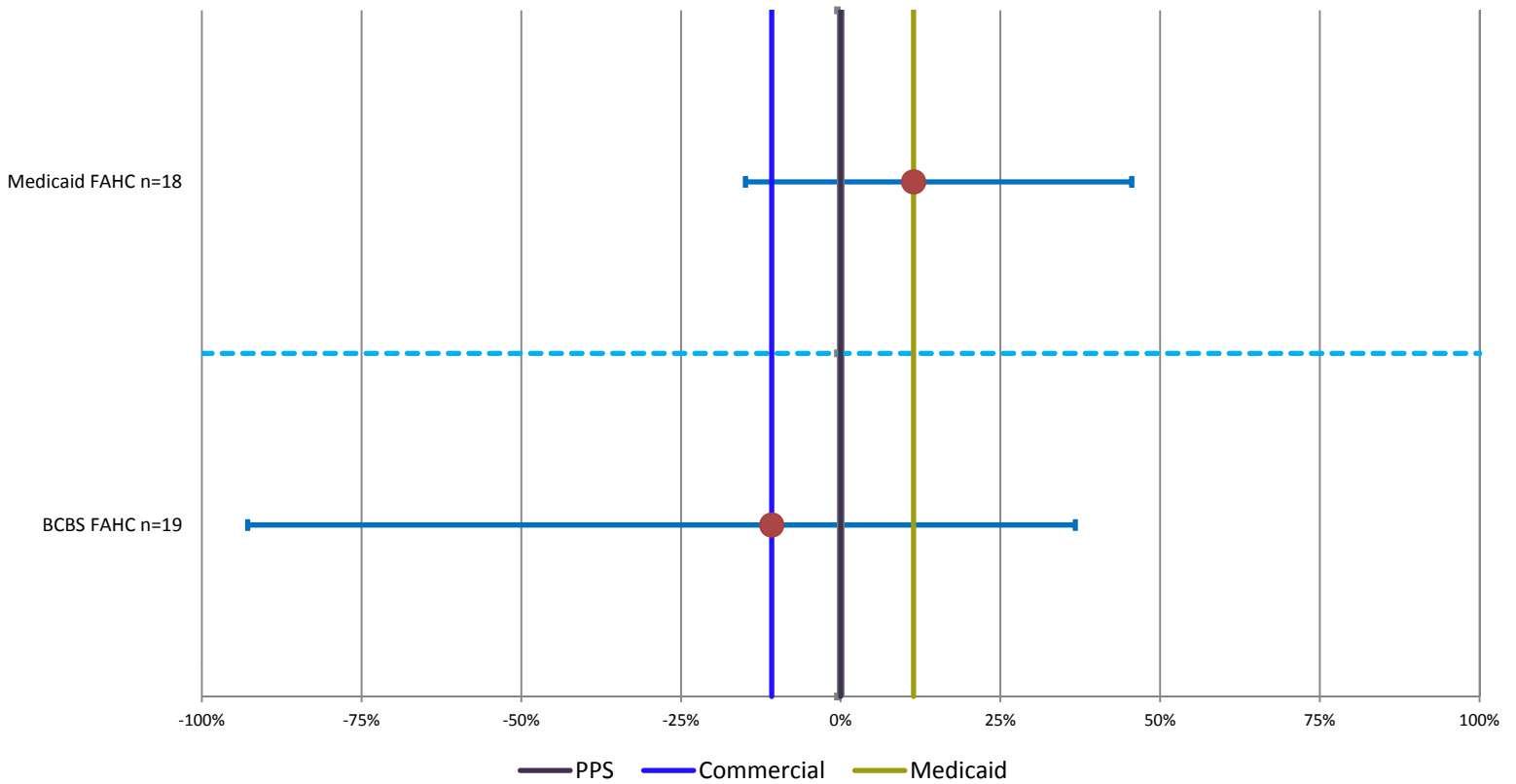
FY2012 Hospital Outpatient ICD-9 Procedure 1341 - PHACOEMULSIFICATION&ASPIR CATARACT Charge Variation



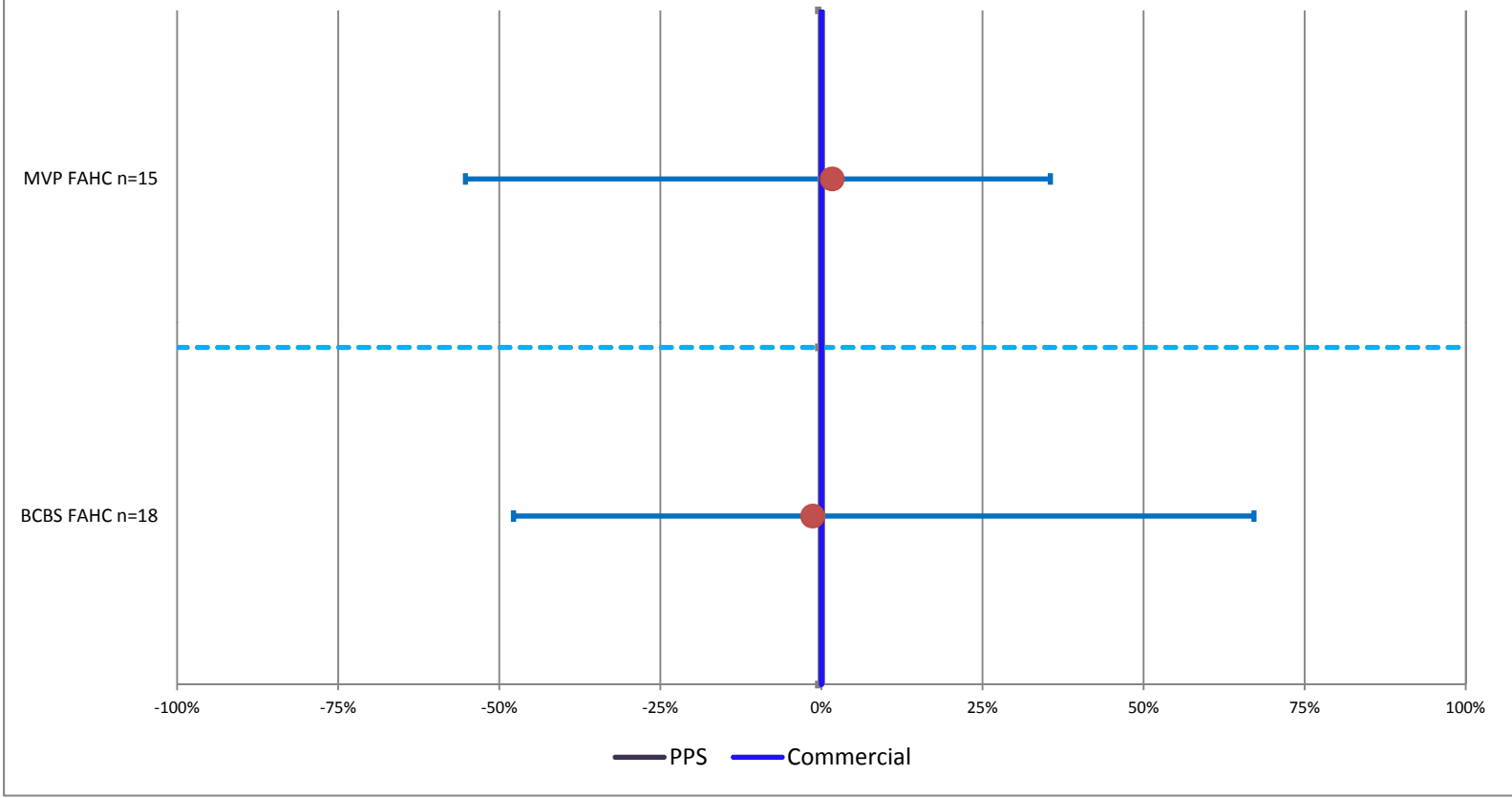
FY2012 Hospital Outpatient ICD-9 Procedure 9851 - ESWL KIDNEY-URETER &/ BLADDER Charge Variation



FY2012 Hospital Outpatient ICD-9 Procedure 560 - TRANSURETH REMOV OBST URETER-PELV Charge Variation

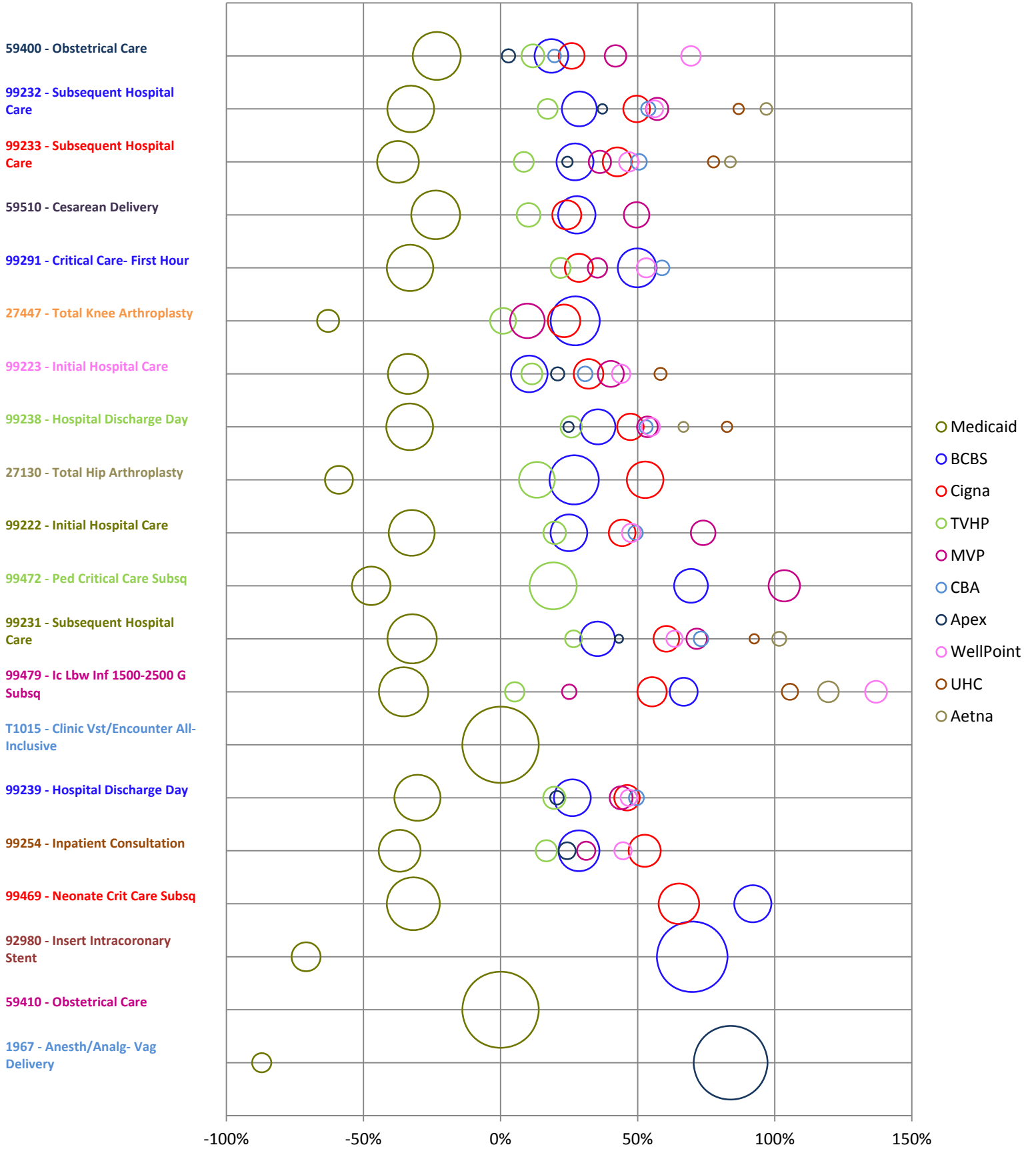


FY2012 Hospital Outpatient ICD-9 Procedure 8521 - LOCAL EXCISION OF LESION OF BREAST Charge Variation

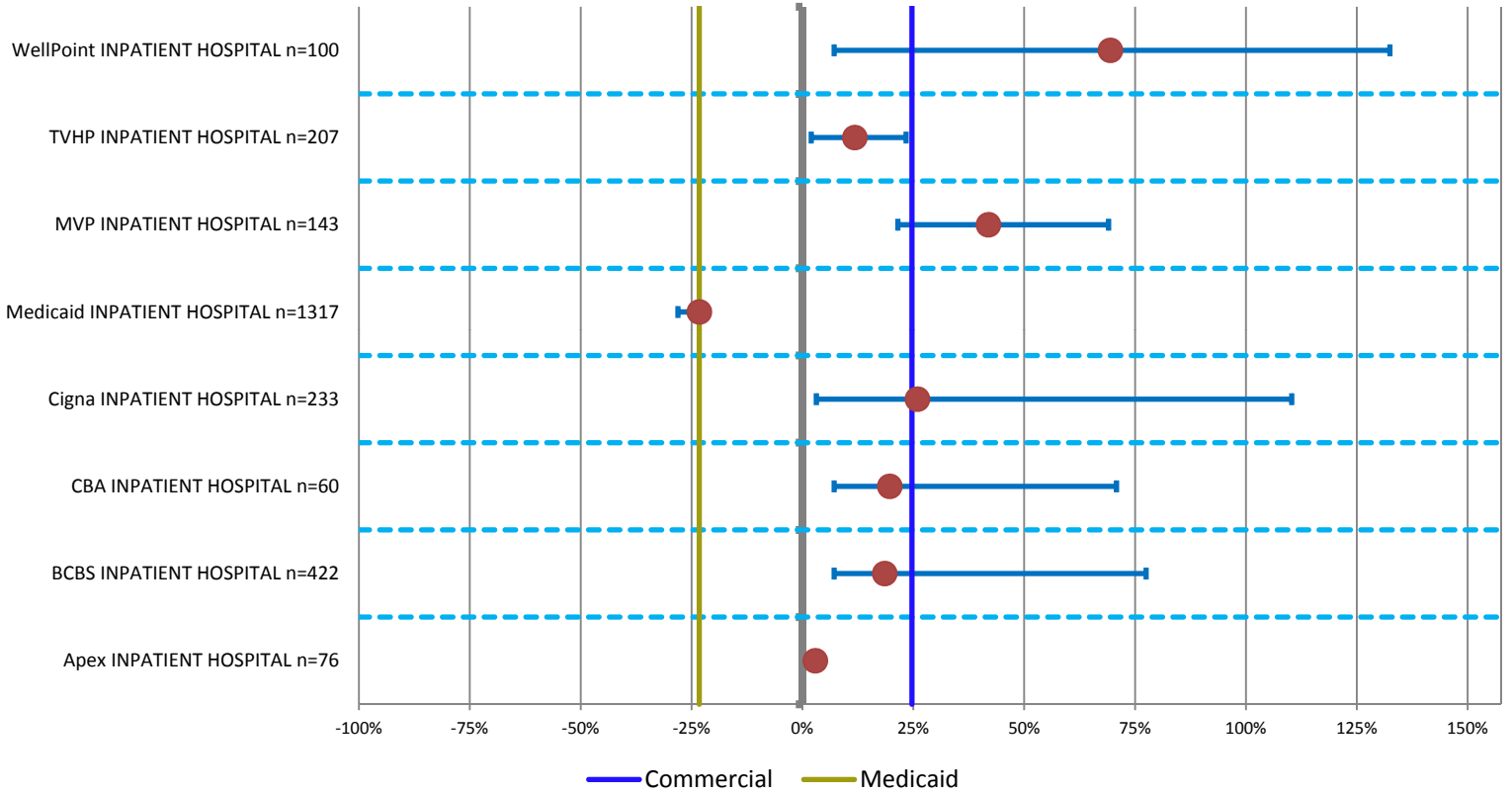


FY2012 Inpatient Hospital Professional Allowed Payment Amount Variation

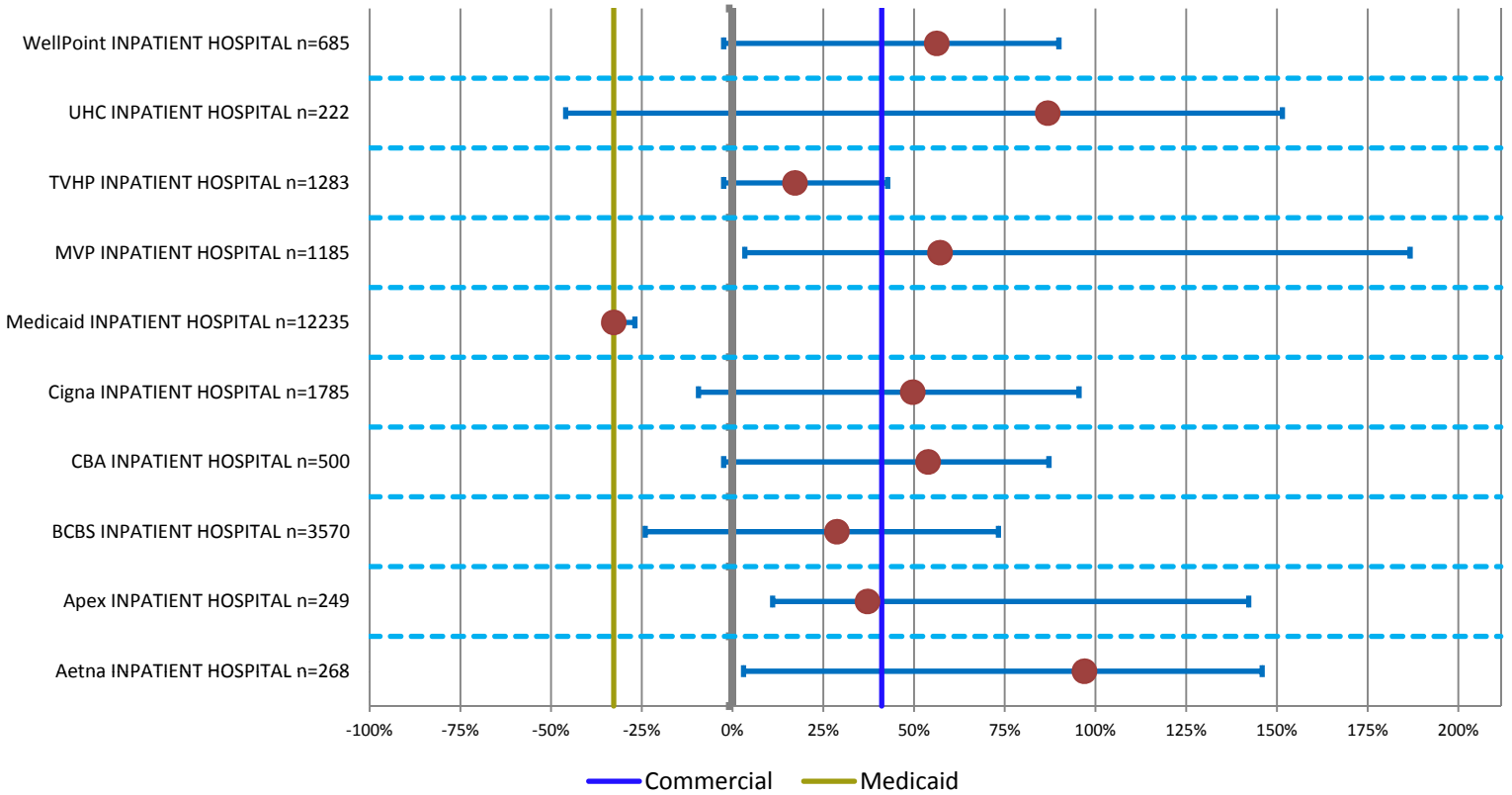
FY2012 Inpatient Hospital Professional Allowed Payment Amount Variation (Min 50 Discharges)



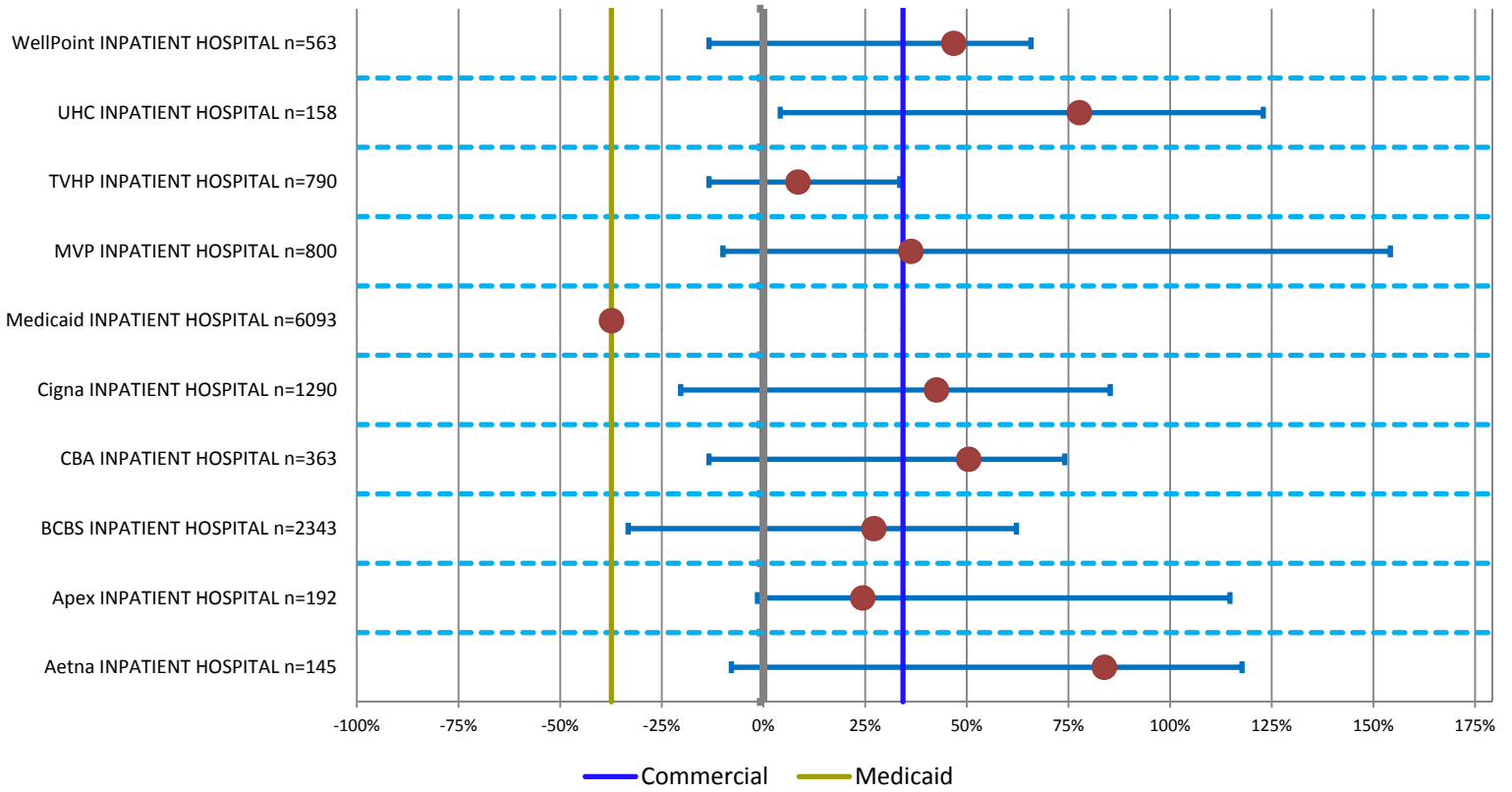
FY2012 Inpatient Professional 59400 - OBSTETRICAL CARE Allowed Payment Amount Variation



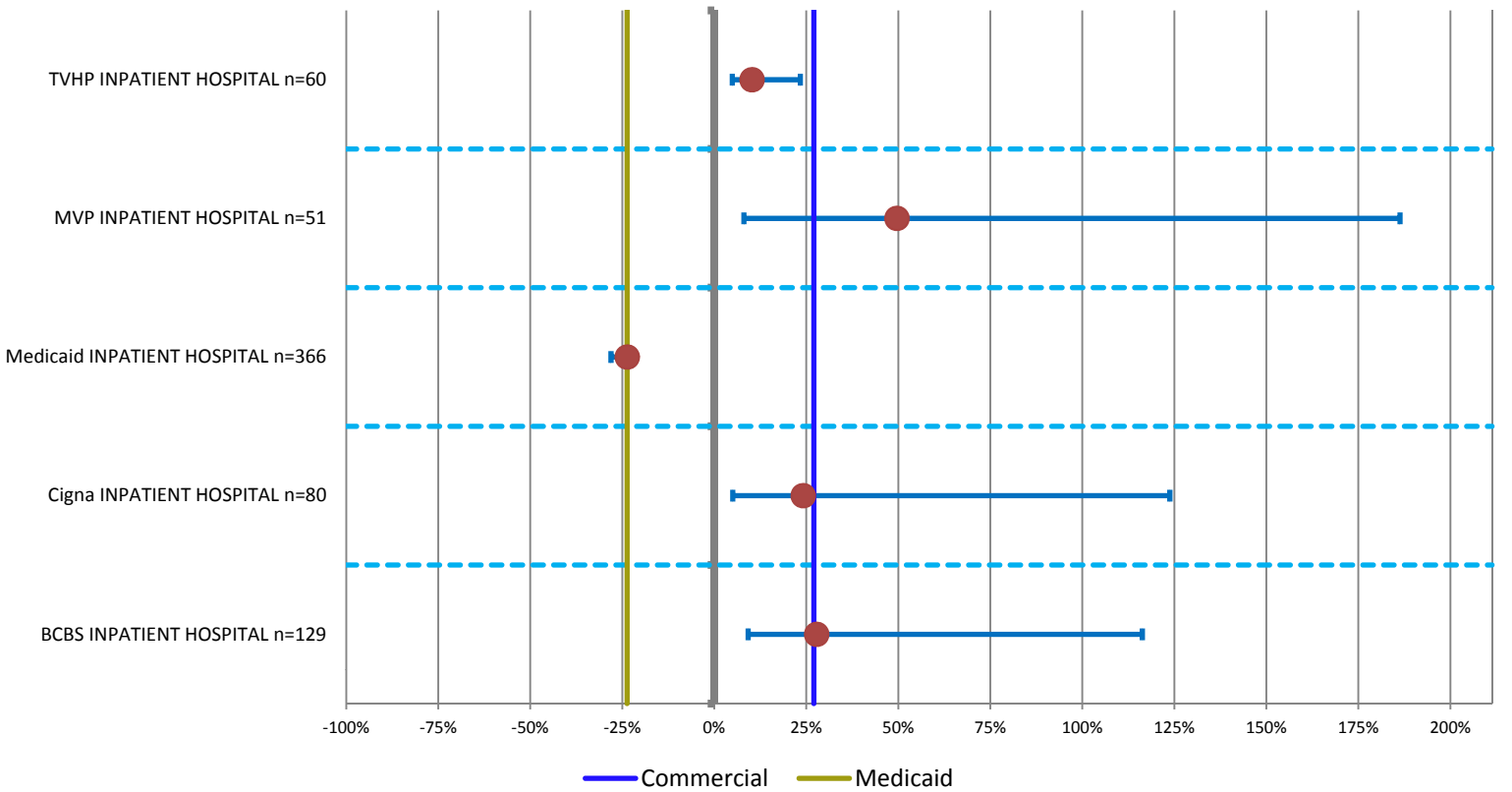
FY2012 Inpatient Professional 99232 - SUBSEQUENT HOSPITAL CARE Allowed Payment Amount Variation



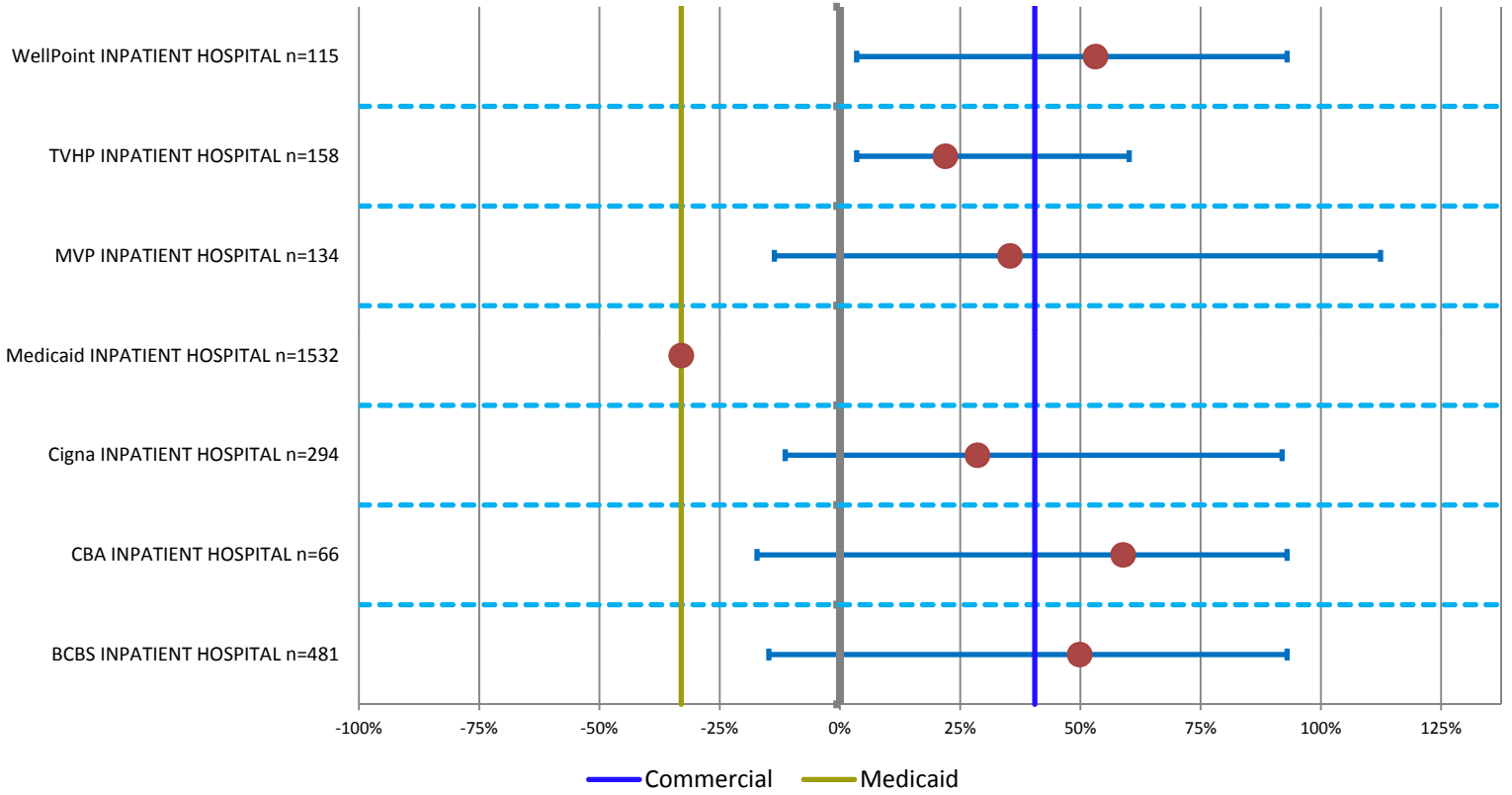
FY2012 Inpatient Professional 99233 - SUBSEQUENT HOSPITAL CARE Allowed Payment Amount Variation



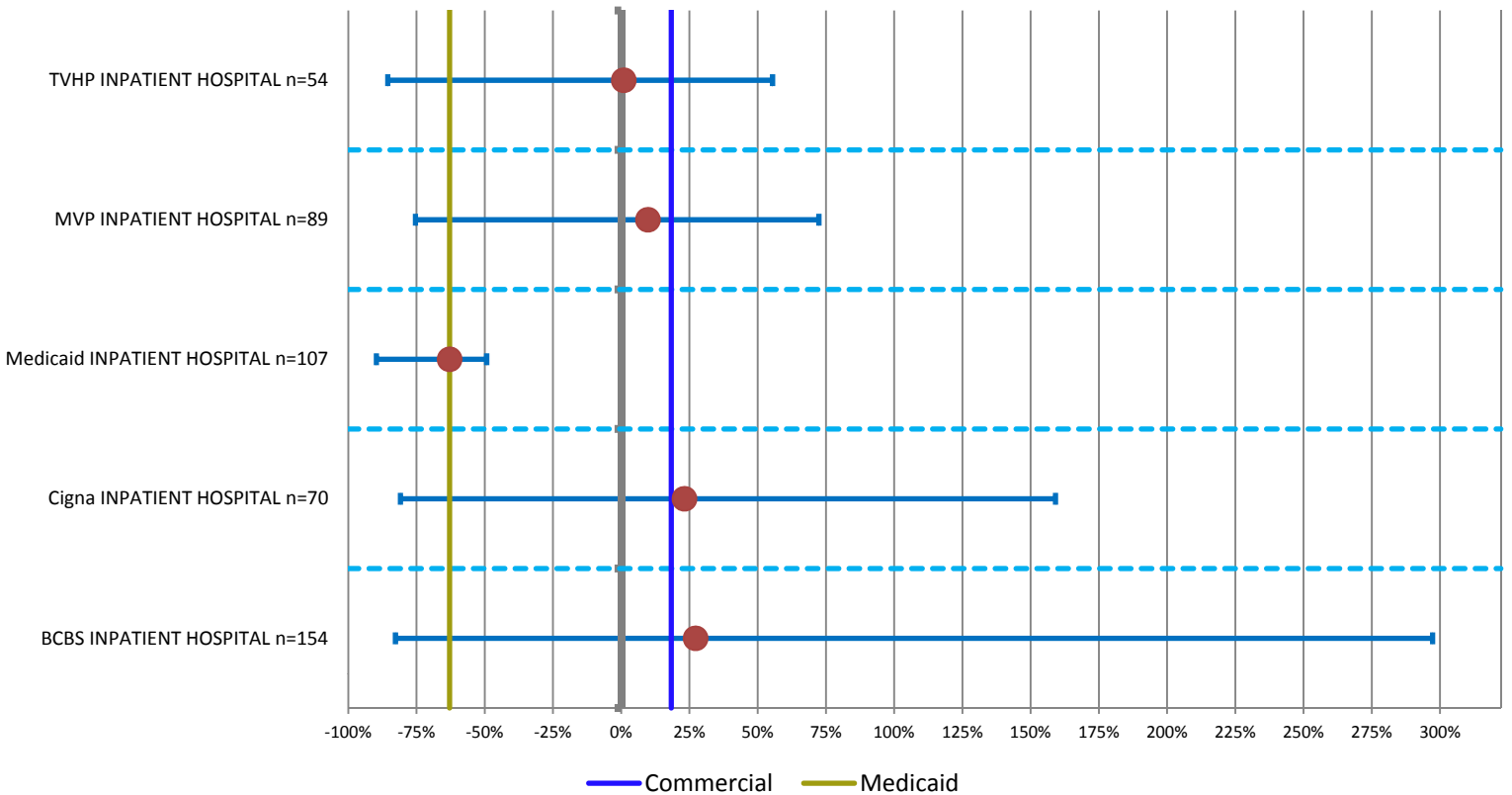
FY2012 Inpatient Professional 59510 - CESAREAN DELIVERY Allowed Payment Amount Variation



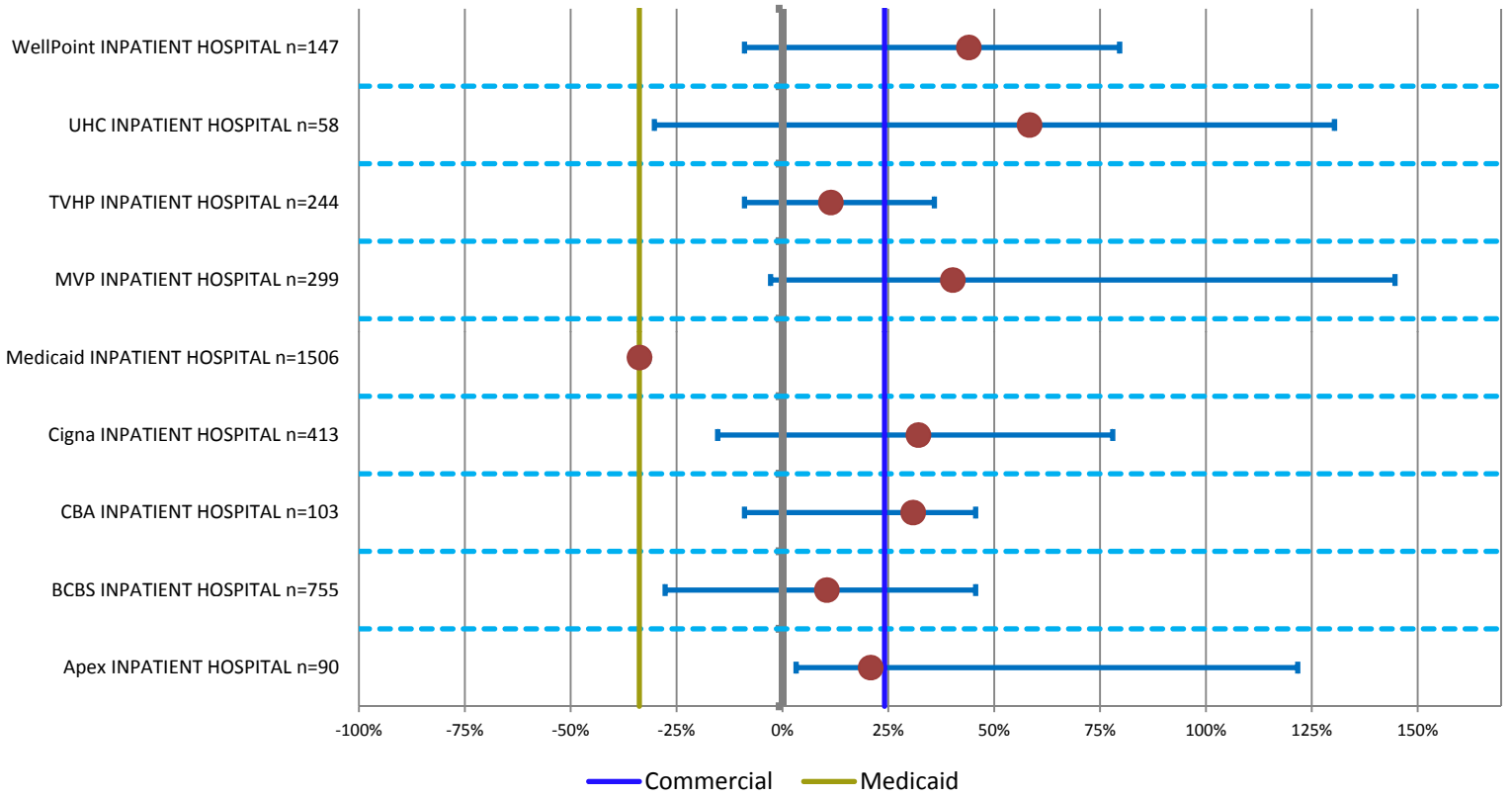
FY2012 Inpatient Professional 99291 - CRITICAL CARE- FIRST HOUR Allowed Payment Amount Variation



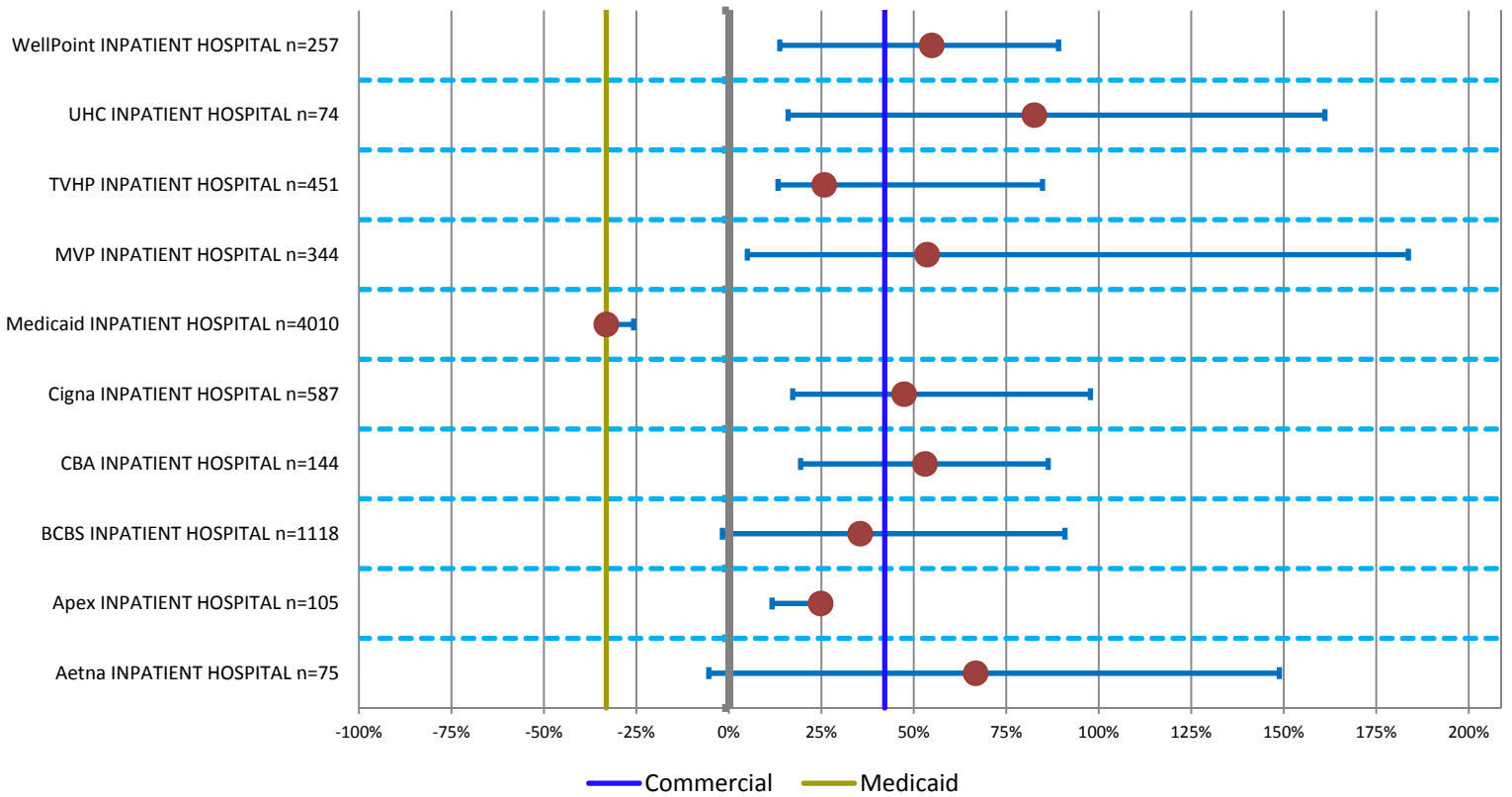
FY2012 Inpatient Professional 27447 - TOTAL KNEE ARTHROPLASTY Allowed Payment Amount Variation



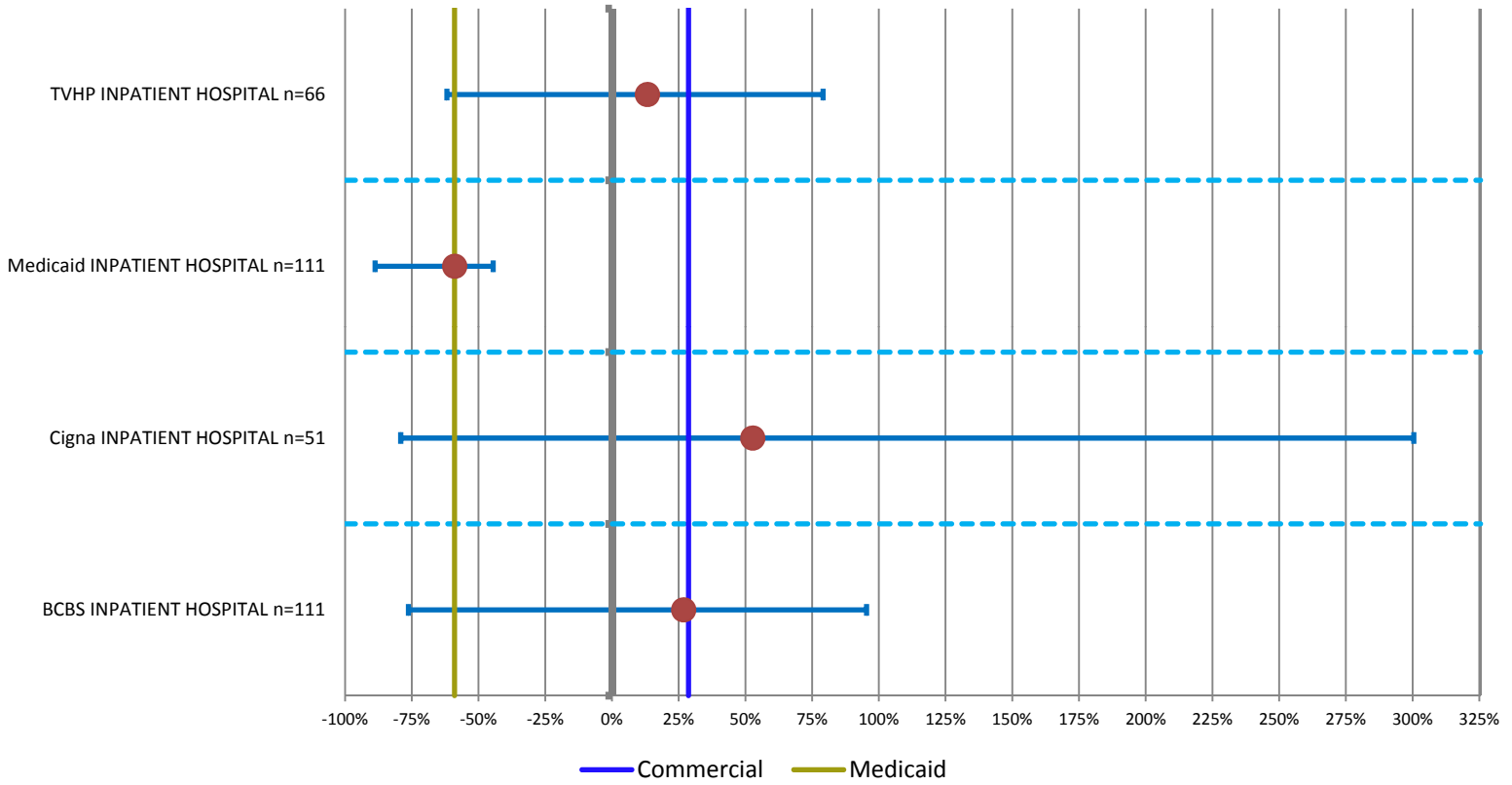
FY2012 Inpatient Professional 99223 - INITIAL HOSPITAL CARE Allowed Payment Amount Variation



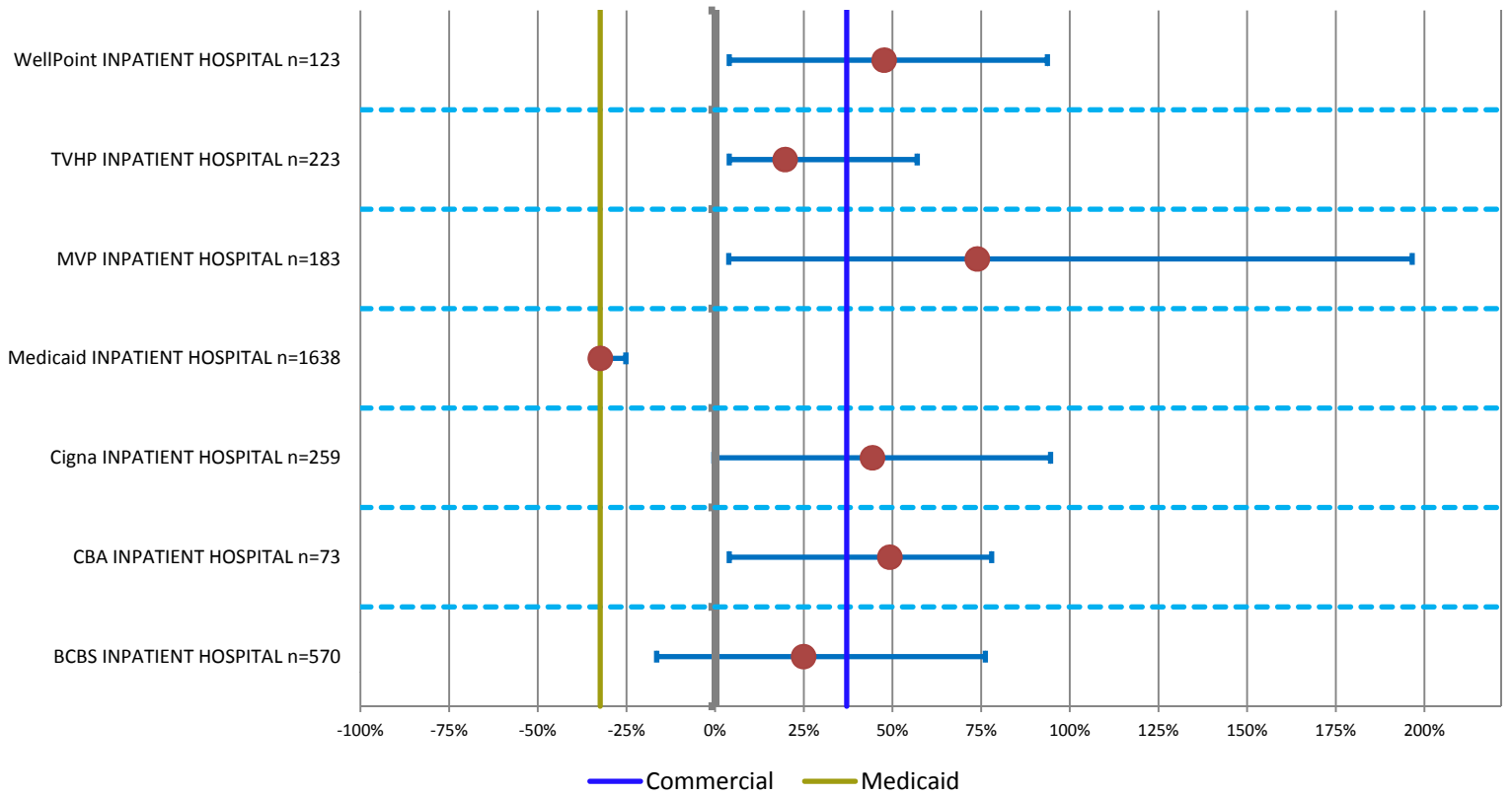
FY2012 Inpatient Professional 99238 - HOSPITAL DISCHARGE DAY Allowed Payment Amount Variation



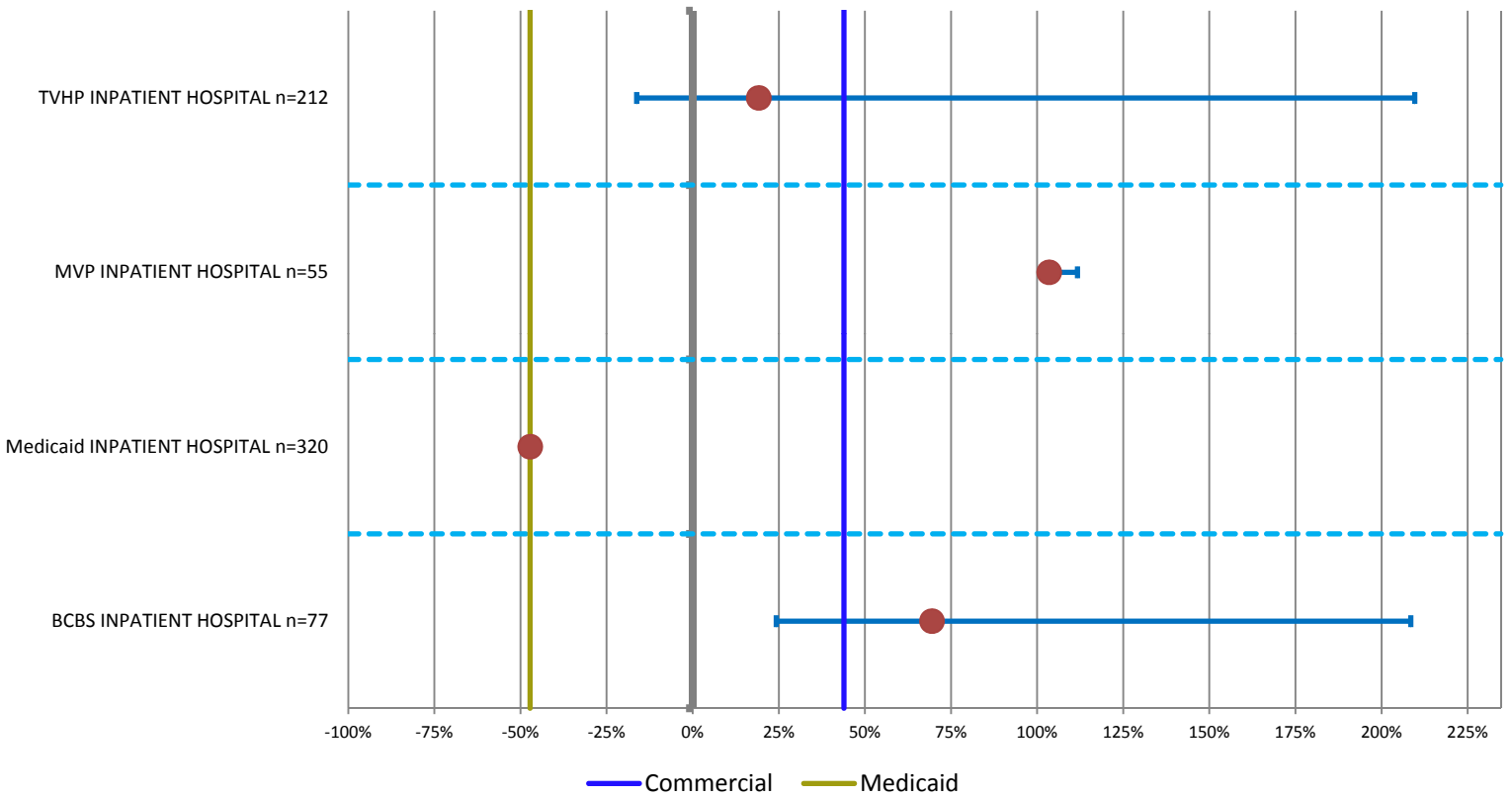
FY2012 Inpatient Professional 27130 - TOTAL HIP ARTHROPLASTY Allowed Payment Amount Variation



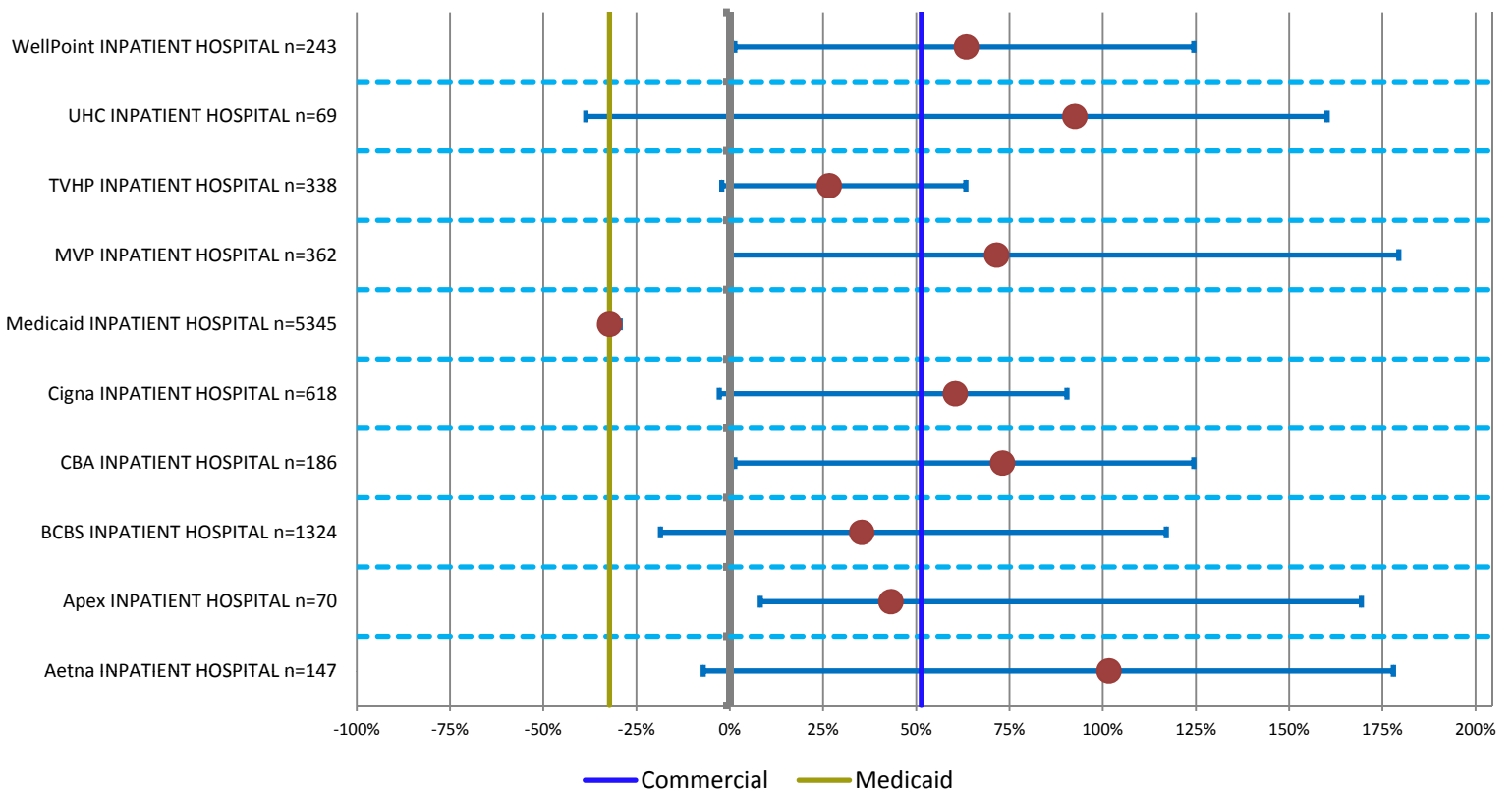
FY2012 Inpatient Professional 99222 - INITIAL HOSPITAL CARE Allowed Payment Amount Variation



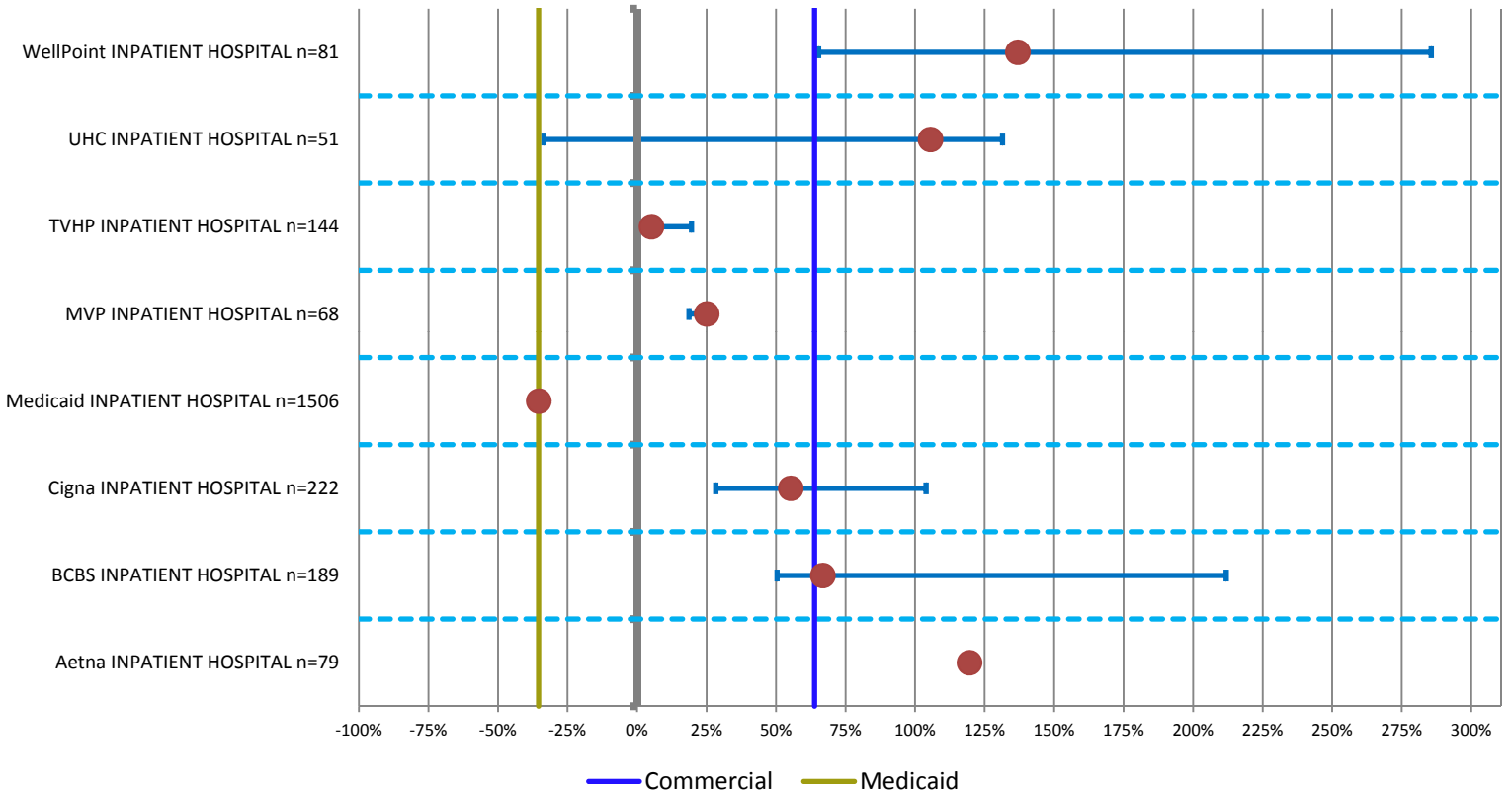
FY2012 Inpatient Professional 99472 - PED CRITICAL CARE SUBSQ Allowed Payment Amount Variation



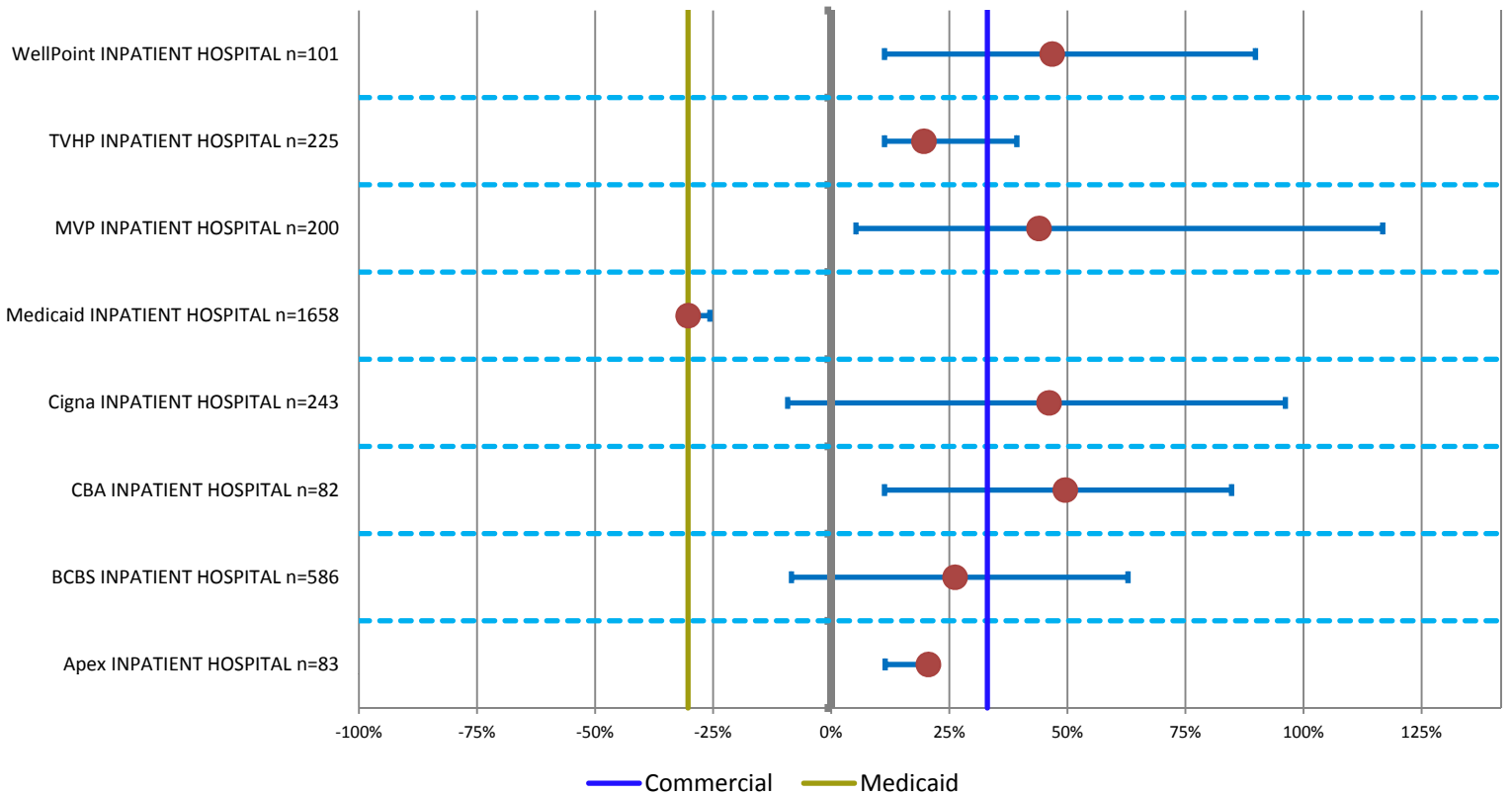
FY2012 Inpatient Professional 99231 - SUBSEQUENT HOSPITAL CARE Allowed Payment Amount Variation



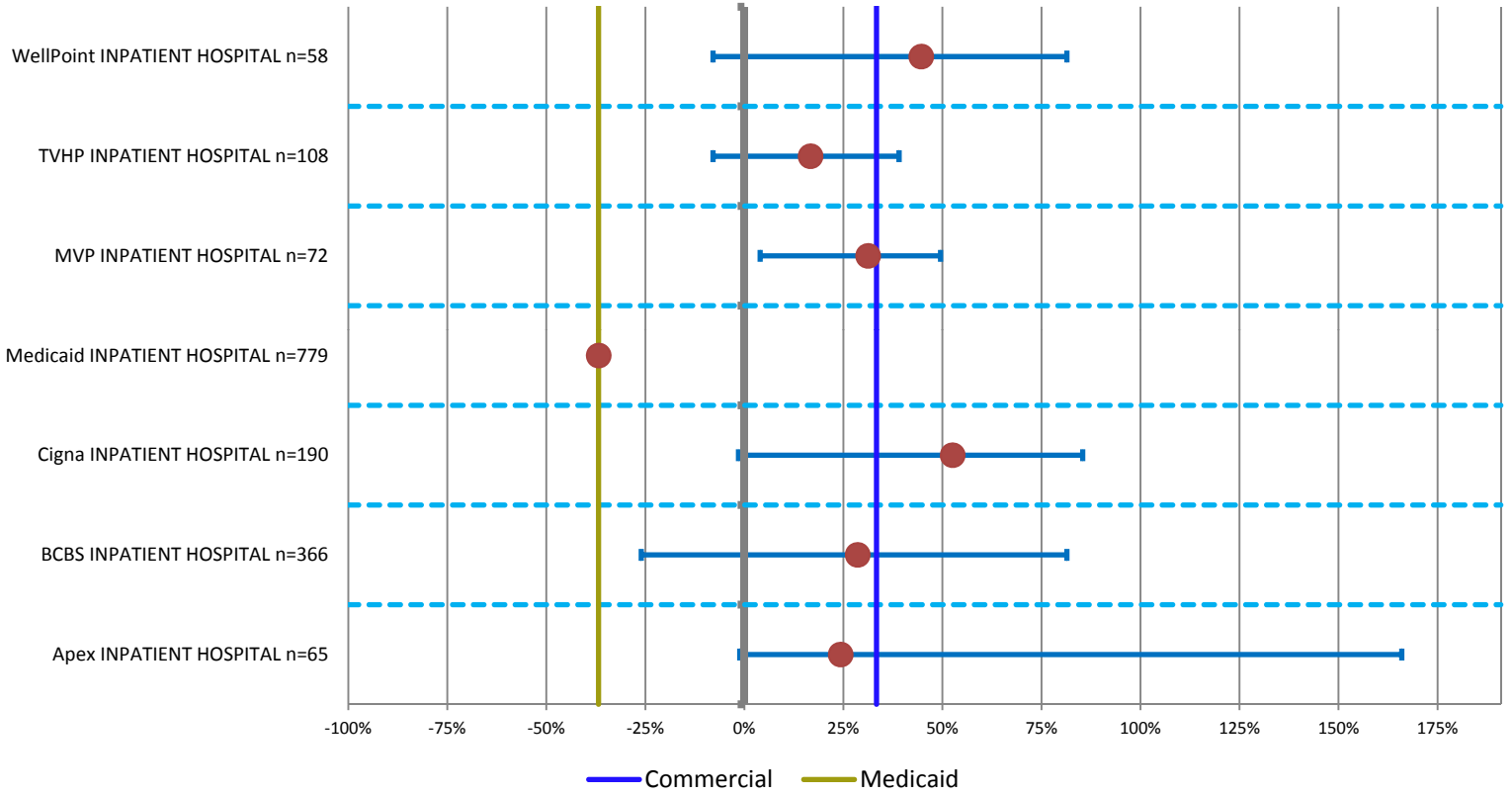
FY2012 Inpatient Professional 99479 - IC LBW INF 1500-2500 G SUBSQ Allowed Payment Amount Variation



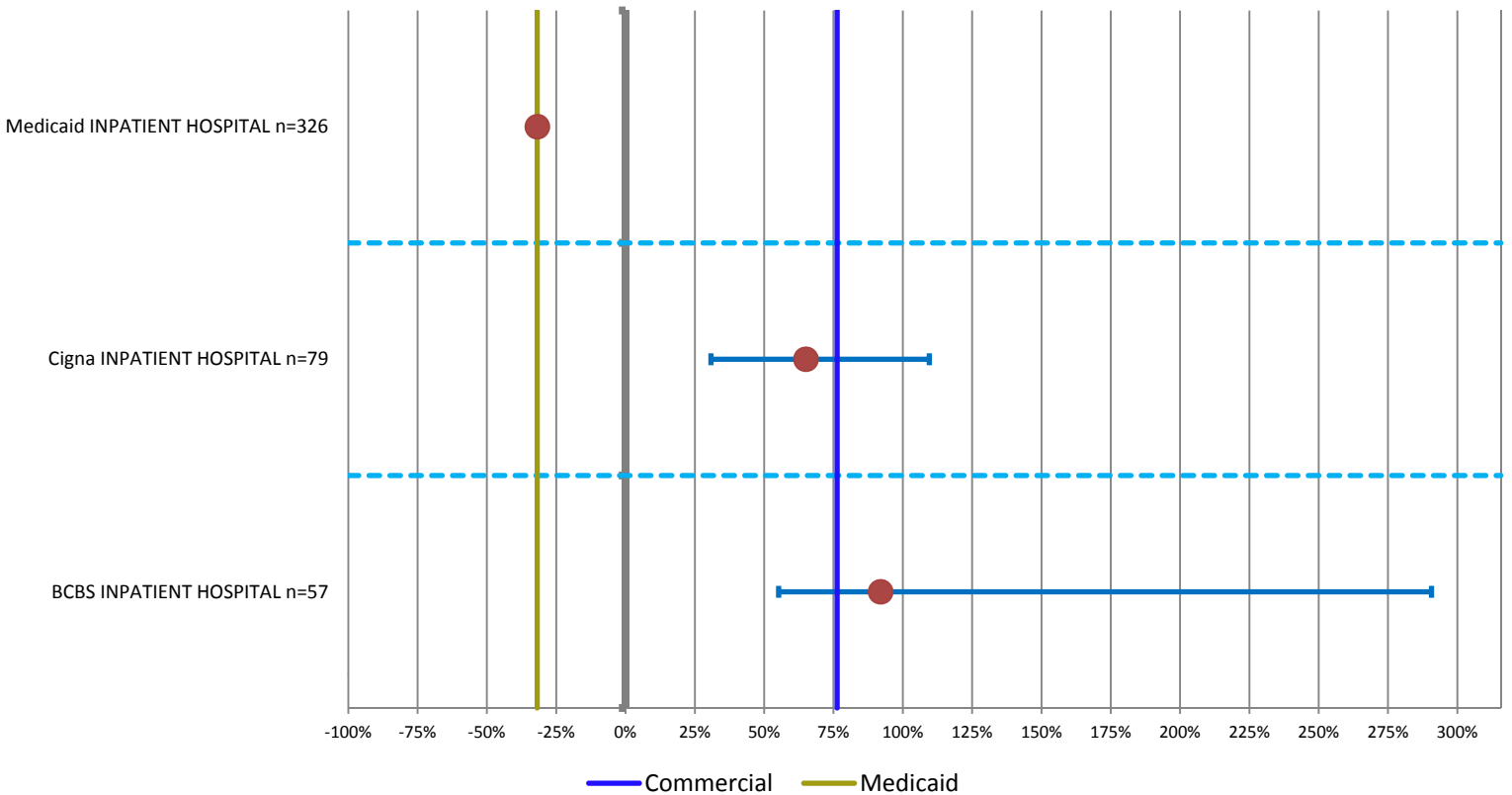
FY2012 Inpatient Professional 99239 - HOSPITAL DISCHARGE DAY Allowed Payment Amount Variation



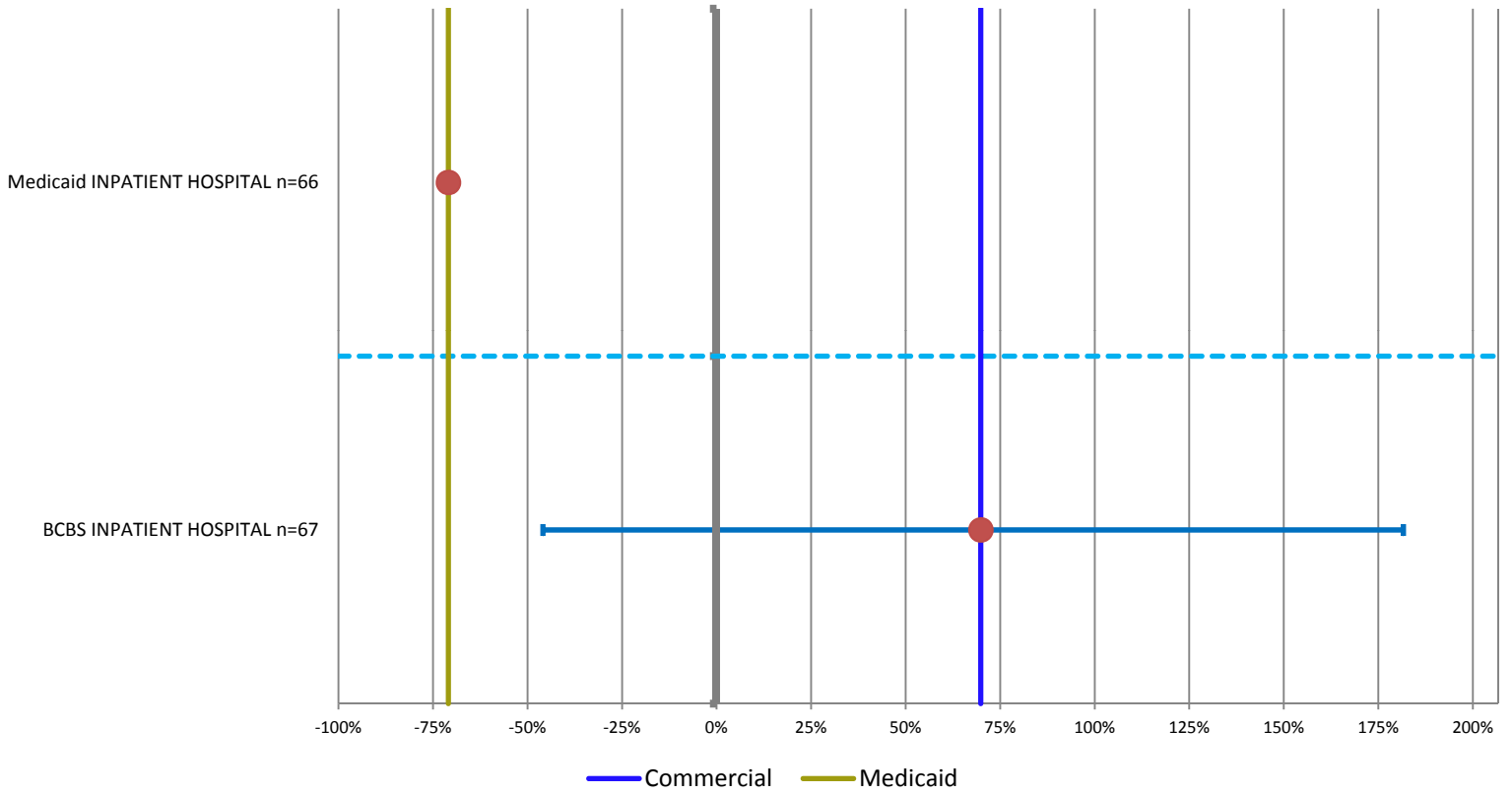
FY2012 Inpatient Professional 99254 - INPATIENT CONSULTATION Allowed Payment Amount Variation



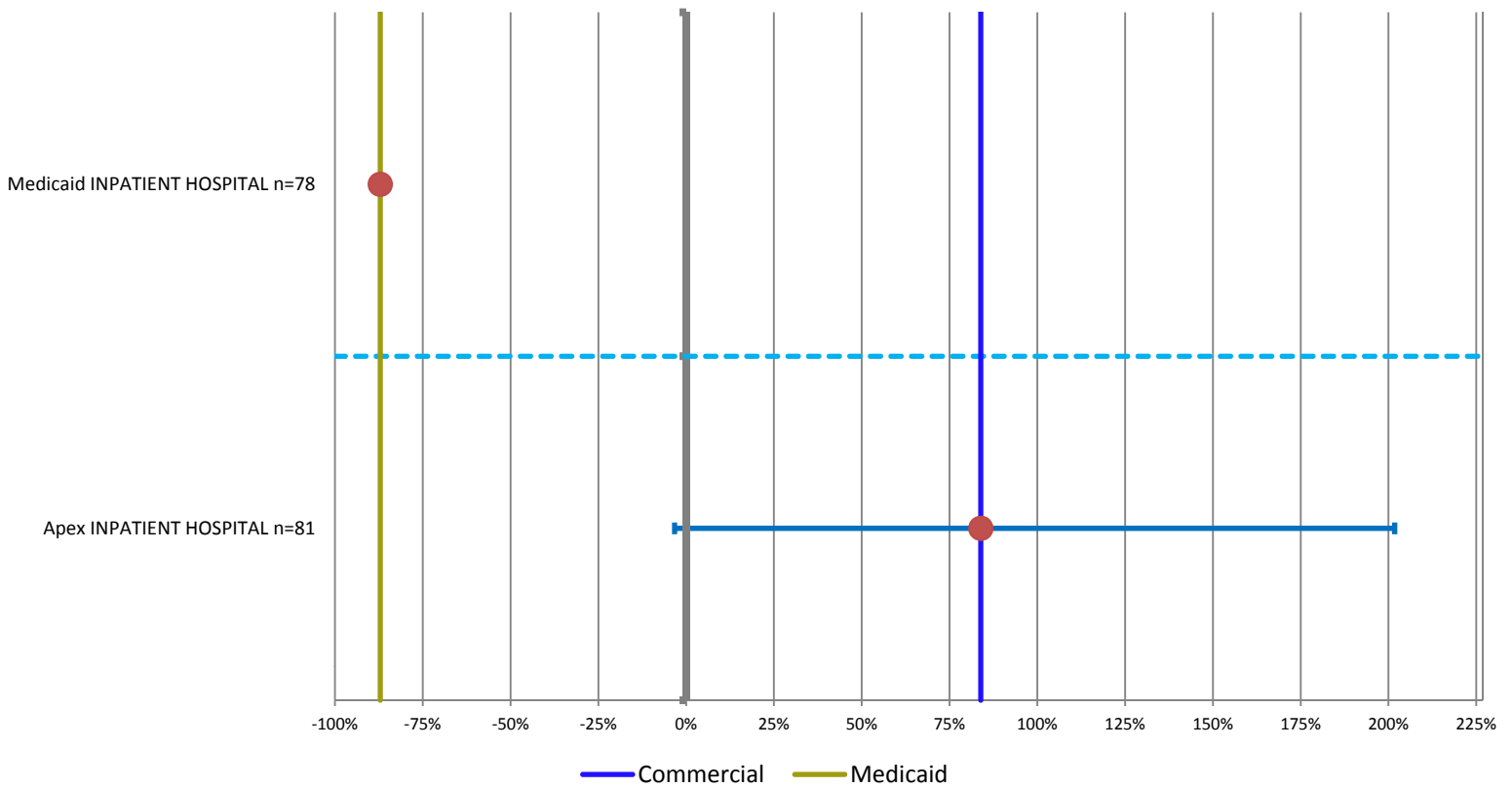
FY2012 Inpatient Professional 99469 - NEONATE CRIT CARE SUBSQ Allowed Payment Amount Variation



FY2012 Inpatient Professional 92980 - INSERT INTRACORONARY STENT Allowed Payment Amount Variation

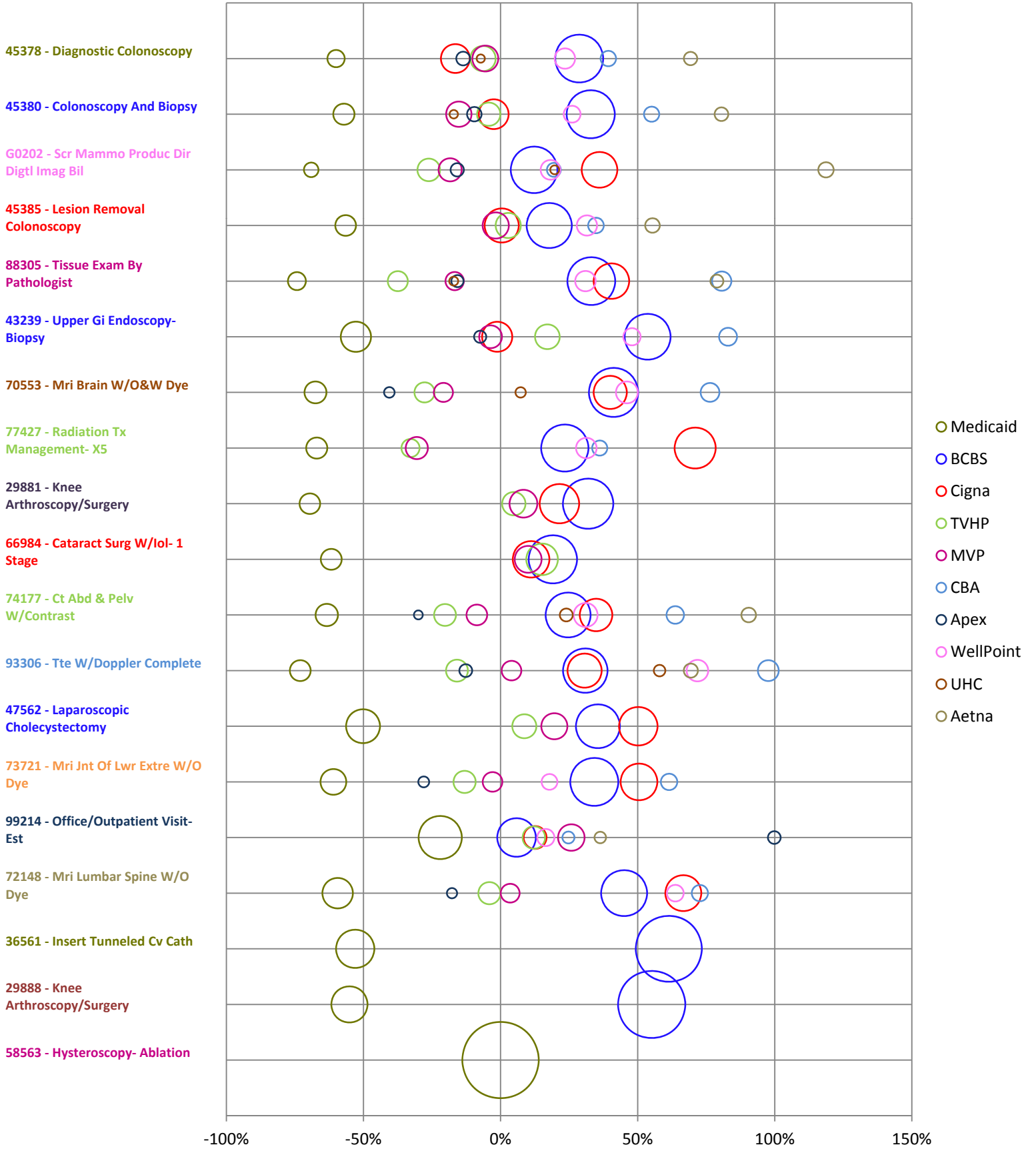


FY2012 Inpatient Professional 1967 - ANESTH/ANALG- VAG DELIVERY Allowed Payment Amount Variation

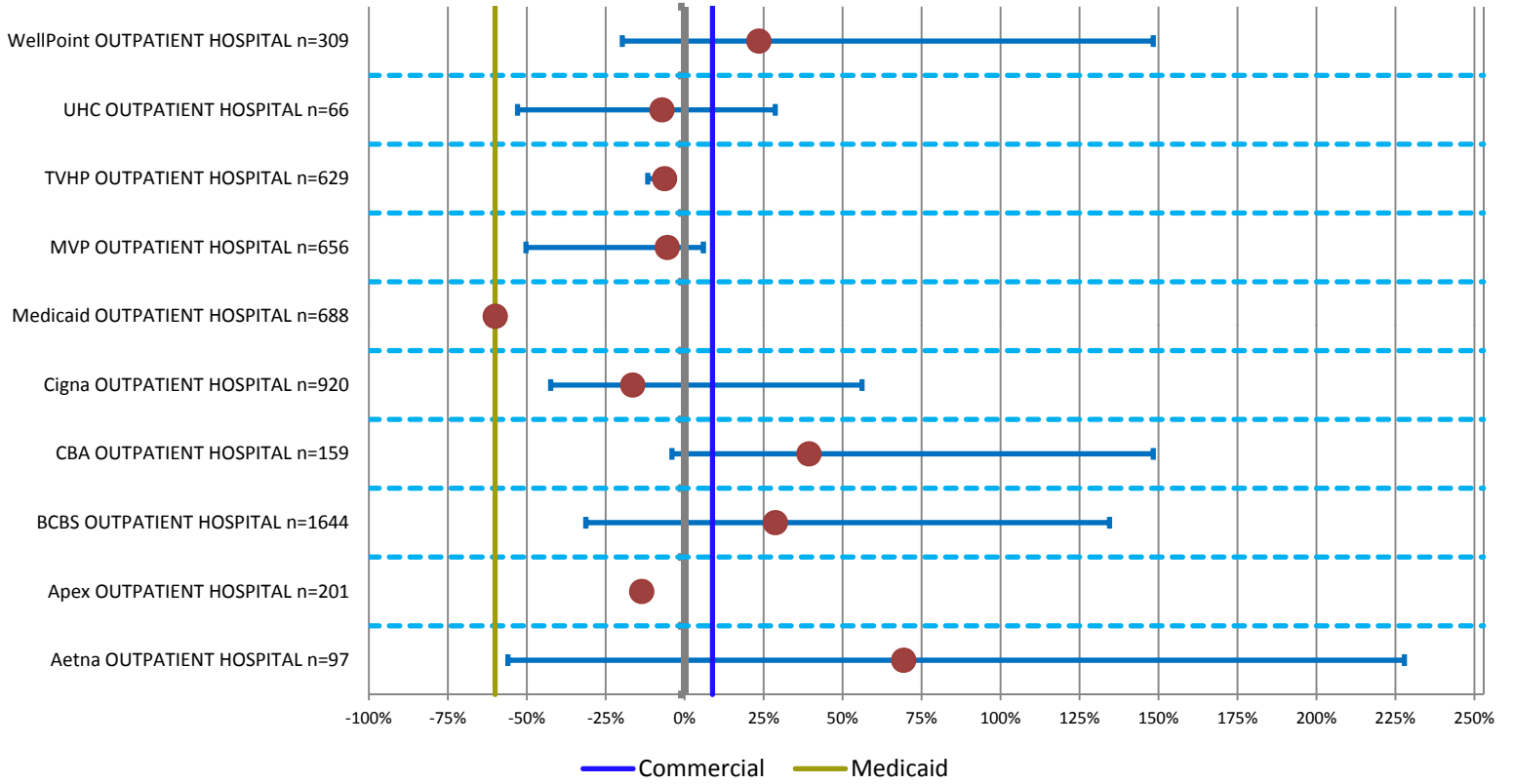


FY2012 Outpatient Hospital Professional Allowed Payment Amount Variation

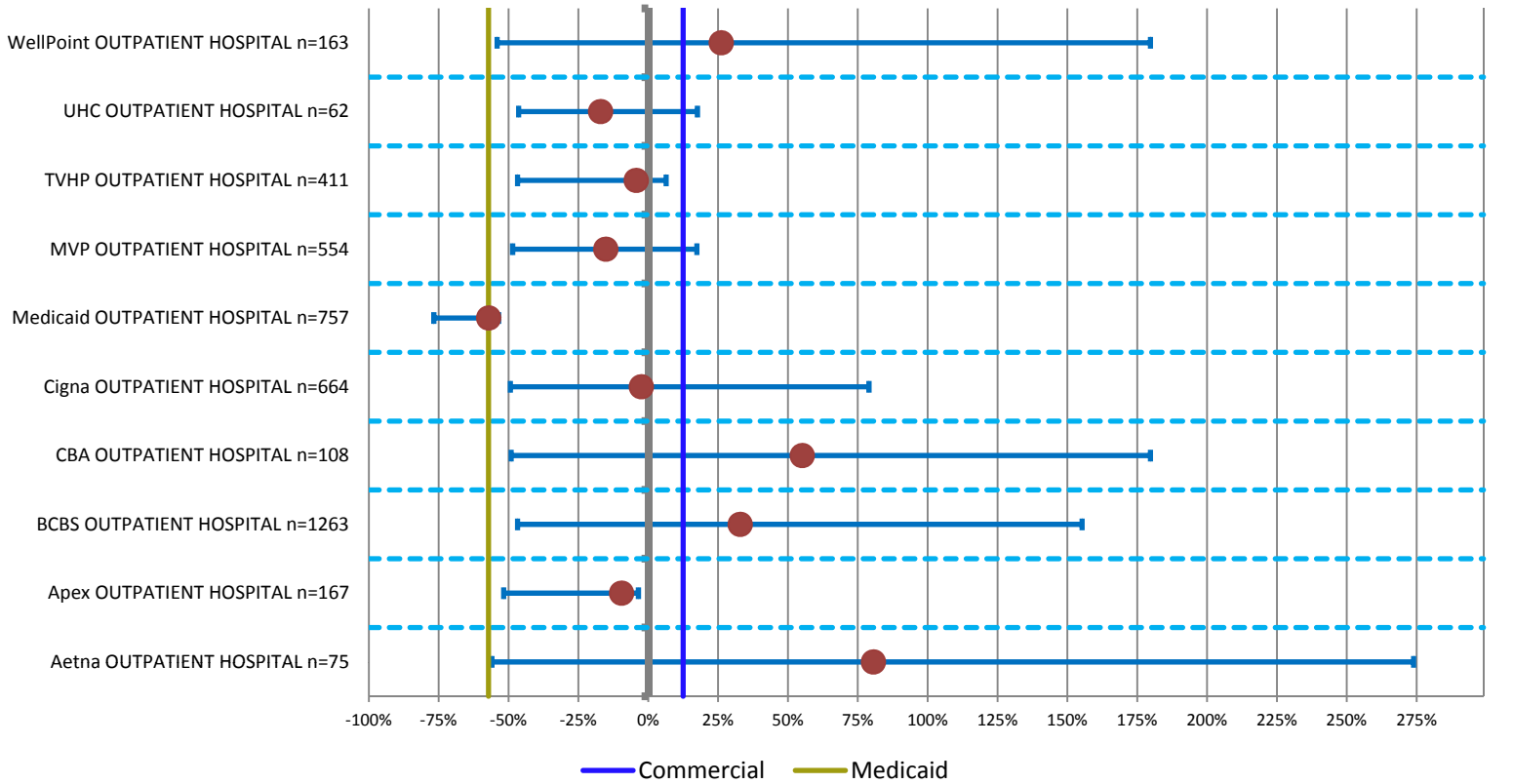
FY2012 Outpatient Hospital Professional Allowed Payment Amount Variation (Min 50 Visits)



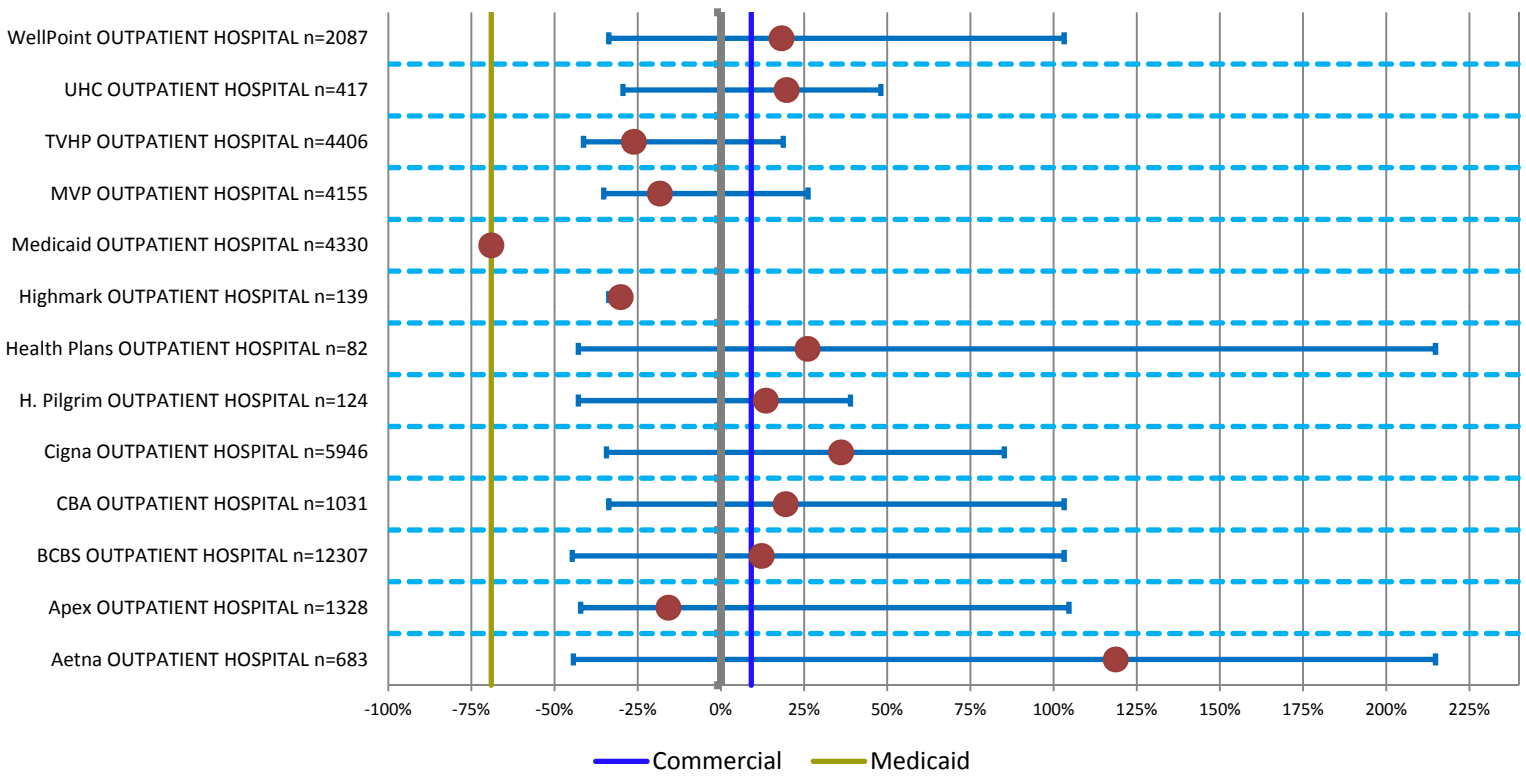
FY2012 Outpatient Professional 45378 - DIAGNOSTIC COLONOSCOPY Allowed Payment Amount Variation



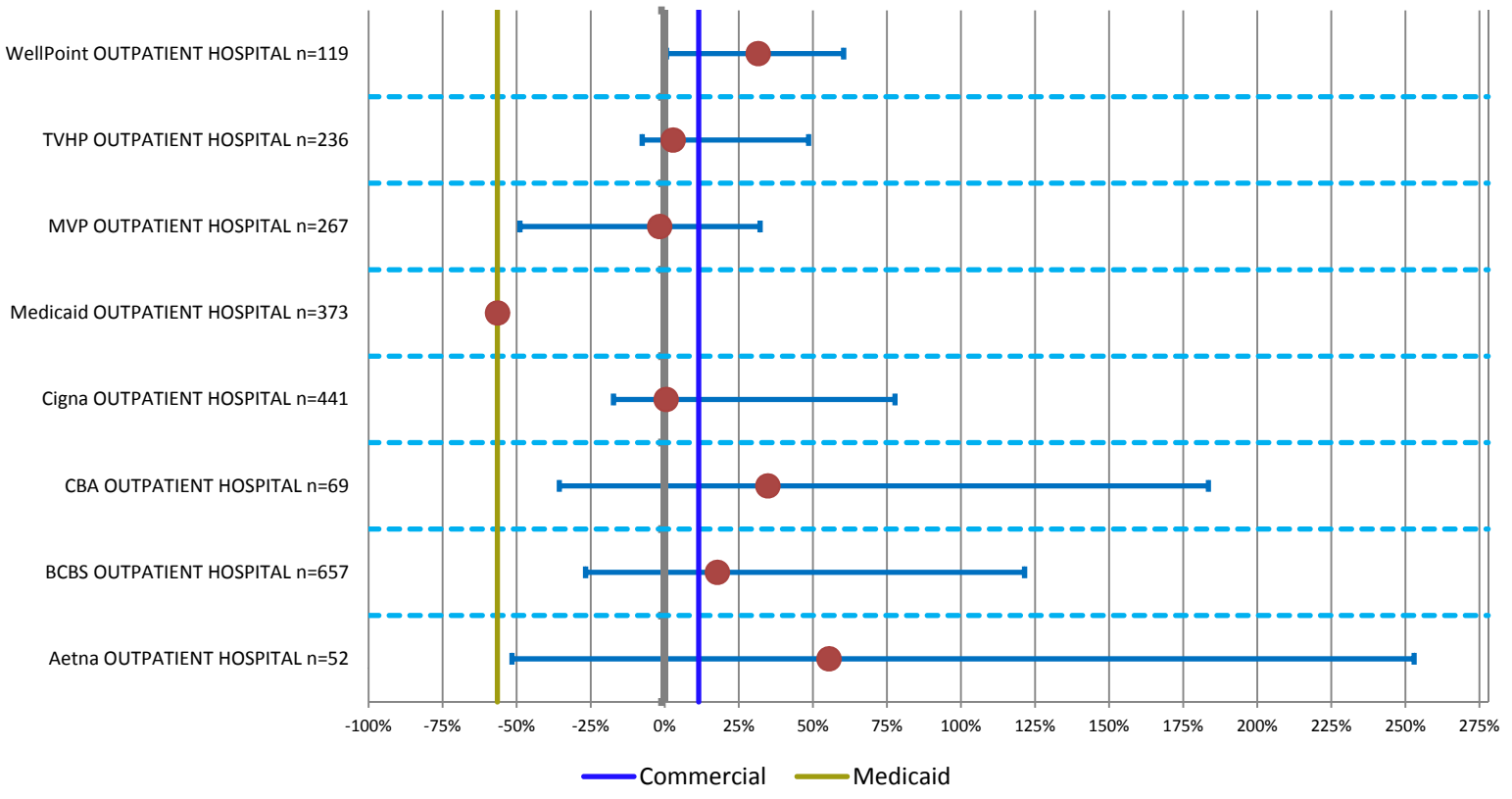
FY2012 Outpatient Professional 45380 - COLONOSCOPY AND BIOPSY Allowed Payment Amount Variation



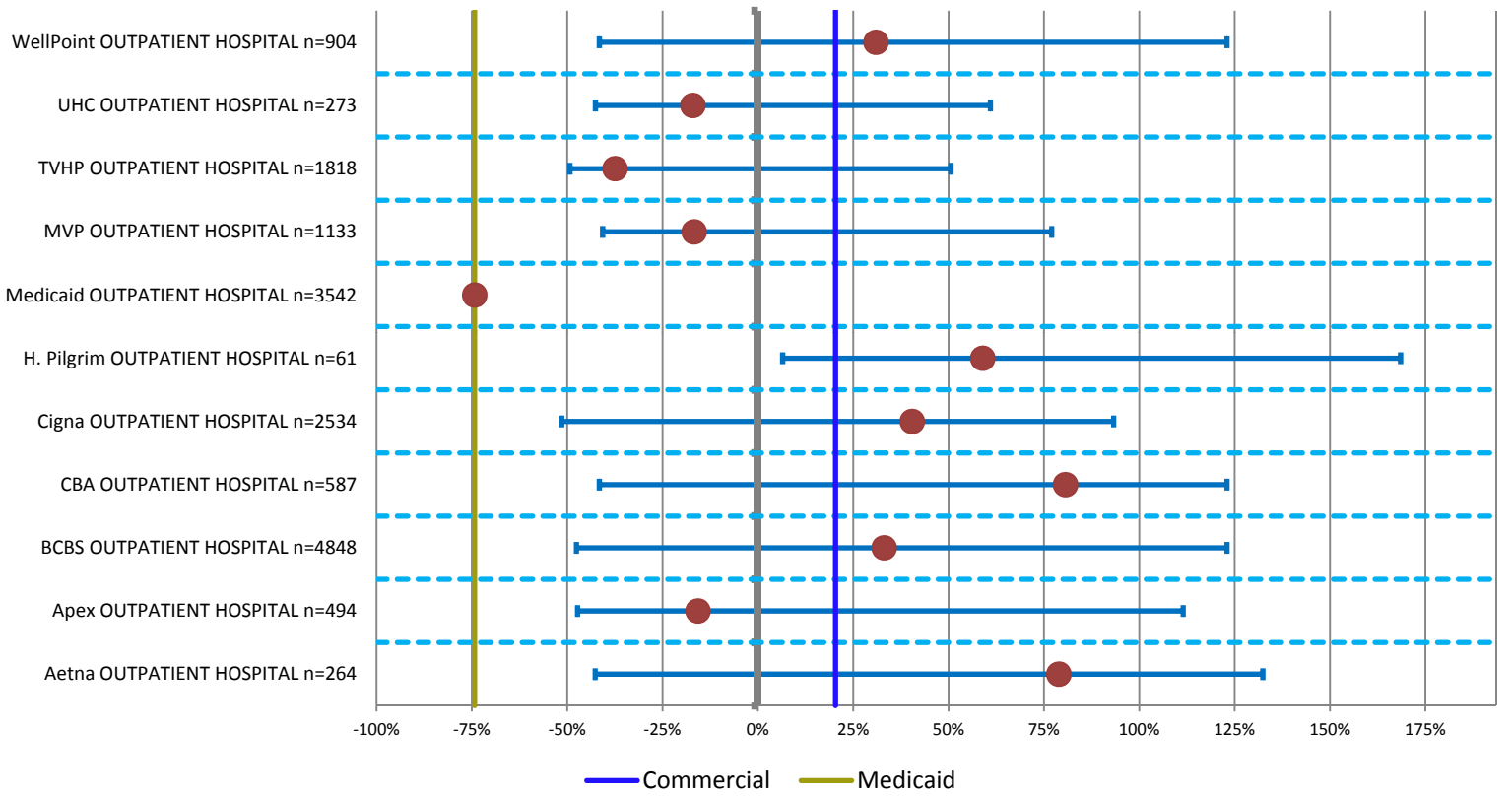
FY2012 Outpatient Professional G0202 - SCR MAMMO PRODUC DIR DIGTL IMAG BIL Allowed Payment Amount Variation



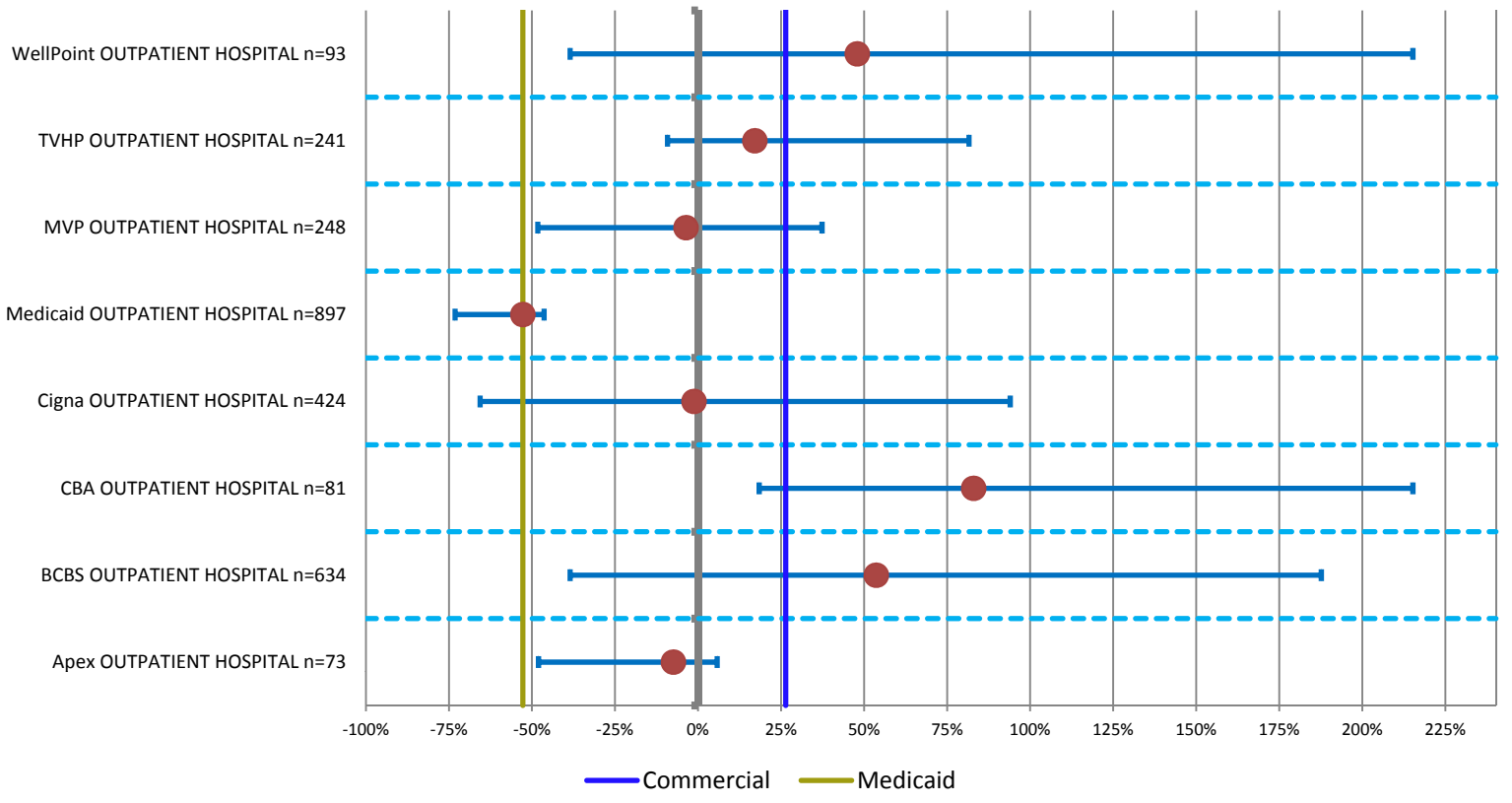
FY2012 Outpatient Professional 45385 - LESION REMOVAL COLONOSCOPY Allowed Payment Amount Variation



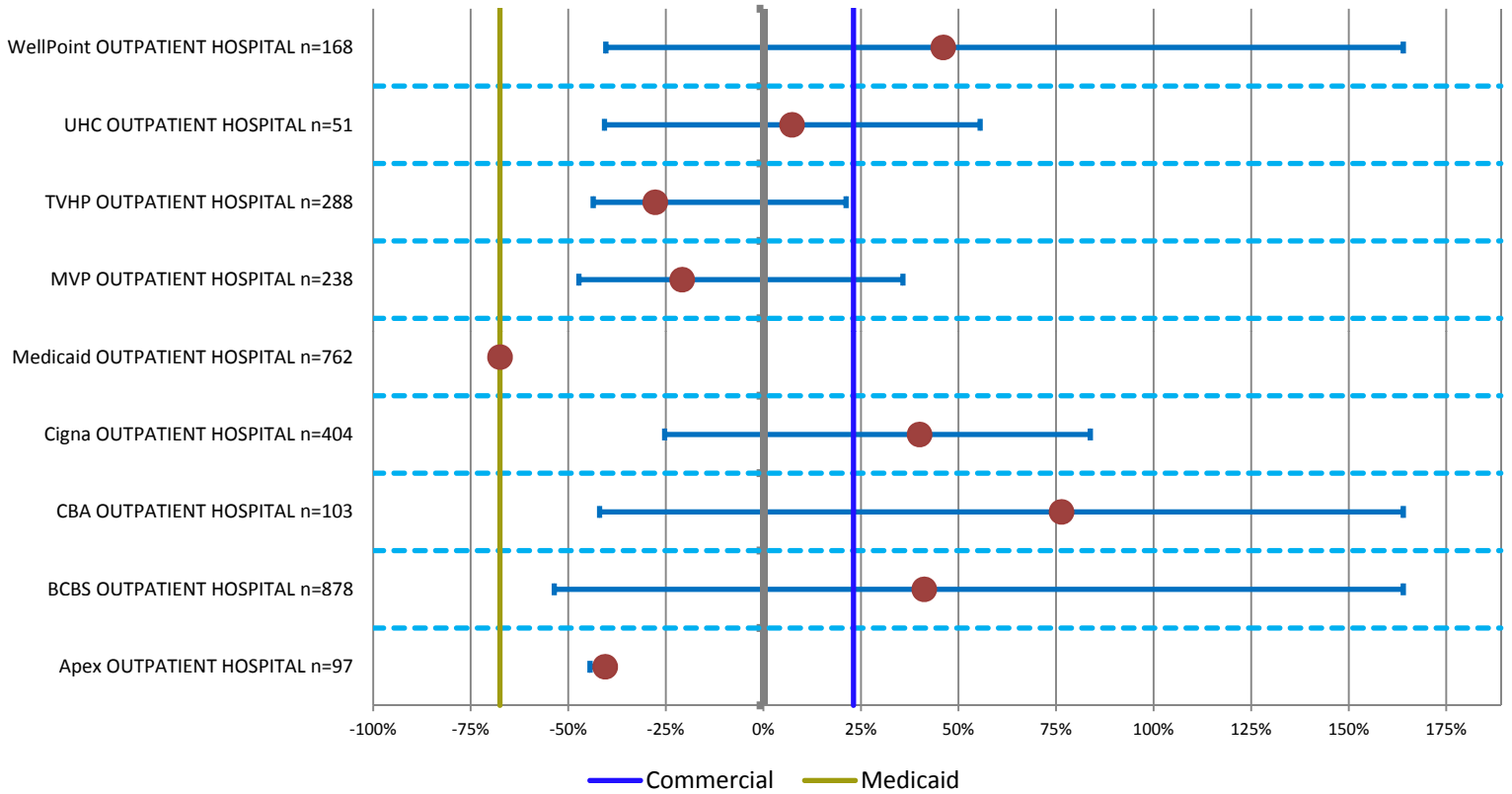
FY2012 Outpatient Professional 88305 - TISSUE EXAM BY PATHOLOGIST Allowed Payment Amount Variation



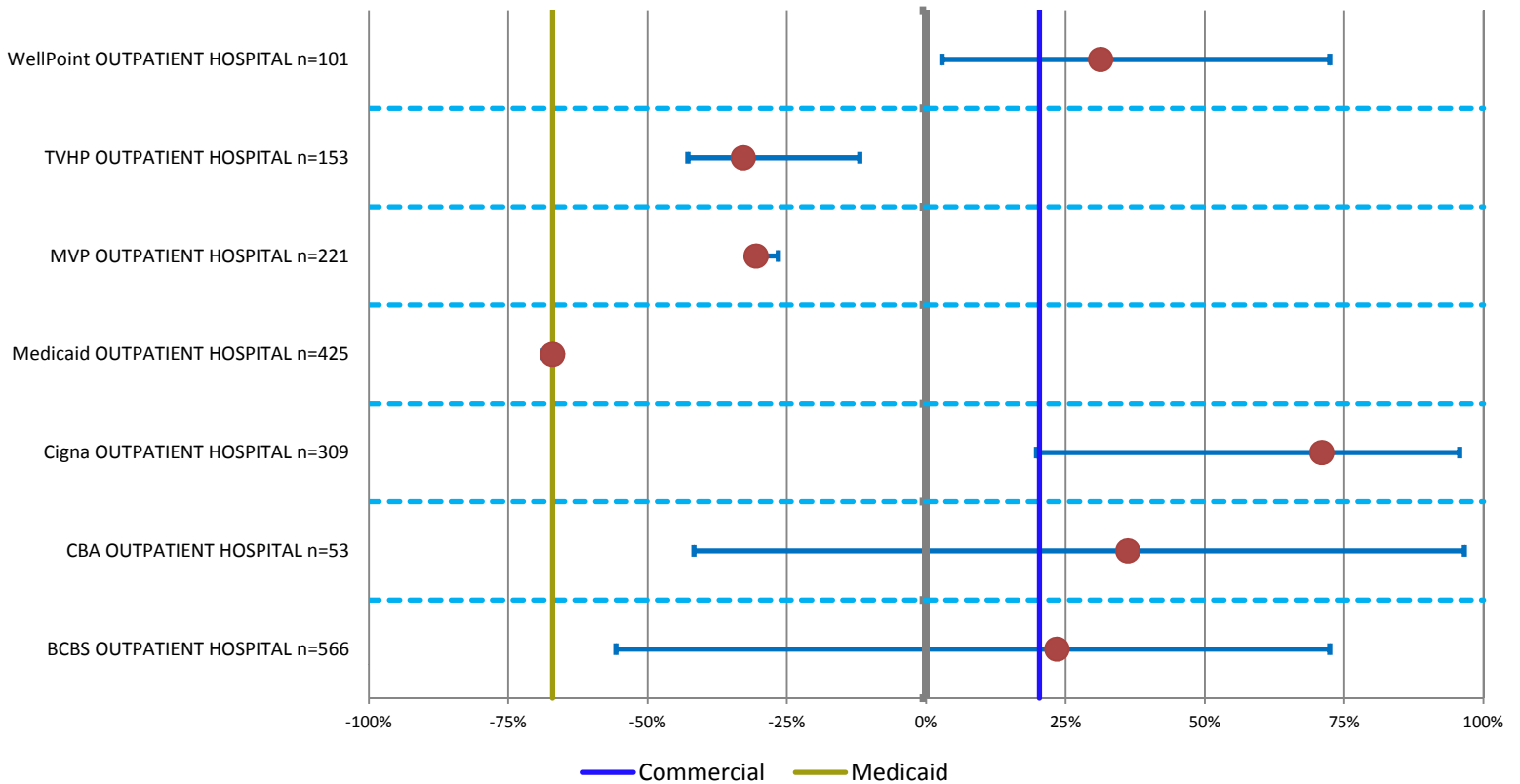
FY2012 Outpatient Professional 43239 - UPPER GI ENDOSCOPY- BIOPSY Allowed Payment Amount Variation



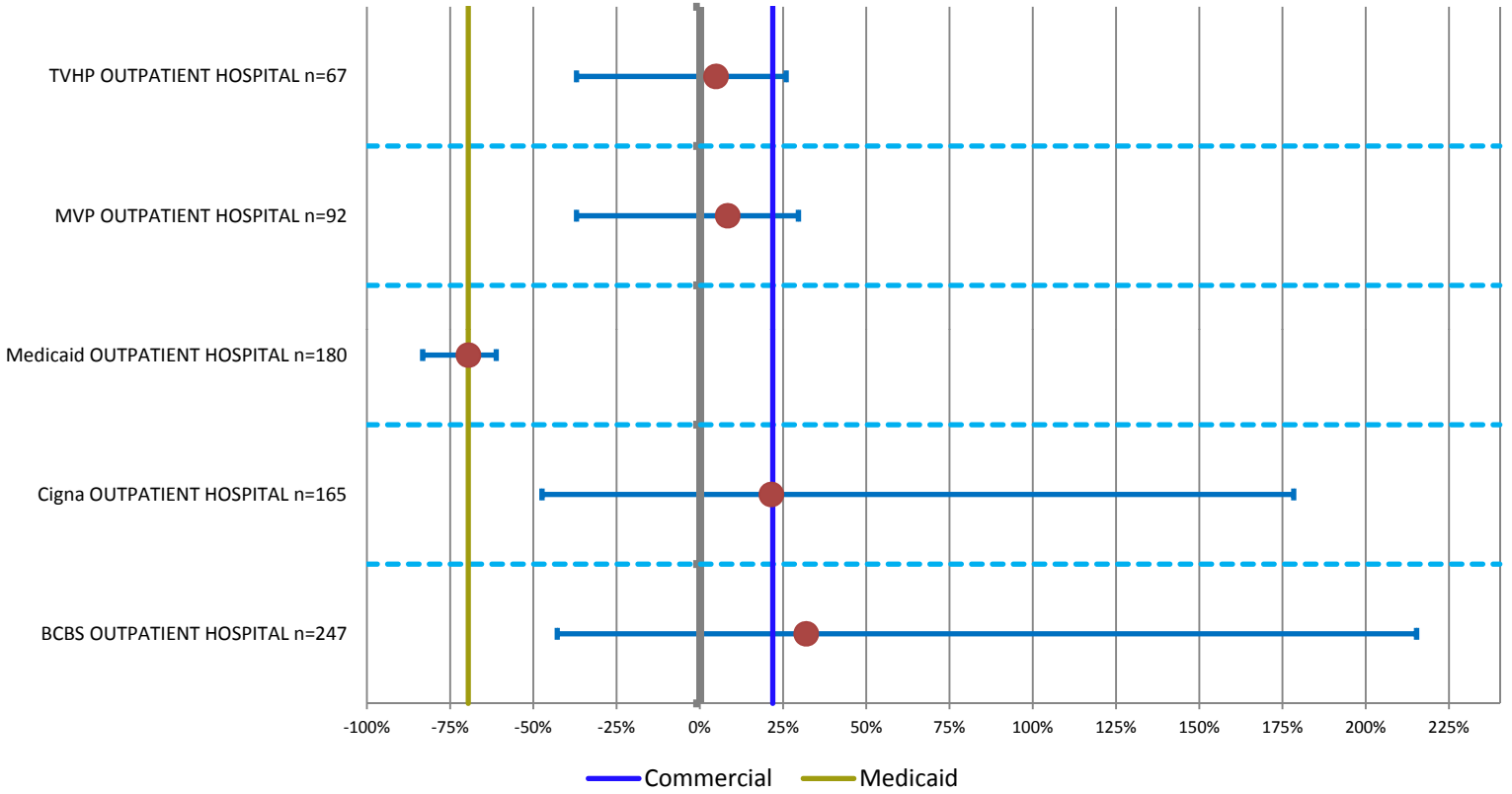
FY2012 Outpatient Professional 70553 - MRI BRAIN W/O&W DYE Allowed Payment Amount Variation



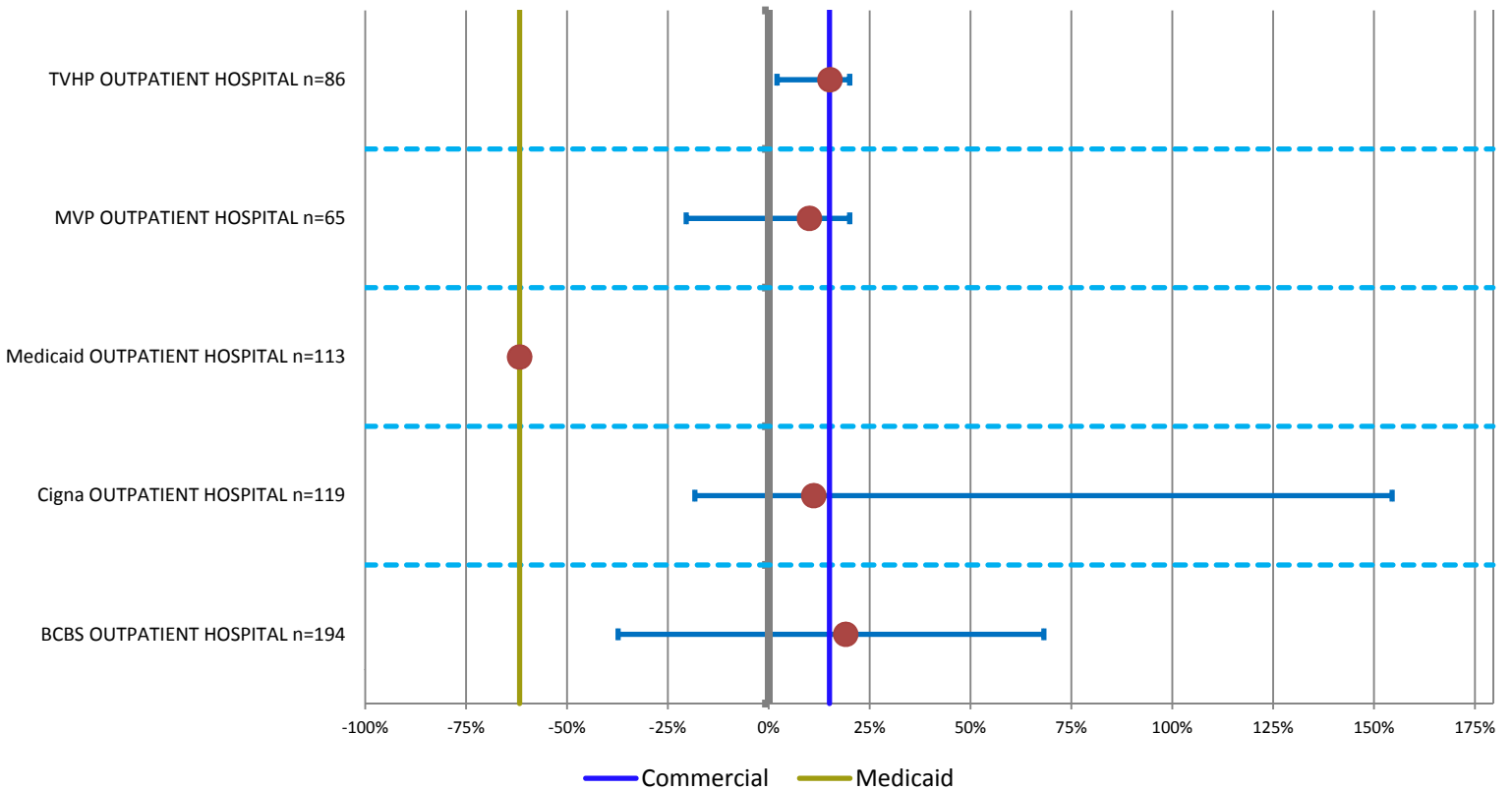
FY2012 Outpatient Professional 77427 - RADIATION TX MANAGEMENT- X5 Allowed Payment Amount Variation



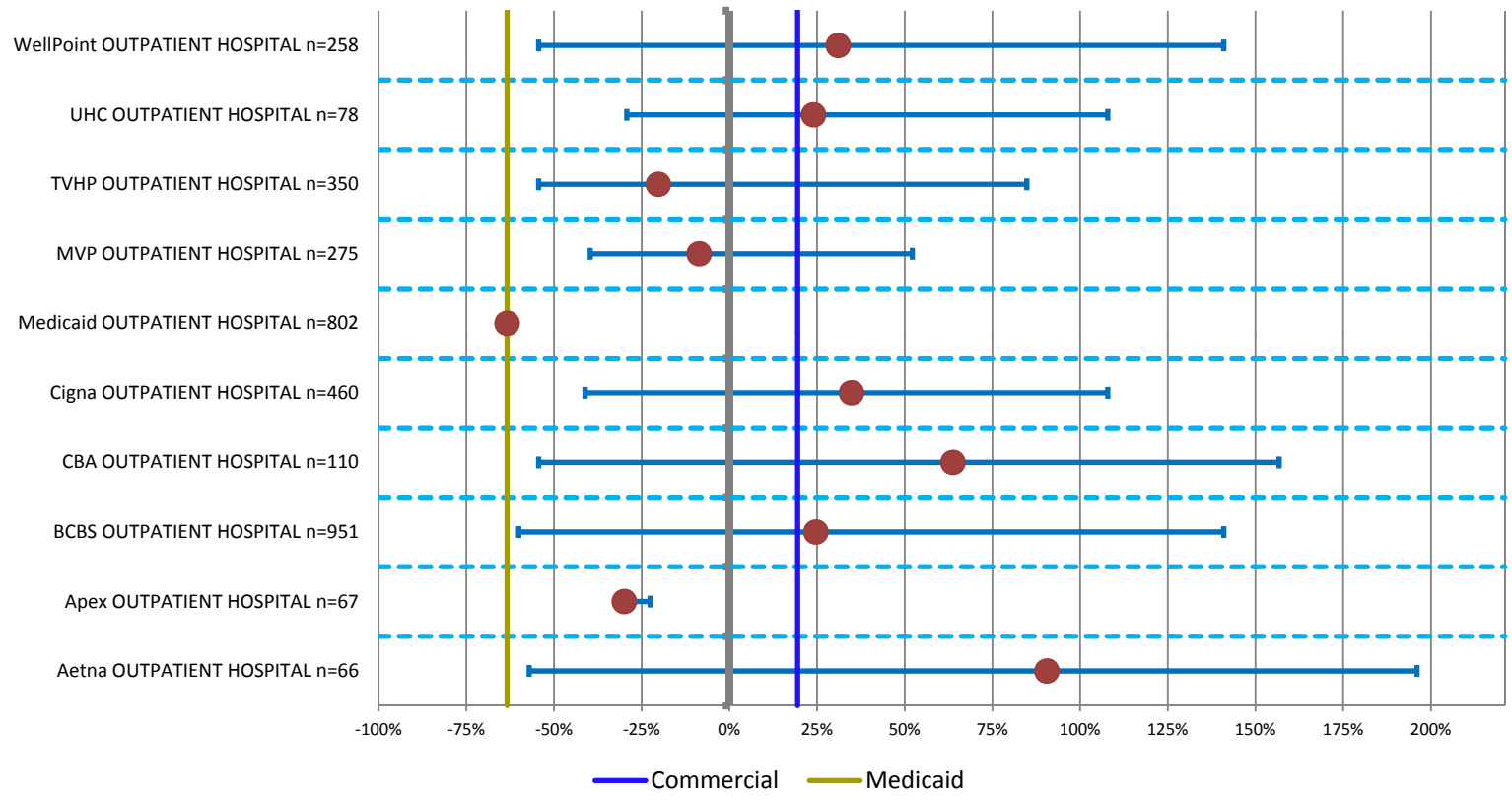
FY2012 Outpatient Professional 29881 - KNEE ARTHROSCOPY/SURGERY Allowed Payment Amount Variation



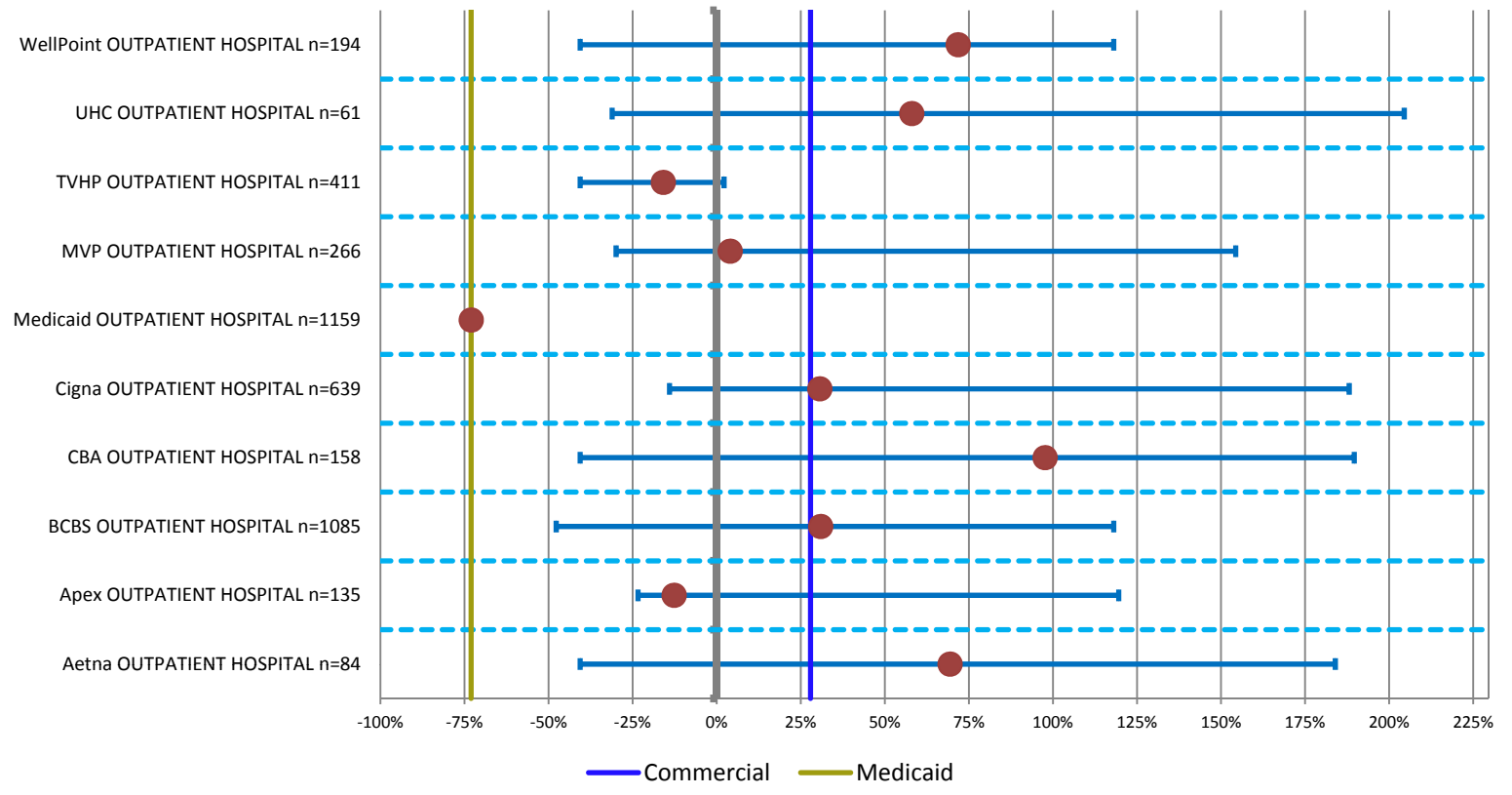
FY2012 Outpatient Professional 66984 - CATARACT SURG W/IOL- 1 STAGE Allowed Payment Amount Variation



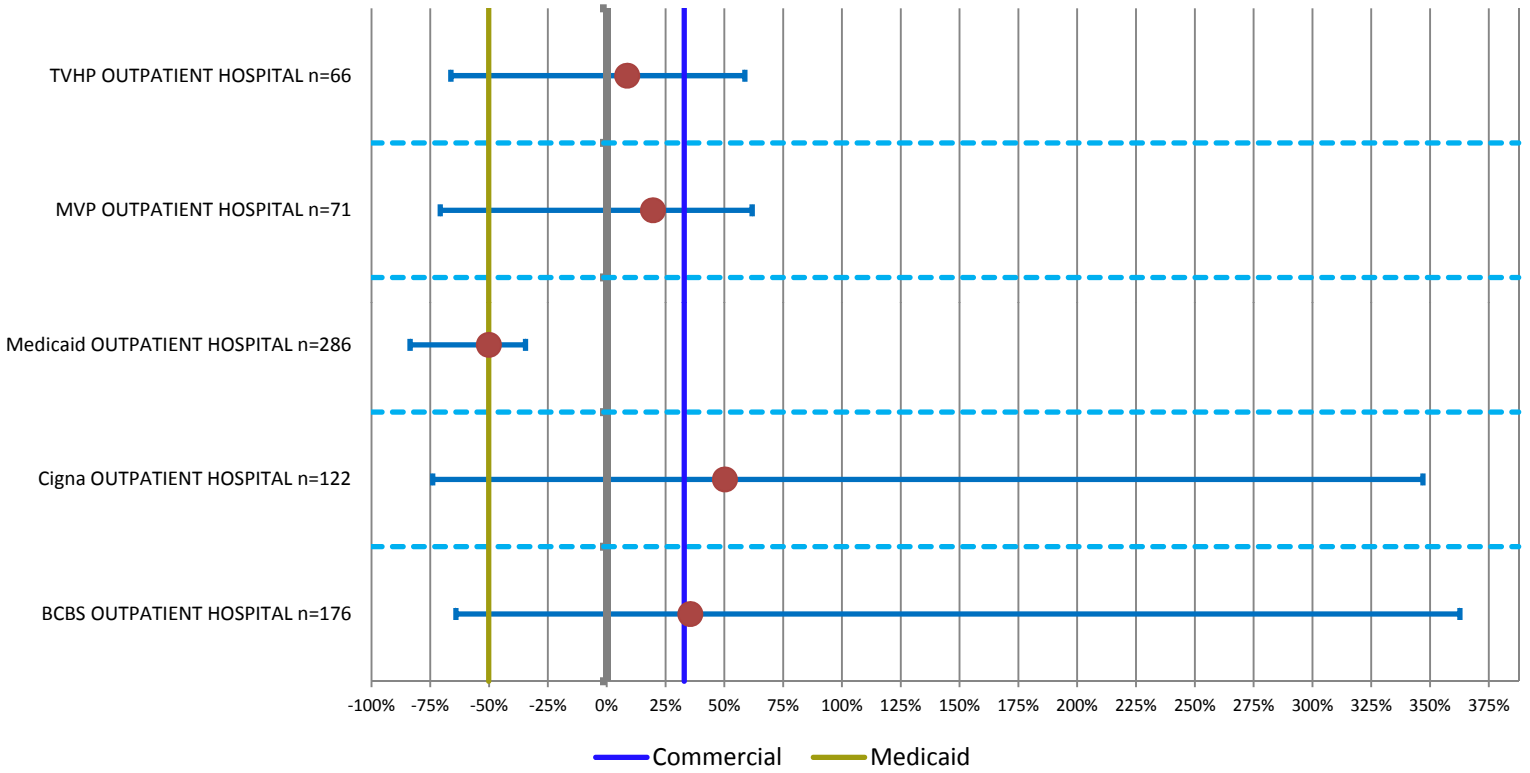
FY2012 Outpatient Professional 74177 - CT ABD & PELV W/CONTRAST Allowed Payment Amount Variation



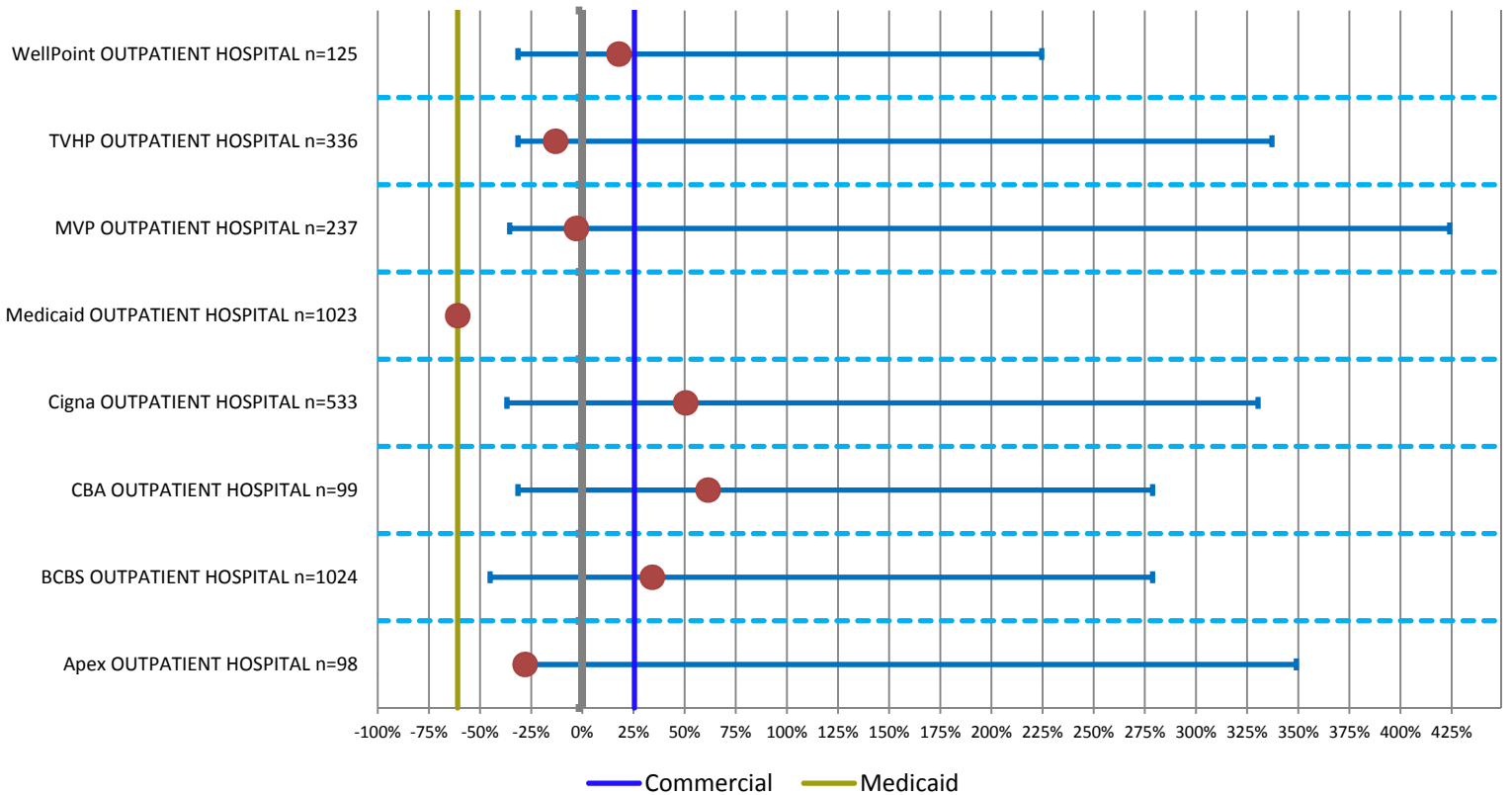
FY2012 Outpatient Professional 93306 - TTE W/DOPPLER COMPLETE Allowed Payment Amount Variation



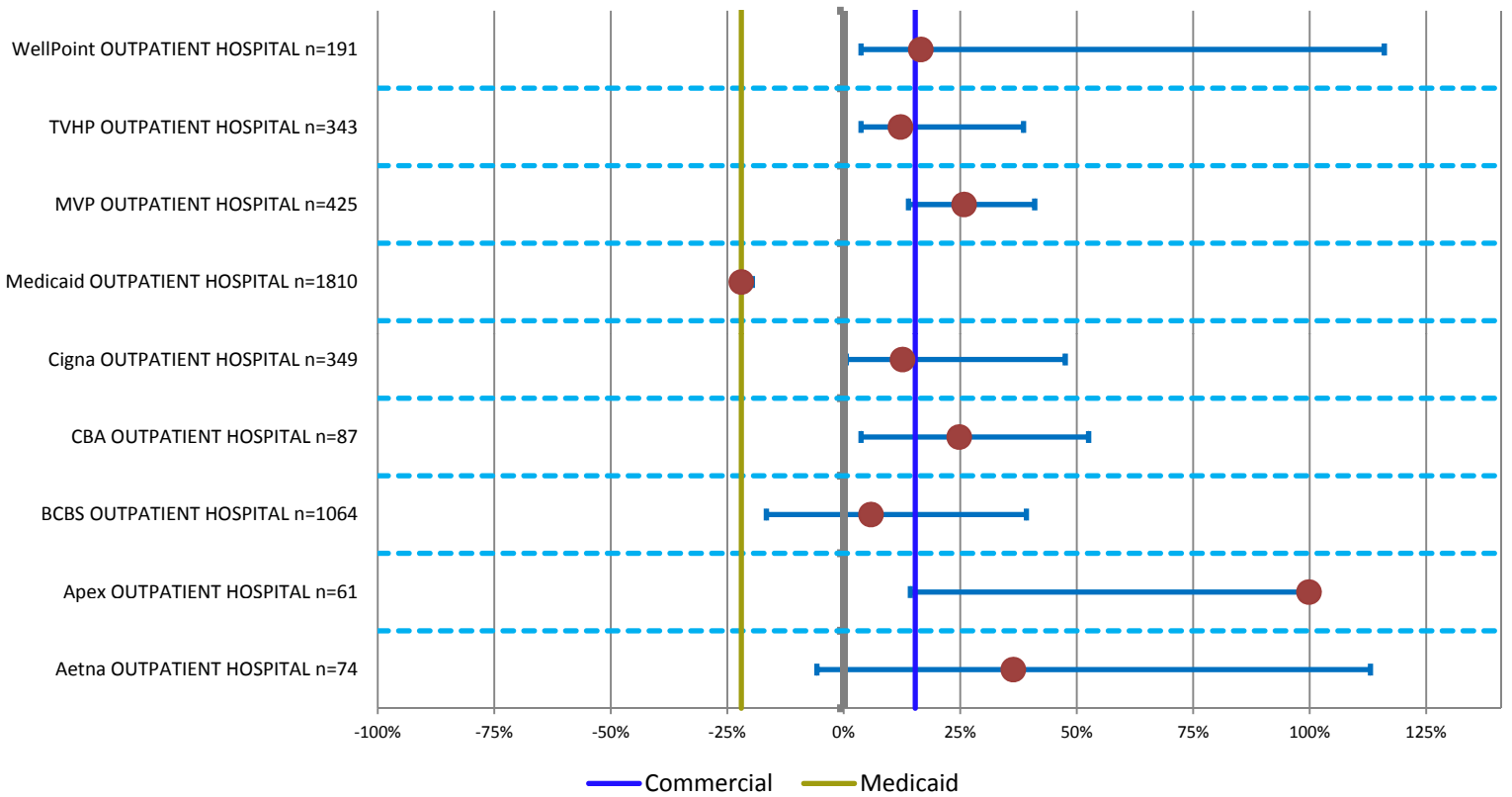
FY2012 Outpatient Professional 47562 - LAPAROSCOPIC CHOLECYSTECTOMY Allowed Payment Amount Variation



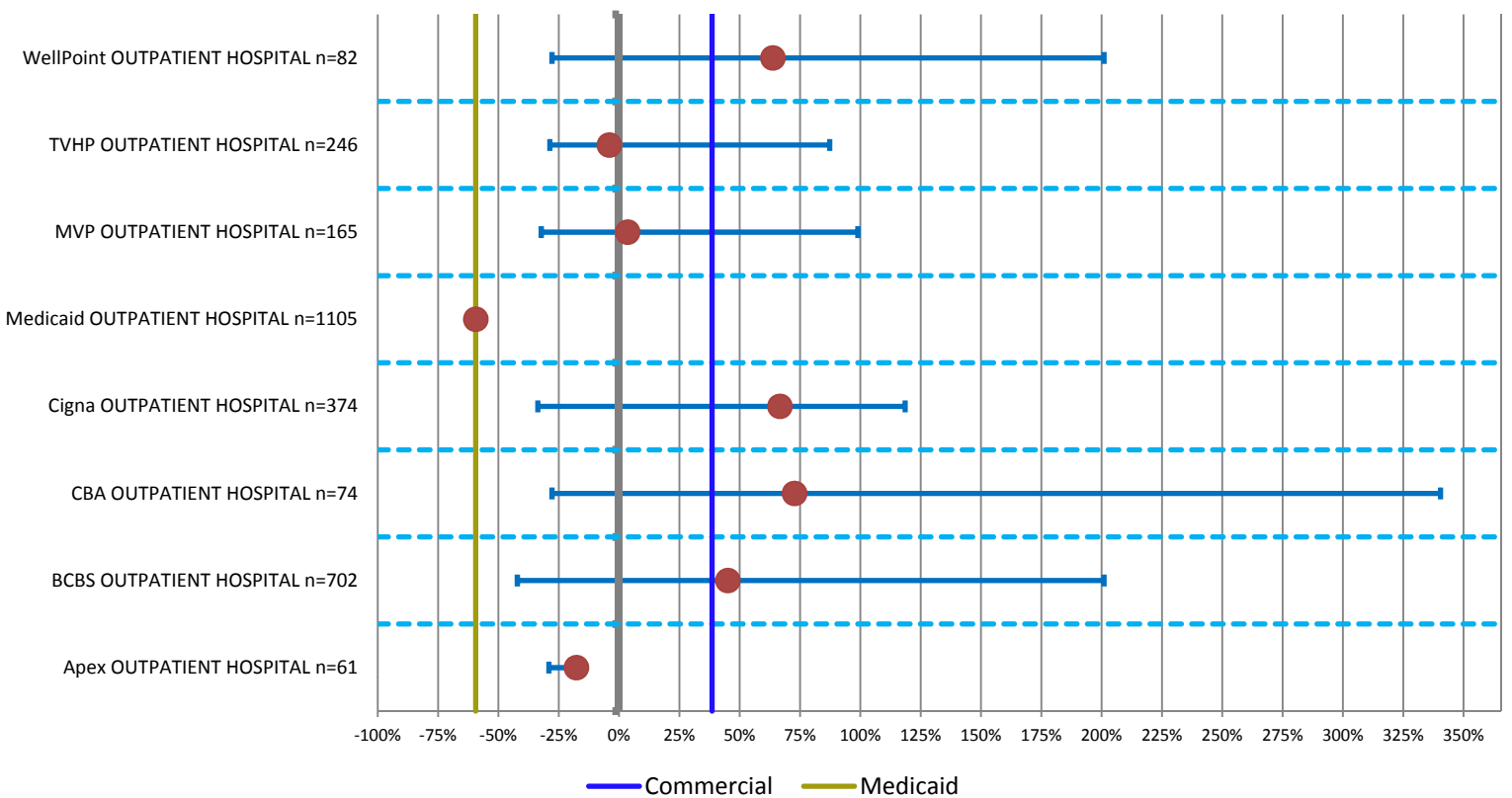
FY2012 Outpatient Professional 73721 - MRI JNT OF LWR EXTRE W/O DYE Allowed Payment Amount Variation



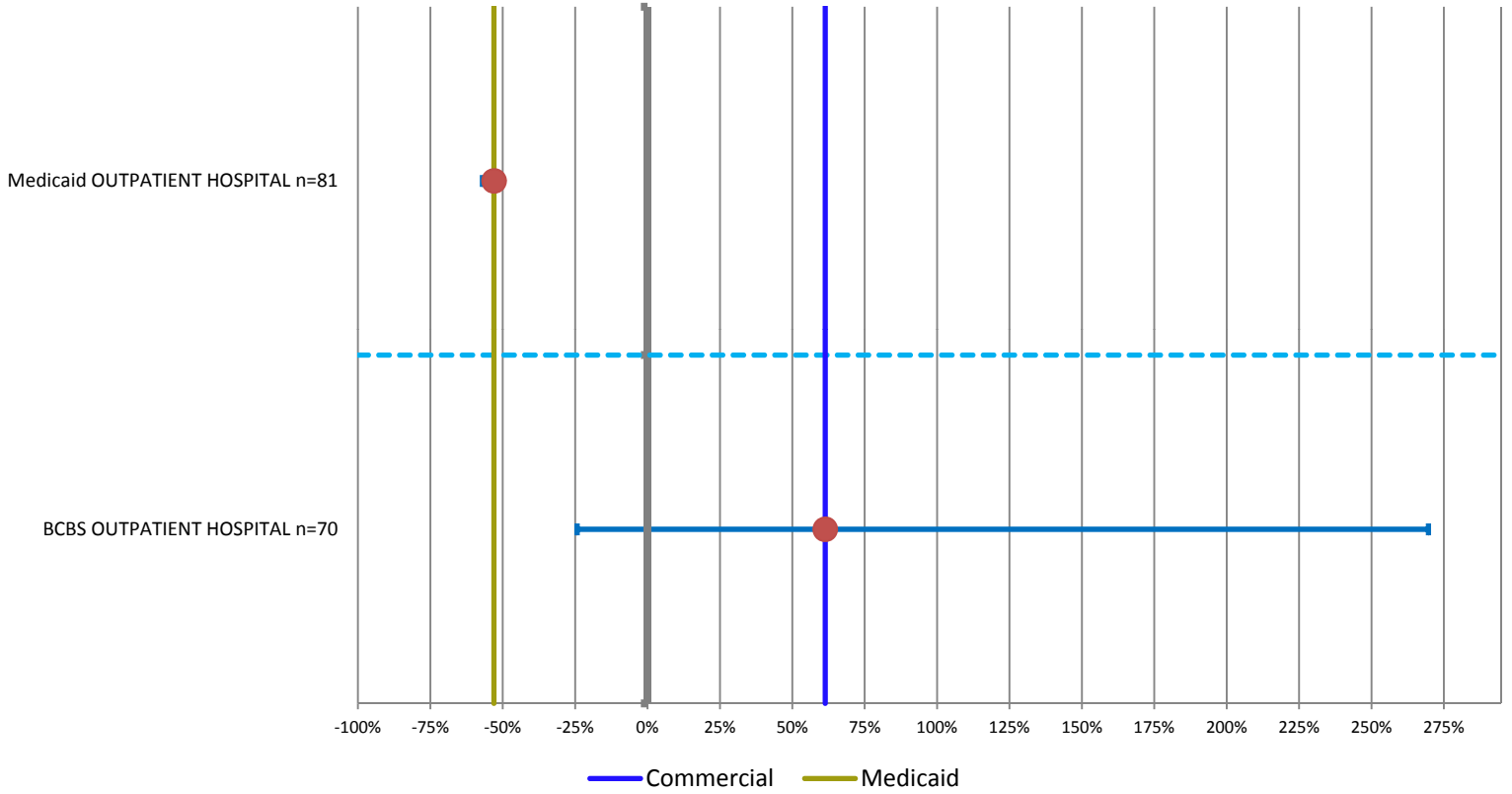
FY2012 Outpatient Professional 99214 - OFFICE/OUTPATIENT VISIT- EST Allowed Payment Amount Variation



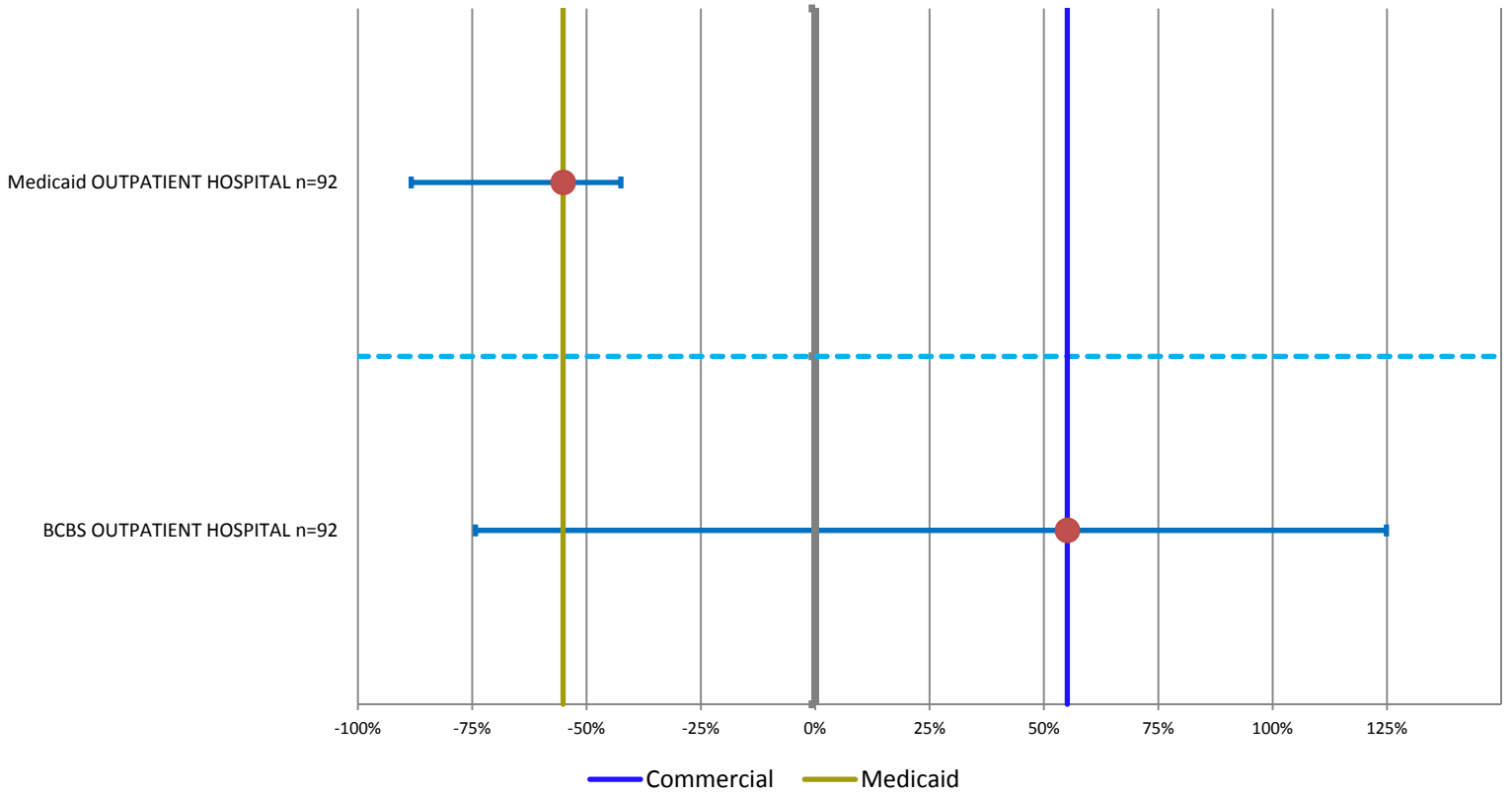
FY2012 Outpatient Professional 72148 - MRI LUMBAR SPINE W/O DYE Allowed Payment Amount Variation



FY2012 Outpatient Professional 36561 - INSERT TUNNELED CV CATH Allowed Payment Amount Variation

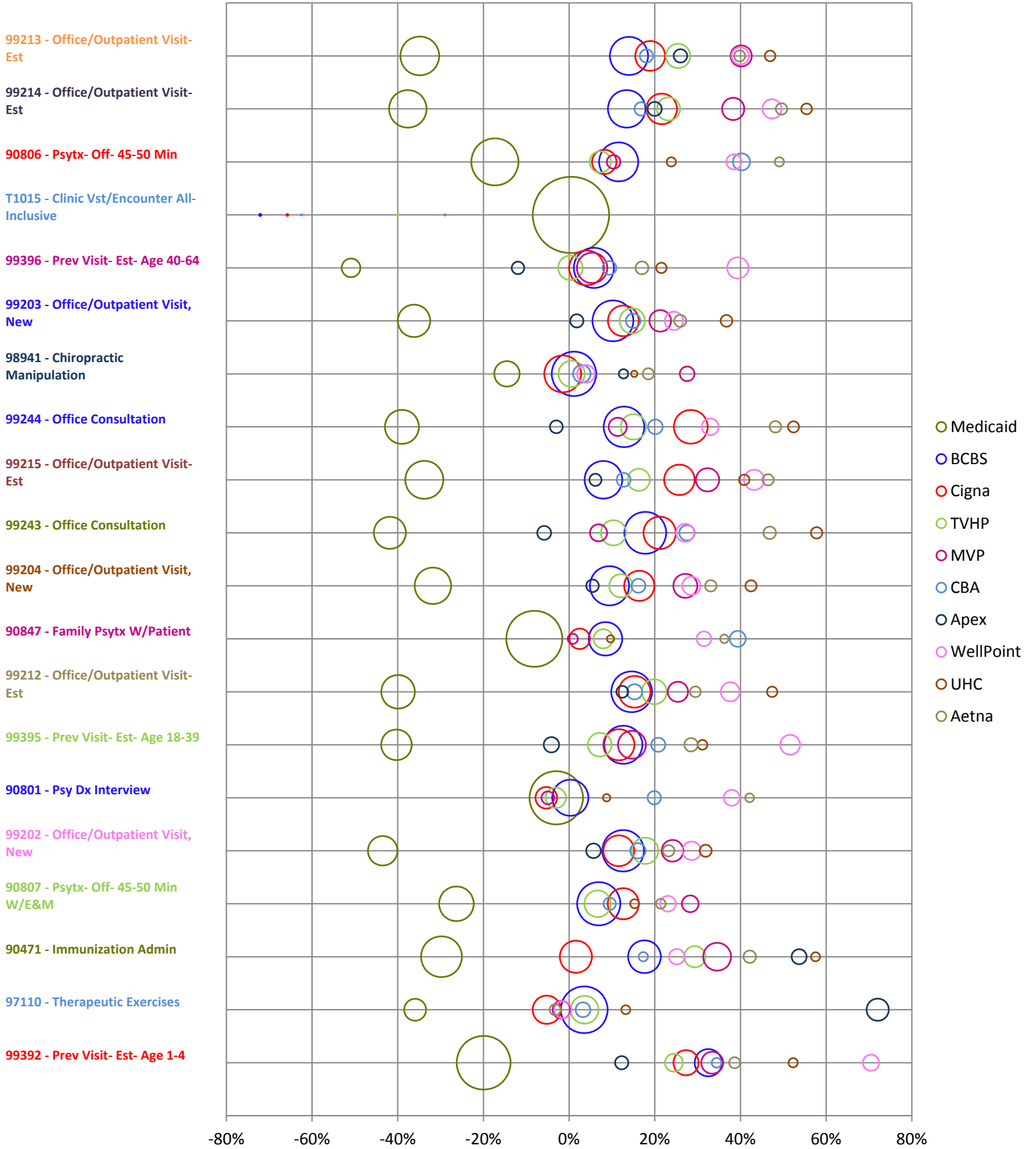


FY2012 Outpatient Professional 29888 - KNEE ARTHROSCOPY/SURGERY Allowed Payment Amount Variation

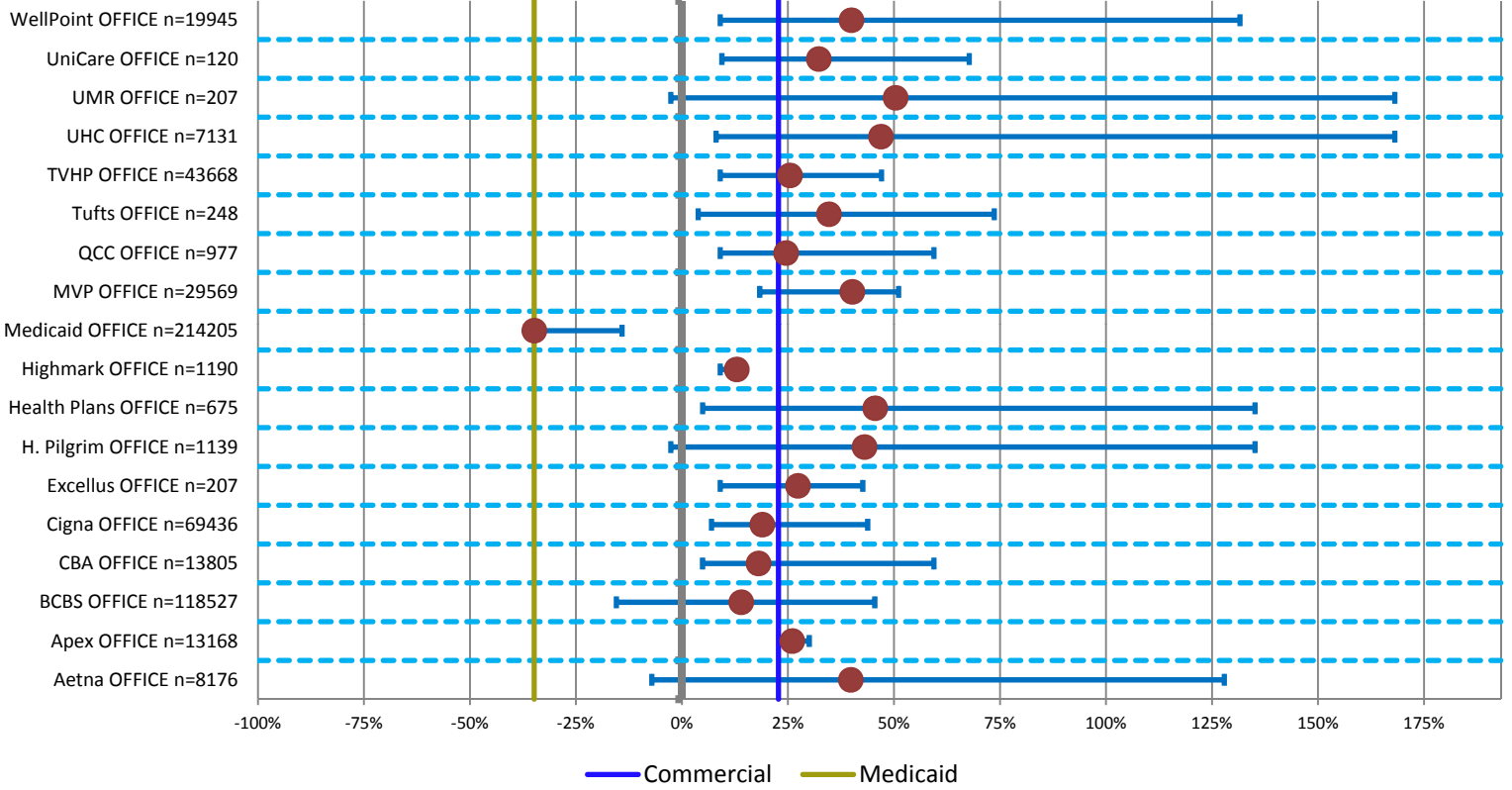


FY2012 Office Professional Allowed Payment Amount Variation

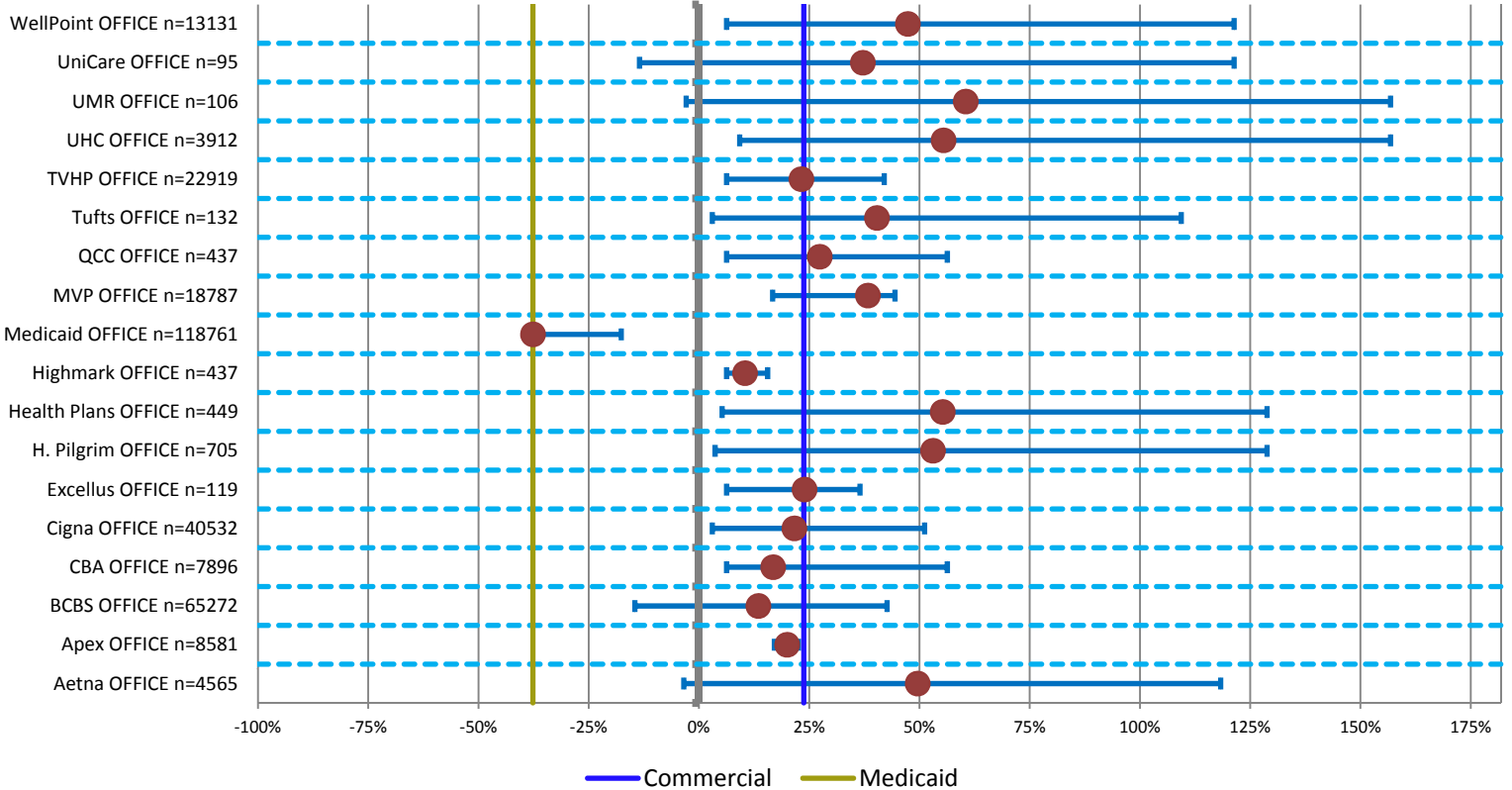
FY2012 Office Professional Allowed Payment Amount Variation (Min 50 Visits)



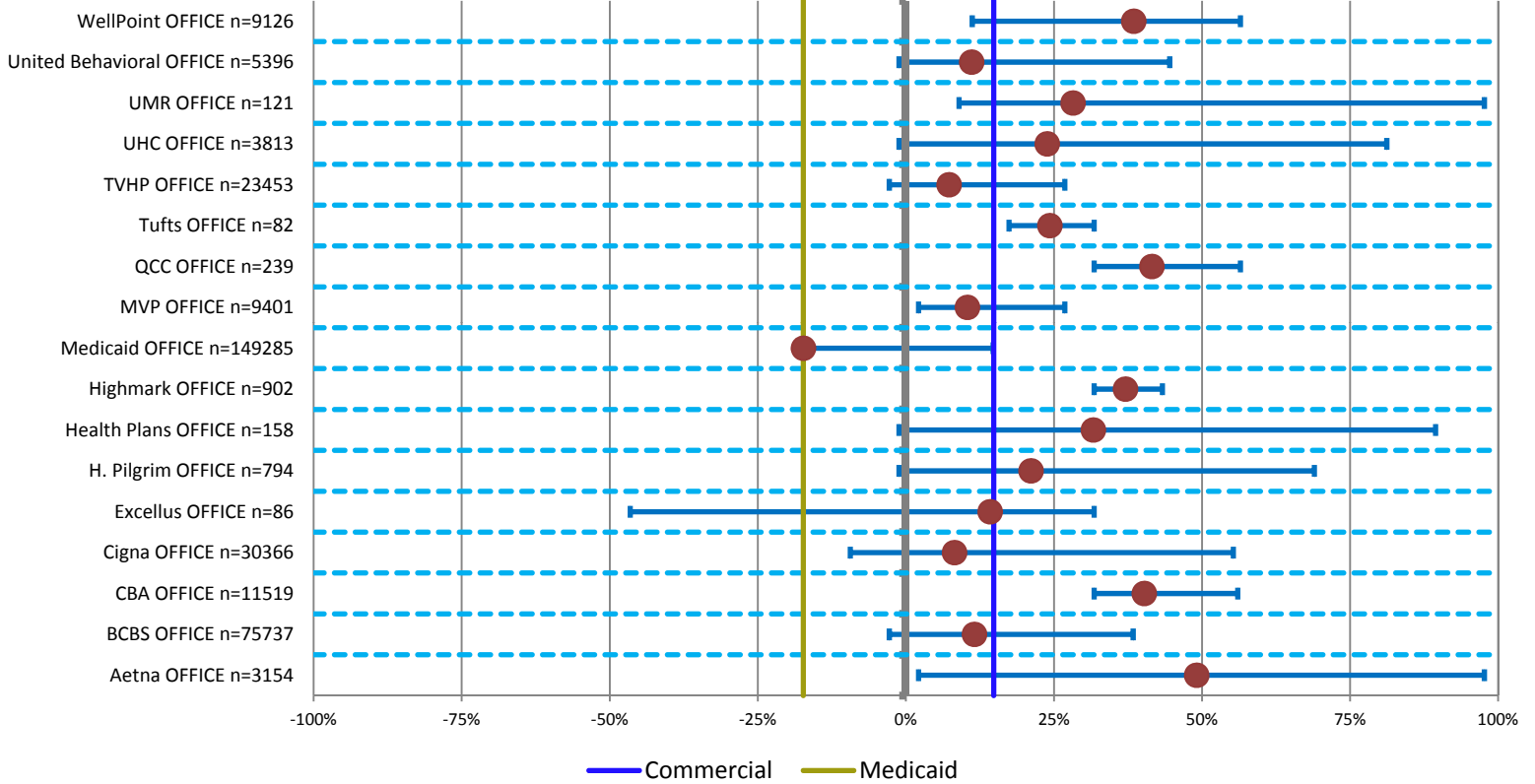
FY2012 Office Professional 99213 - OFFICE/OUTPATIENT VISIT- EST Allowed Payment Amount Variation



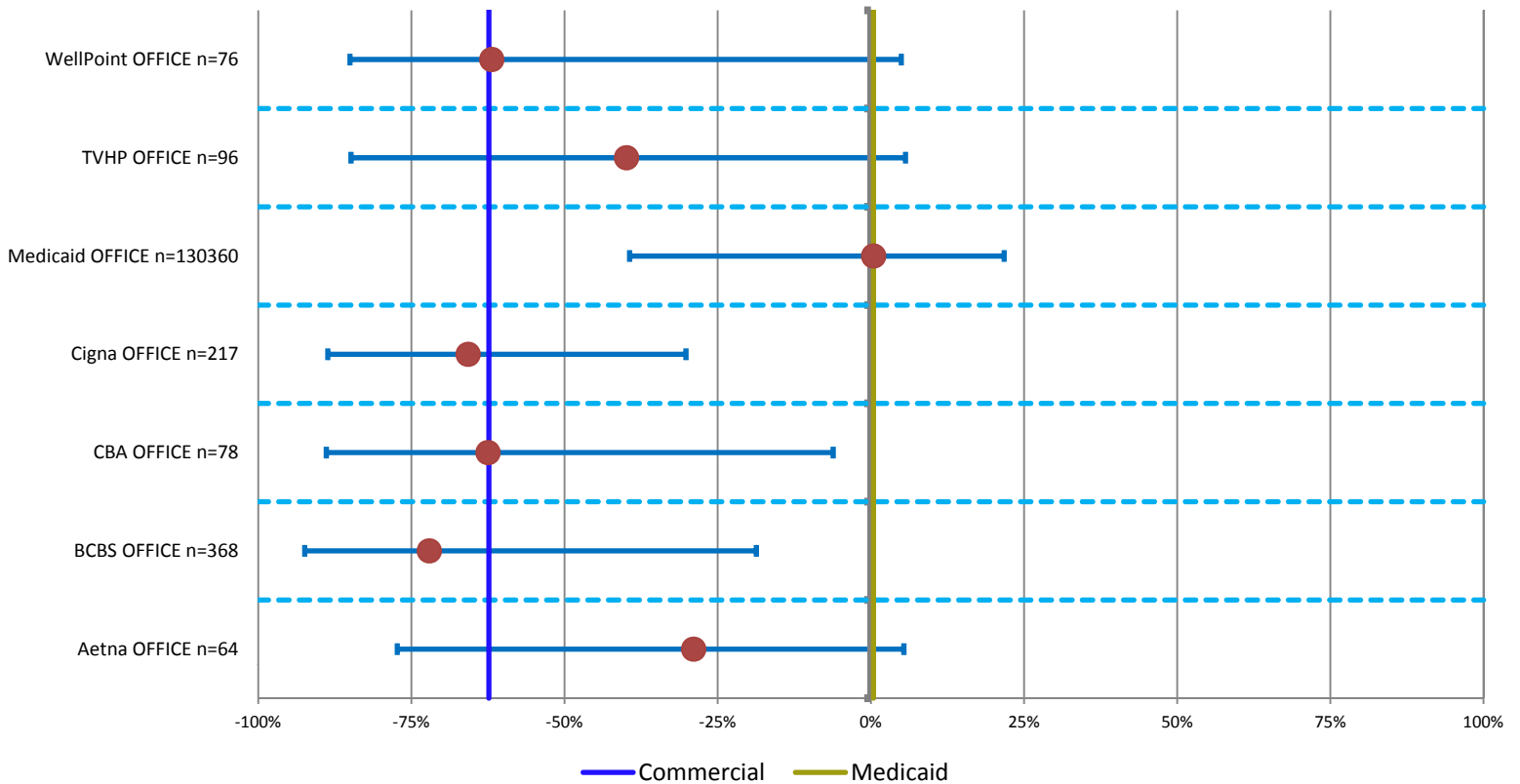
FY2012 Office Professional 99214 - OFFICE/OUTPATIENT VISIT- EST Allowed Payment Amount Variation



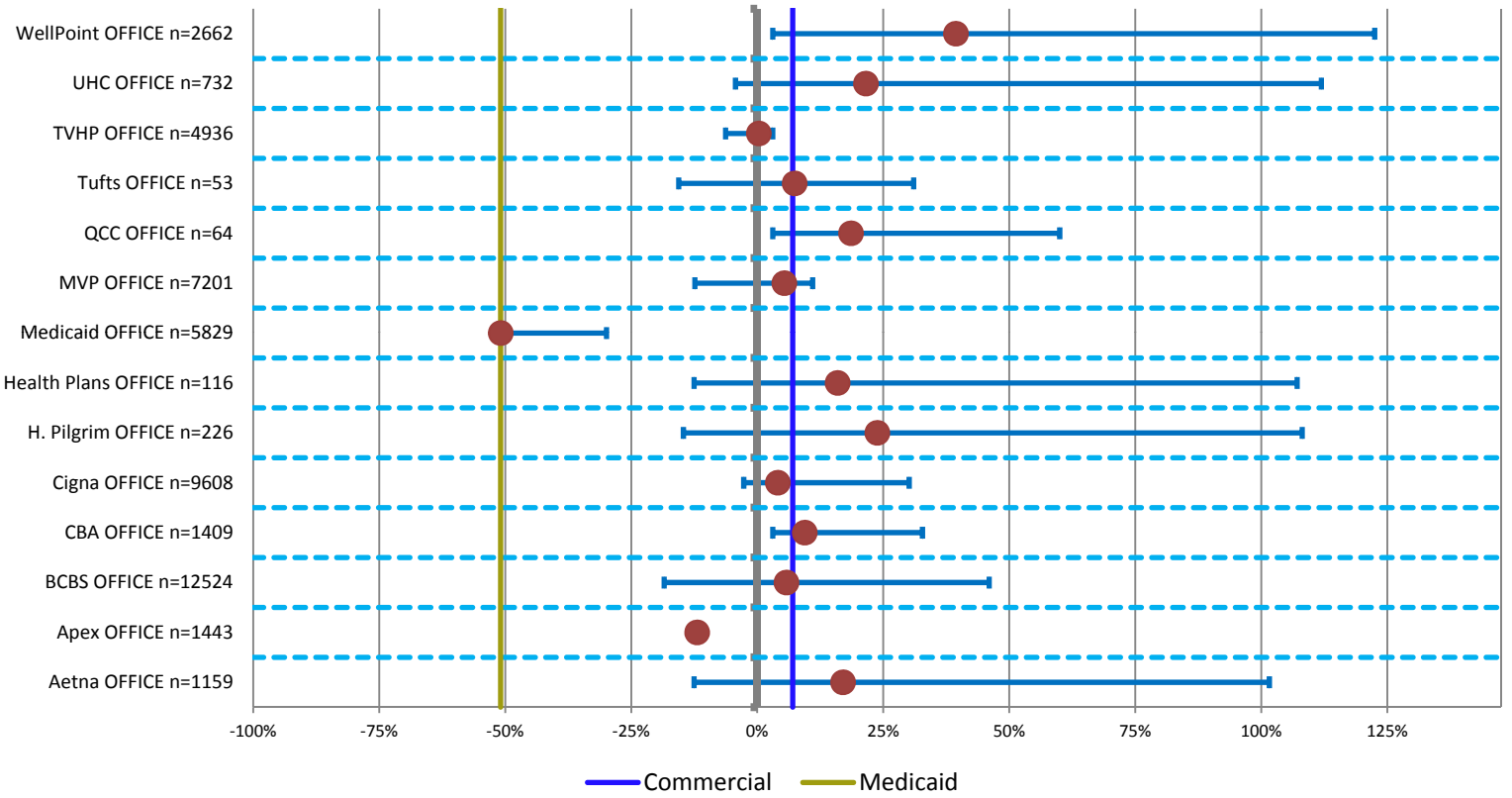
FY2012 Office Professional 90806 - PSYTX- OFF- 45-50 MIN Allowed Payment Amount Variation



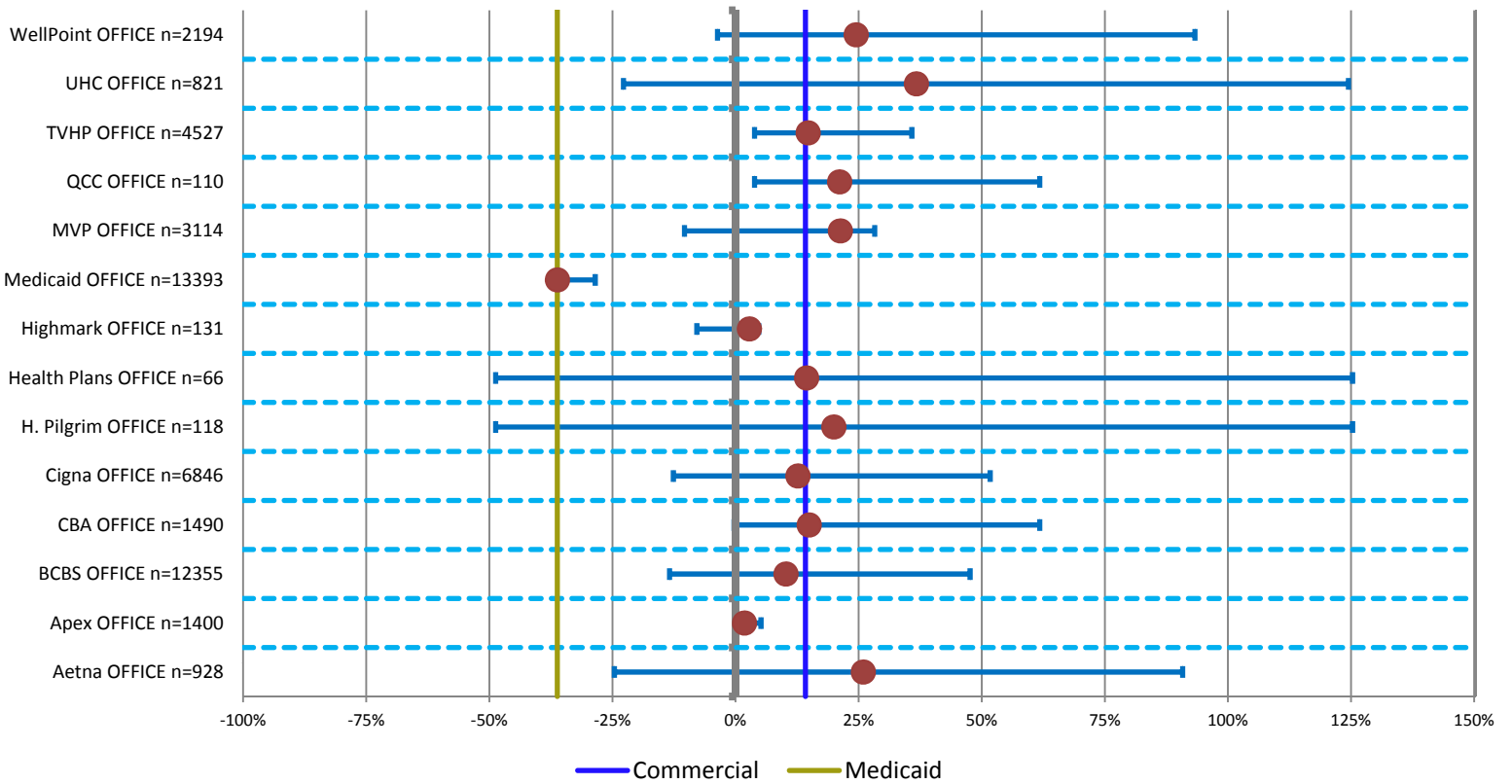
FY2012 Office Professional T1015 - CLINIC VST/ENCOUNTER ALL-INCLUSIVE Allowed Payment Amount Variation



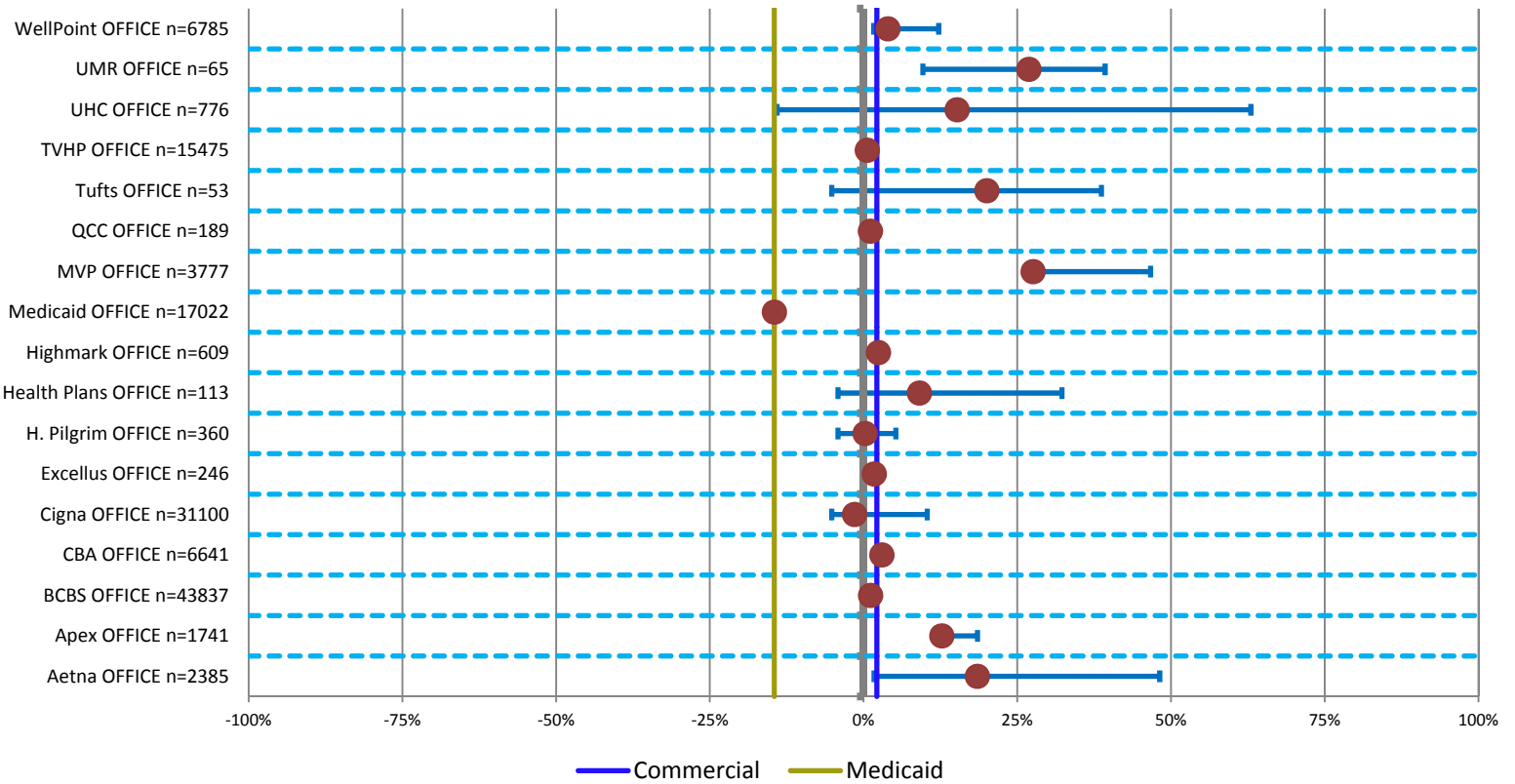
FY2012 Office Professional 99396 - PREV VISIT- EST- AGE 40-64 Allowed Payment Amount Variation



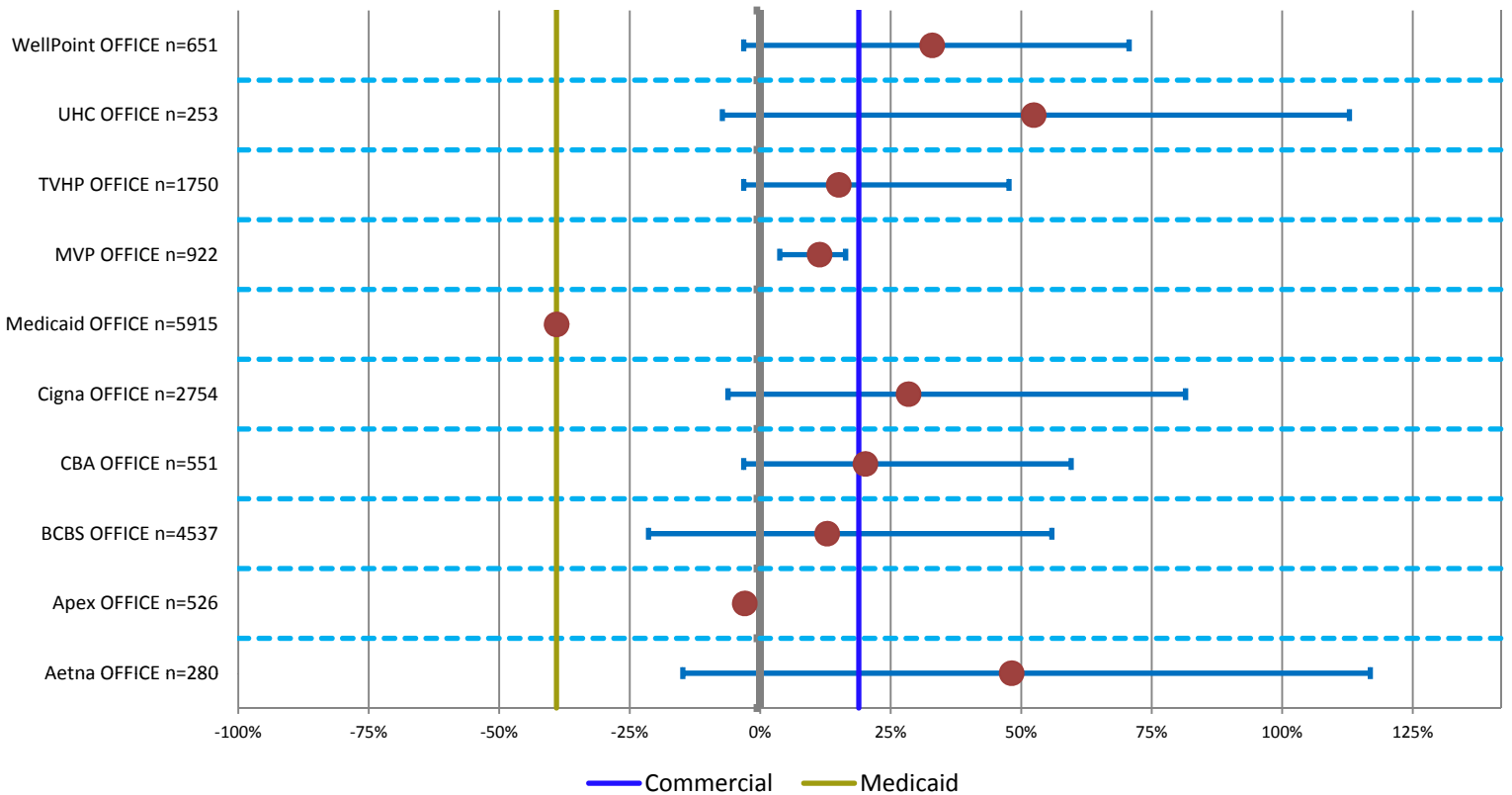
FY2012 Office Professional 99203 - OFFICE/OUTPATIENT VISIT, NEW Allowed Payment Amount Variation



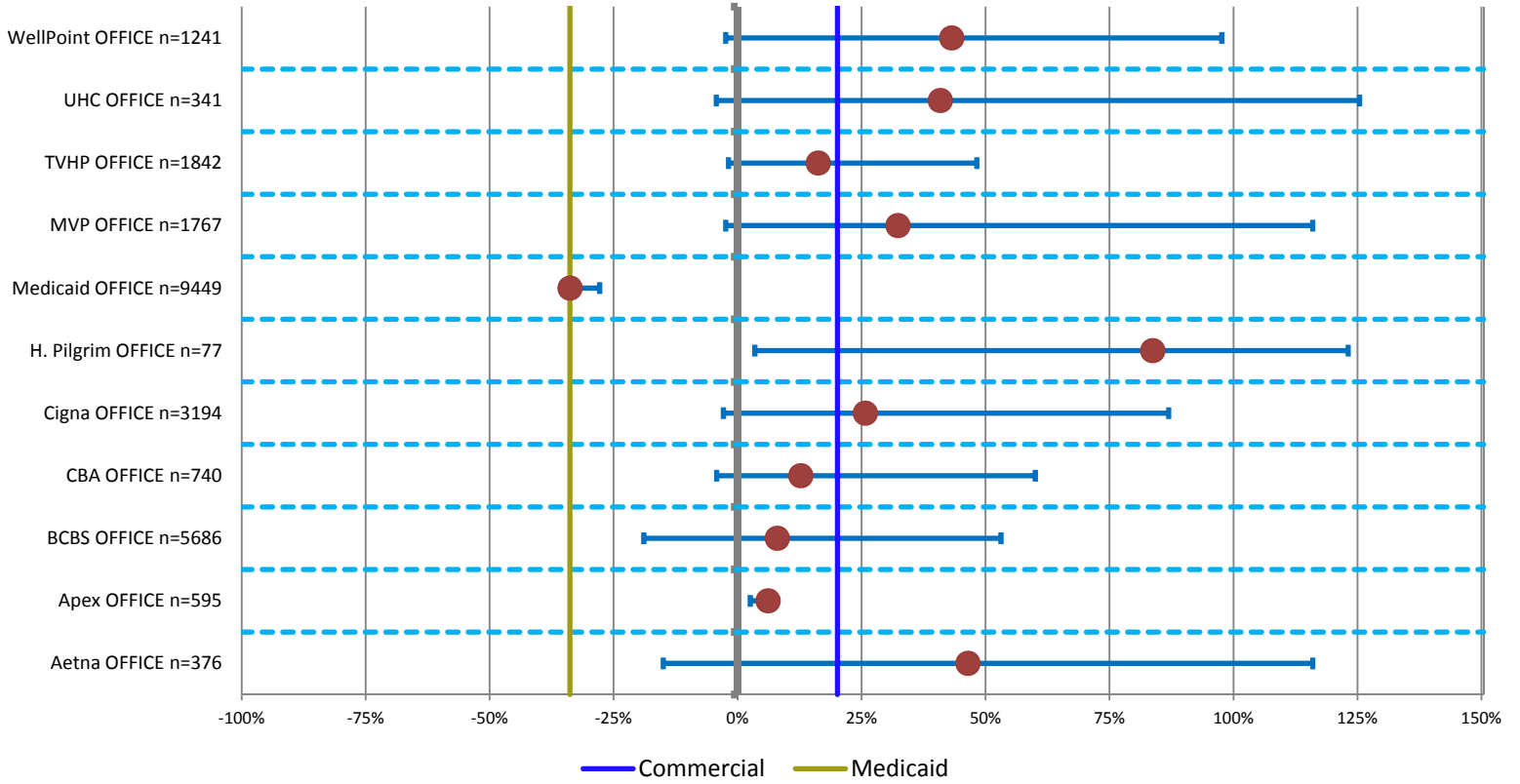
FY2012 Office Professional 98941 - CHIROPRACTIC MANIPULATION Allowed Payment Amount Variation



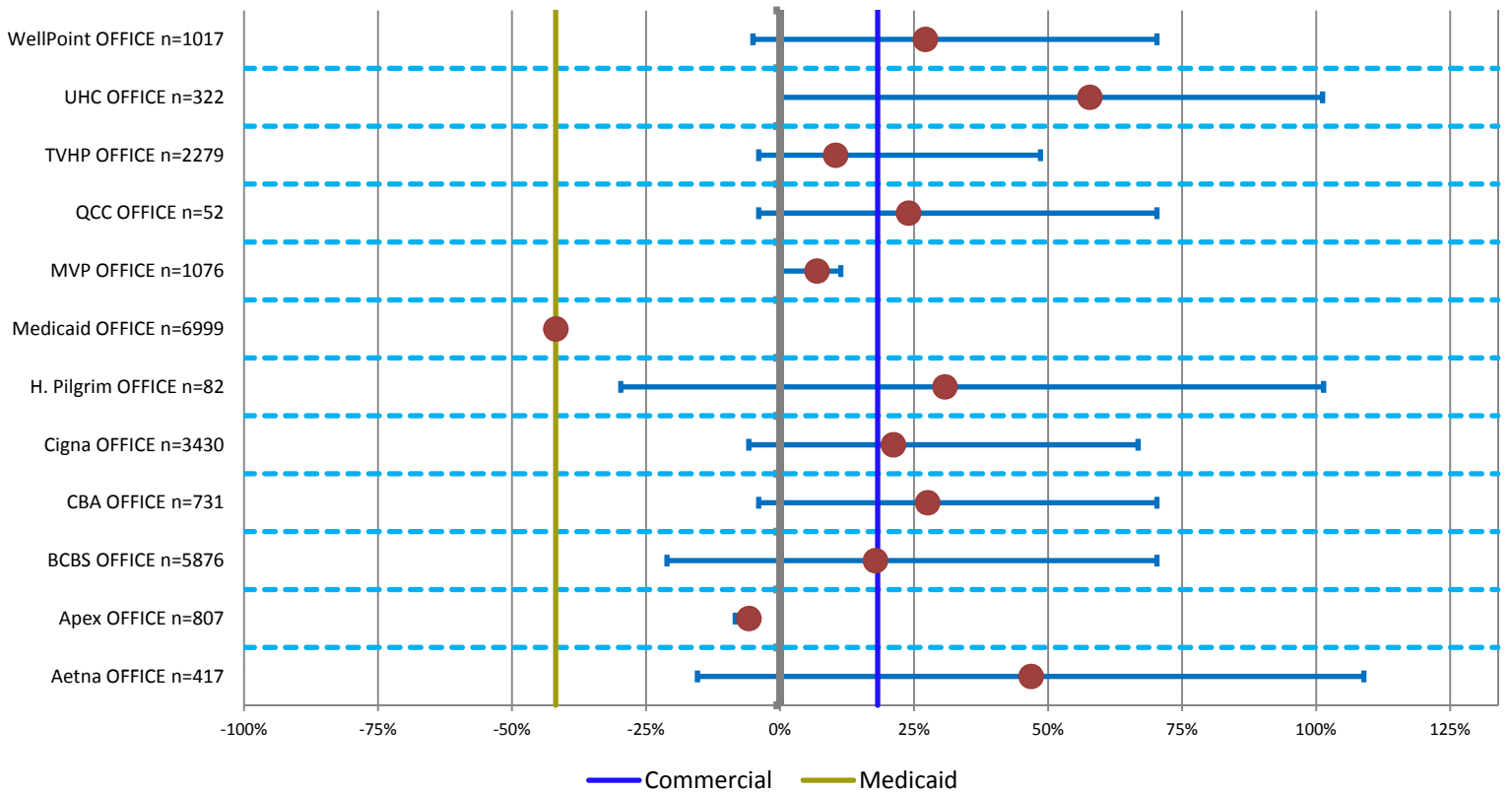
FY2012 Office Professional 99244 - OFFICE CONSULTATION Allowed Payment Amount Variation



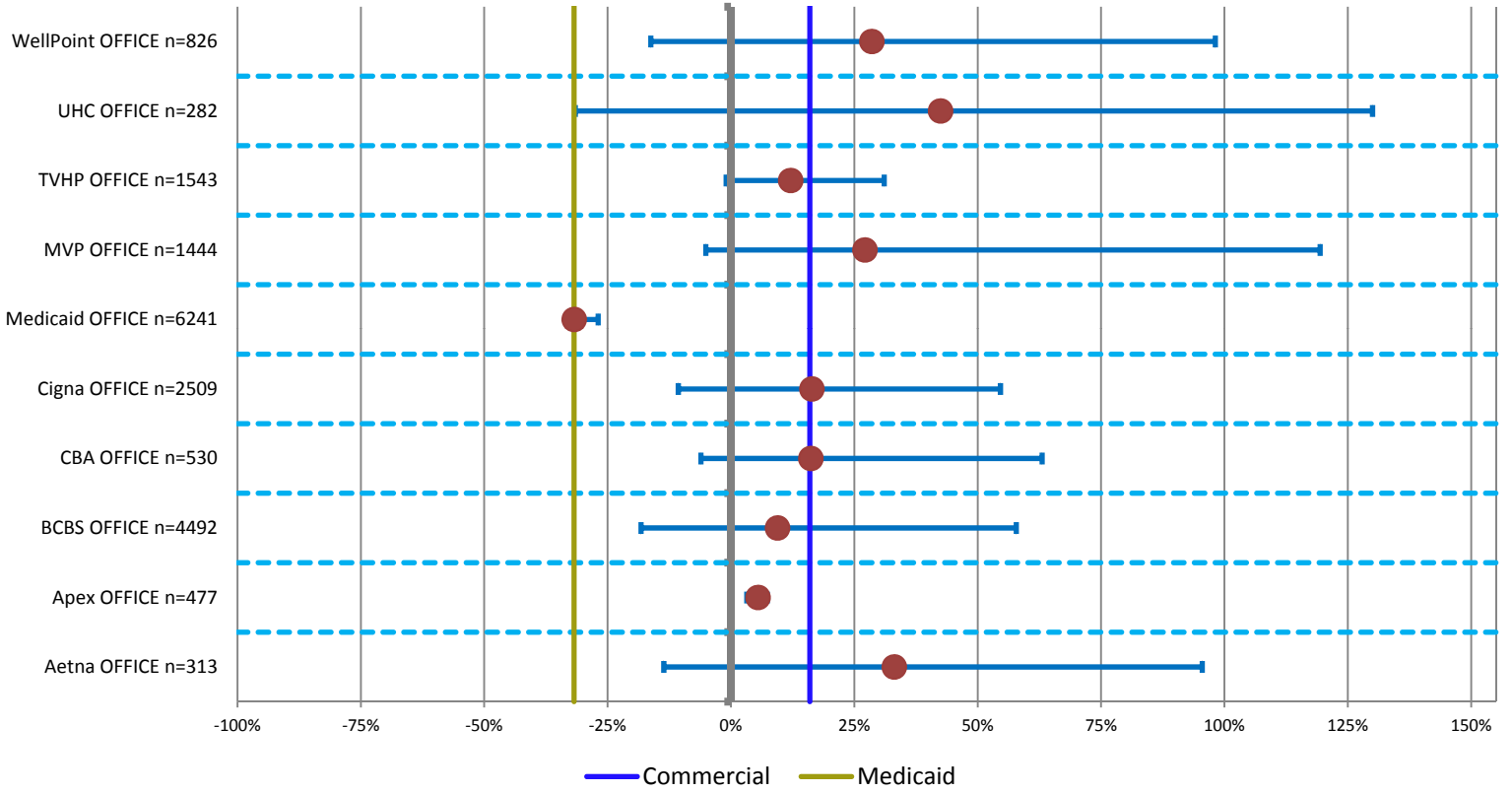
FY2012 Office Professional 99215 - OFFICE/OUTPATIENT VISIT- EST Allowed Payment Amount Variation



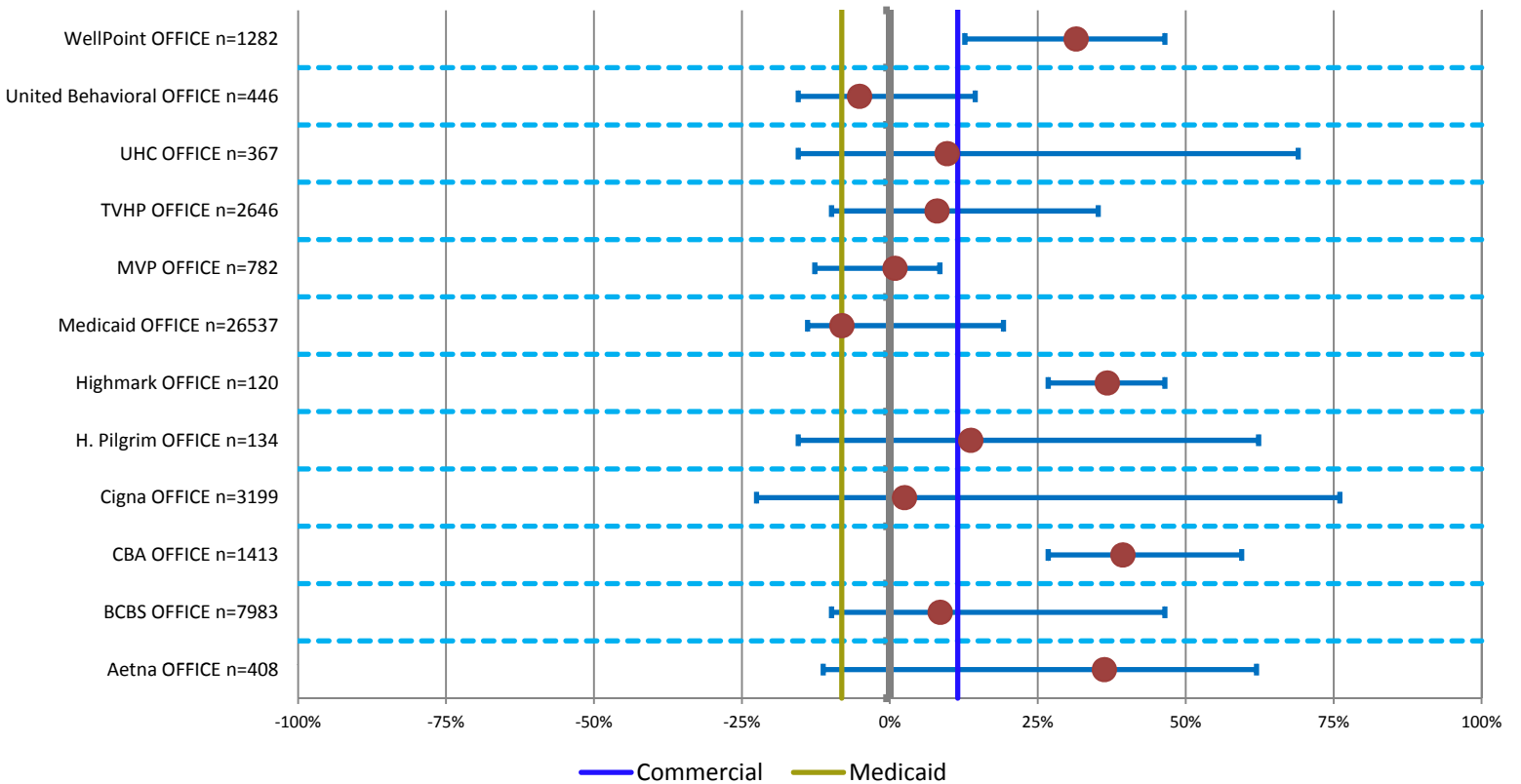
FY2012 Office Professional 99243 - OFFICE CONSULTATION Allowed Payment Amount Variation



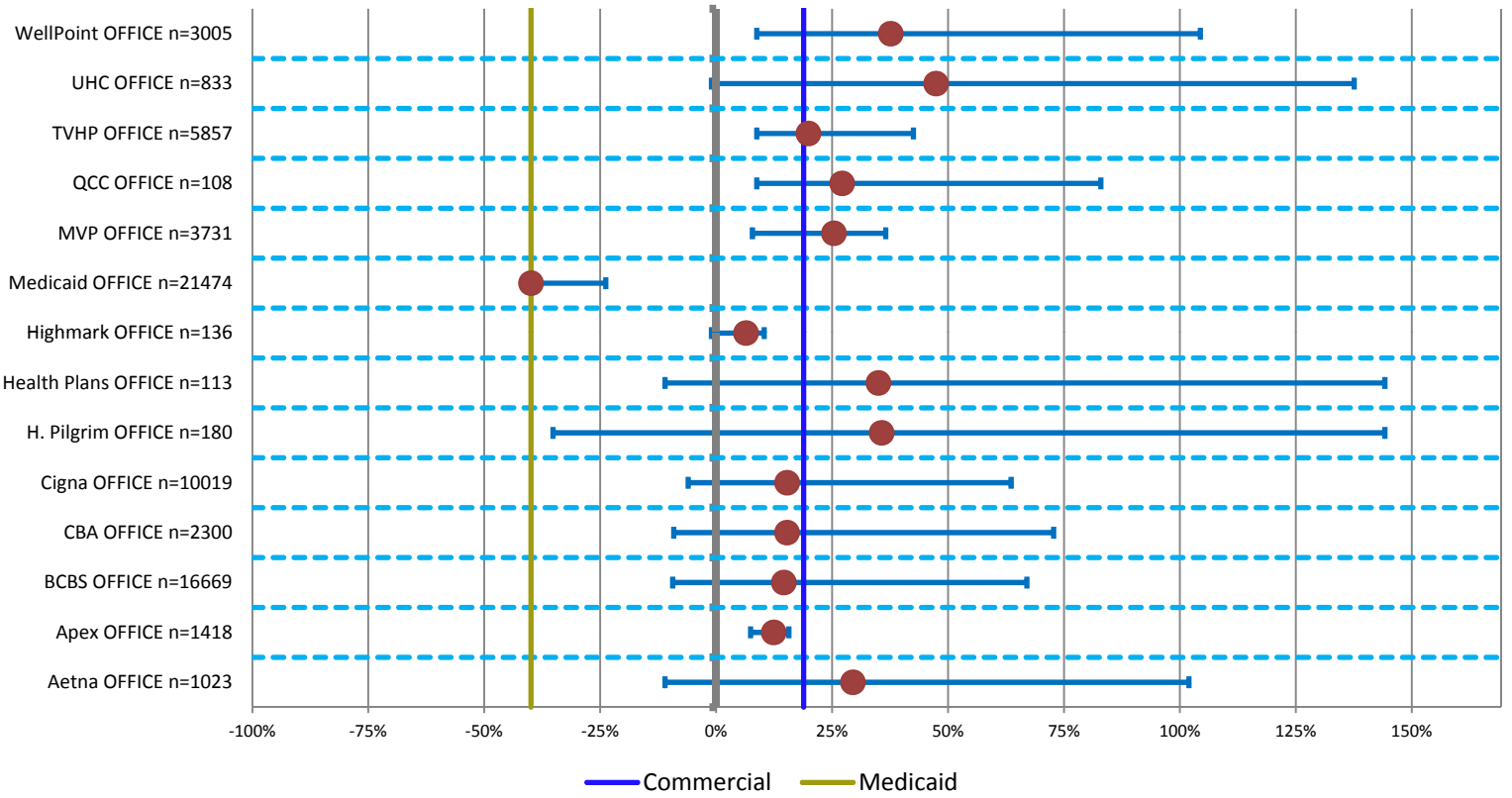
FY2012 Office Professional 99204 - OFFICE/OUTPATIENT VISIT, NEW Allowed Payment Amount Variation



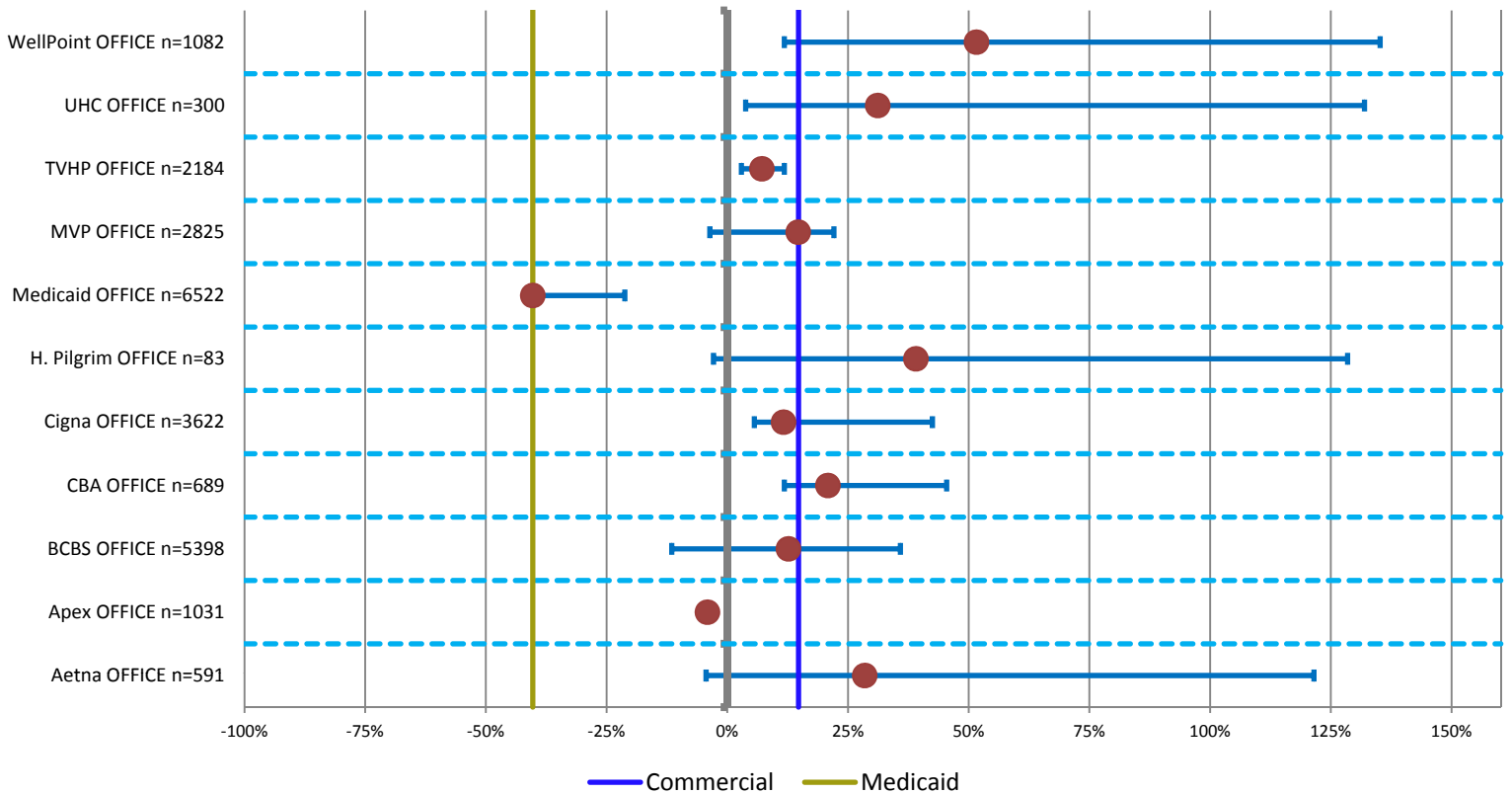
FY2012 Office Professional 90847 - FAMILY PSYTX W/PATIENT Allowed Payment Amount Variation



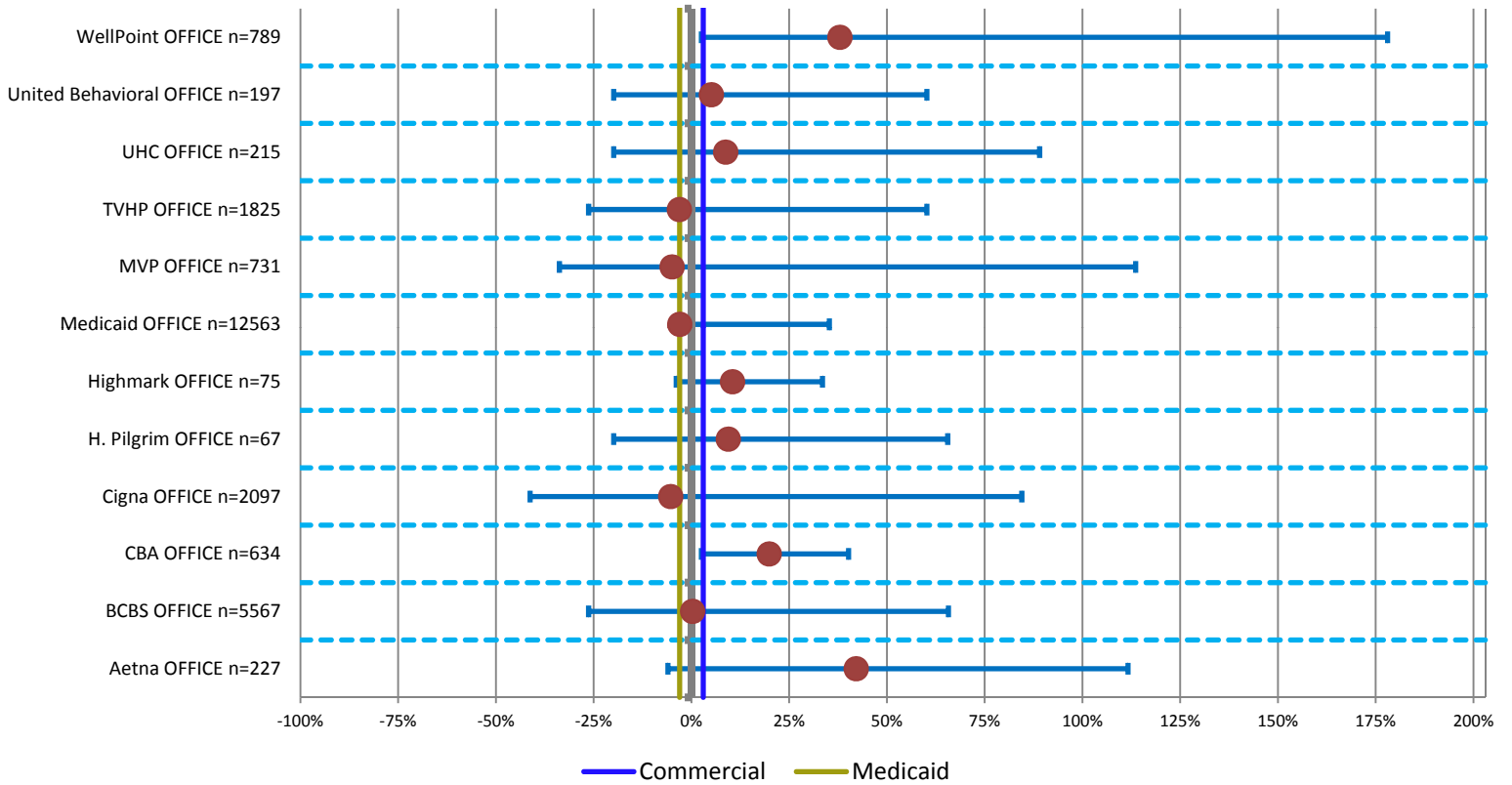
FY2012 Office Professional 99212 - OFFICE/OUTPATIENT VISIT- EST Allowed Payment Amount Variation



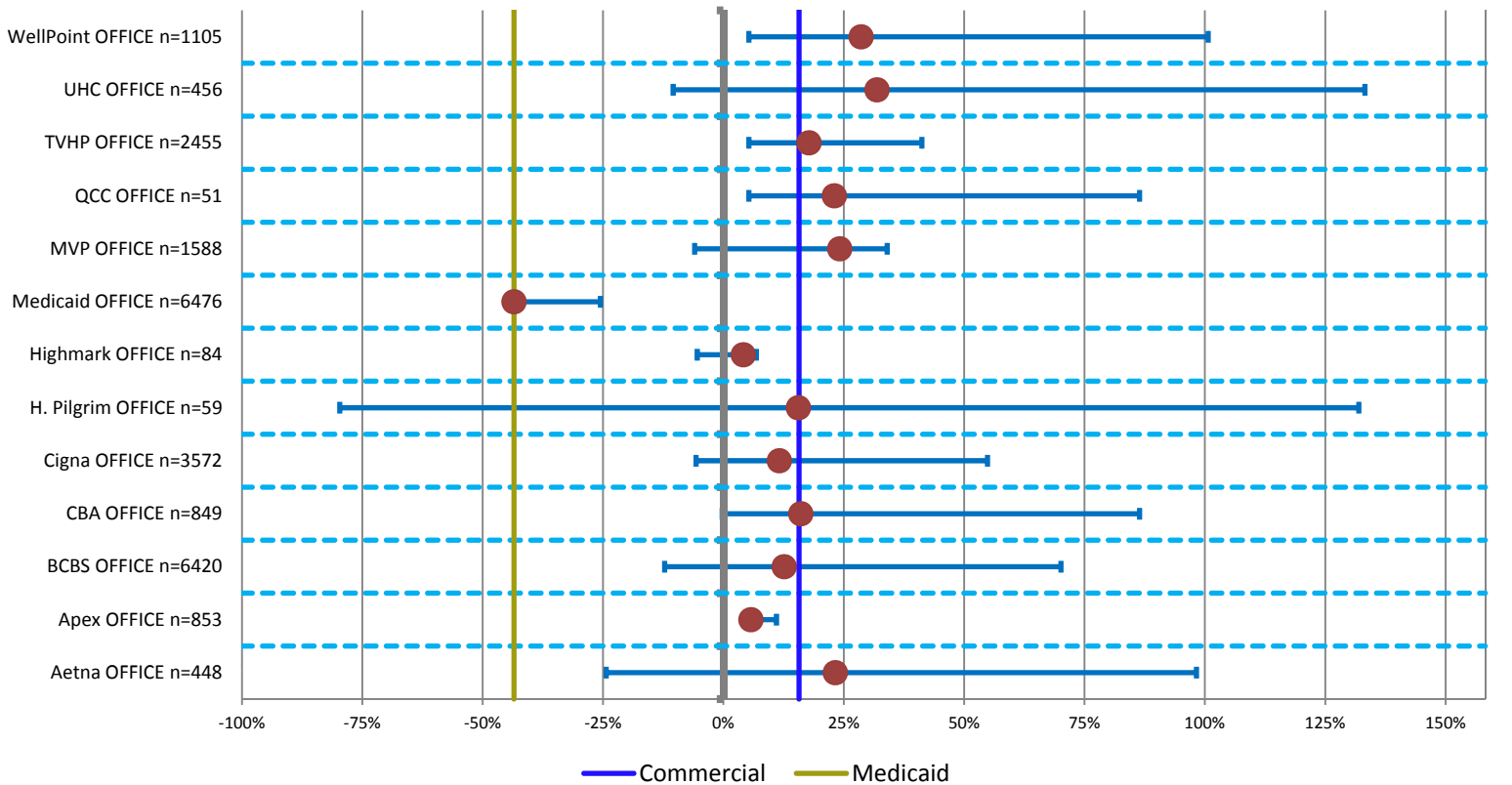
FY2012 Office Professional 99395 - PREV VISIT- EST- AGE 18-39 Allowed Payment Amount Variation



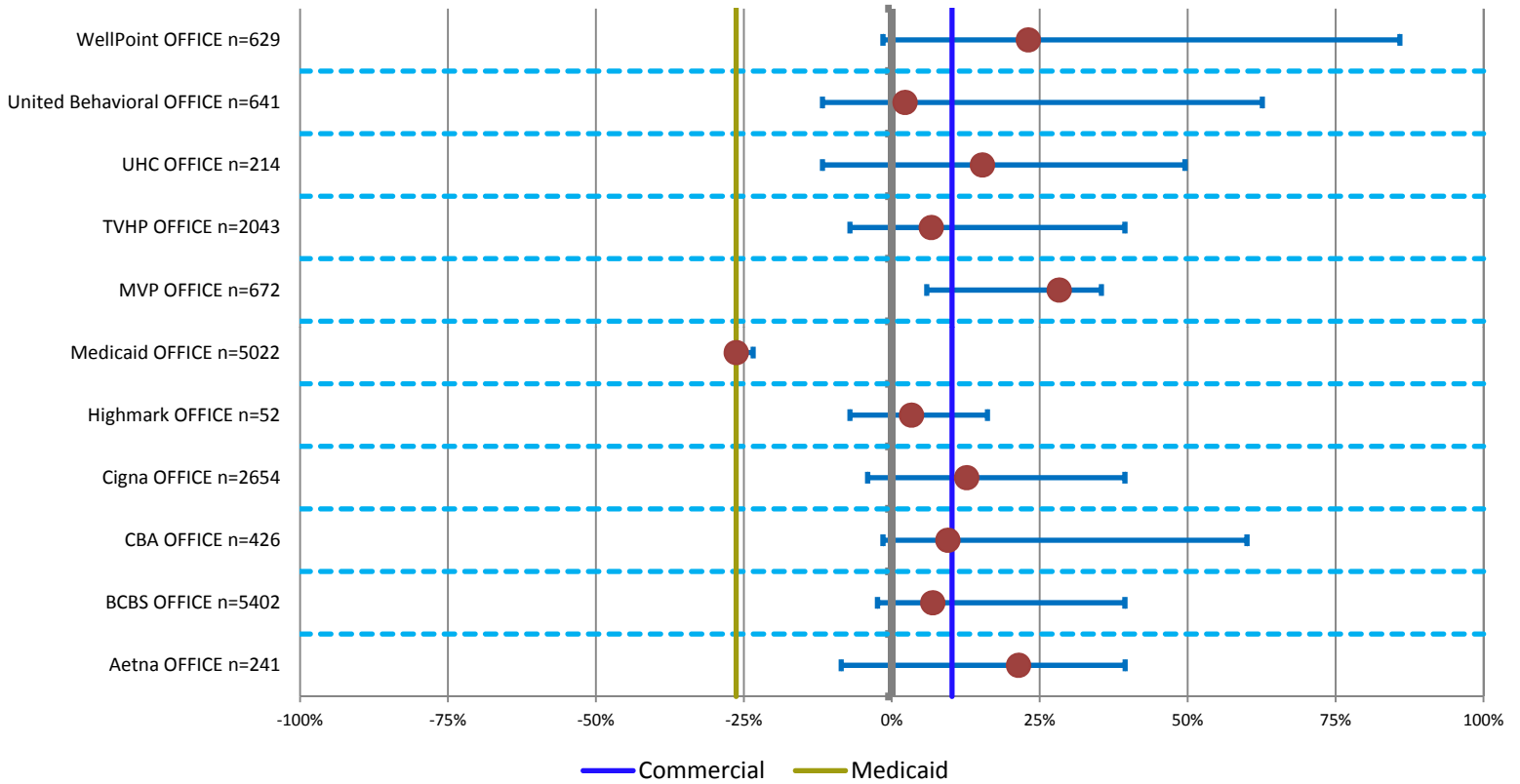
FY2012 Office Professional 90801 - PSY DX INTERVIEW Allowed Payment Amount Variation



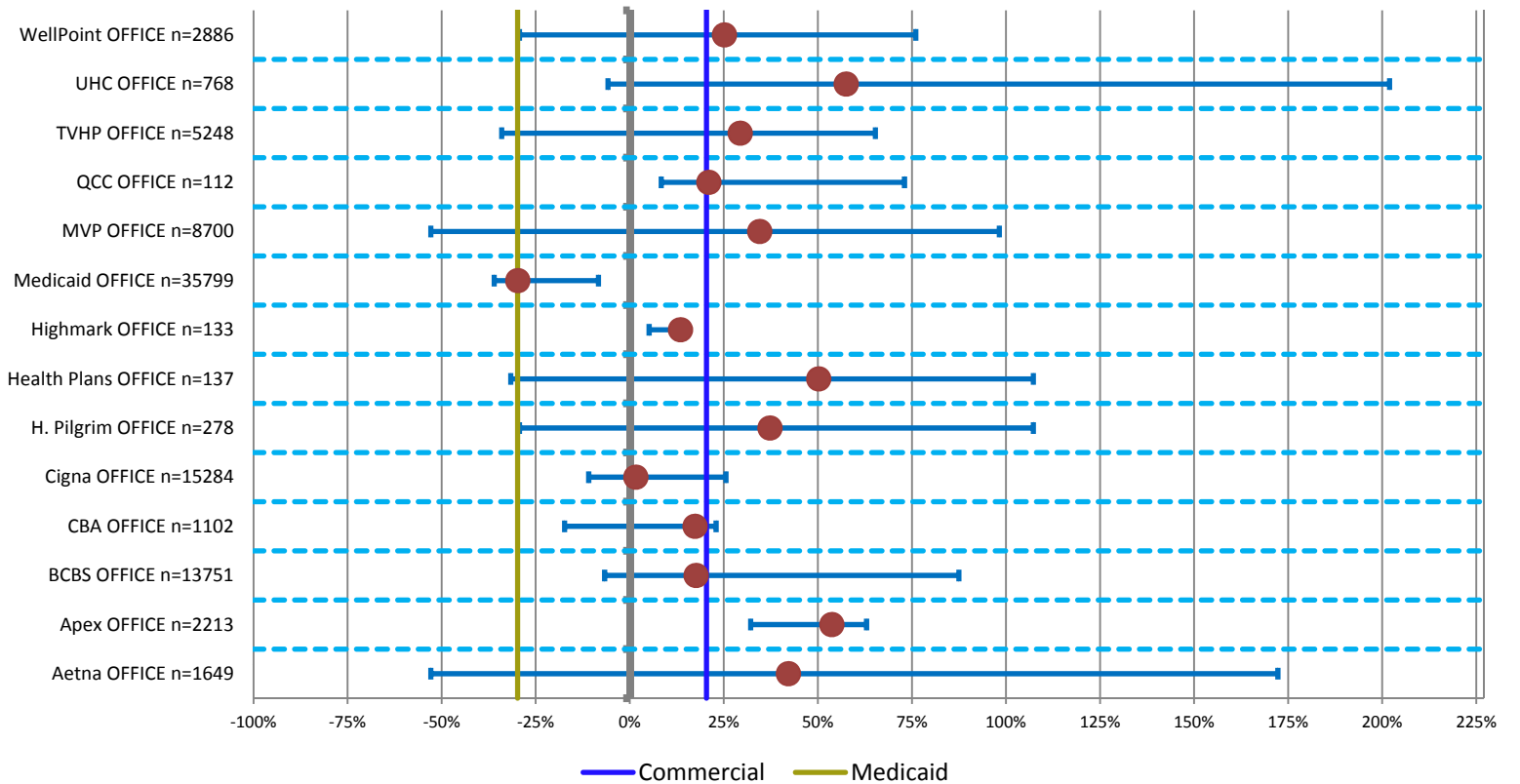
FY2012 Office Professional 99202 - OFFICE/OUTPATIENT VISIT, NEW Allowed Payment Amount Variation



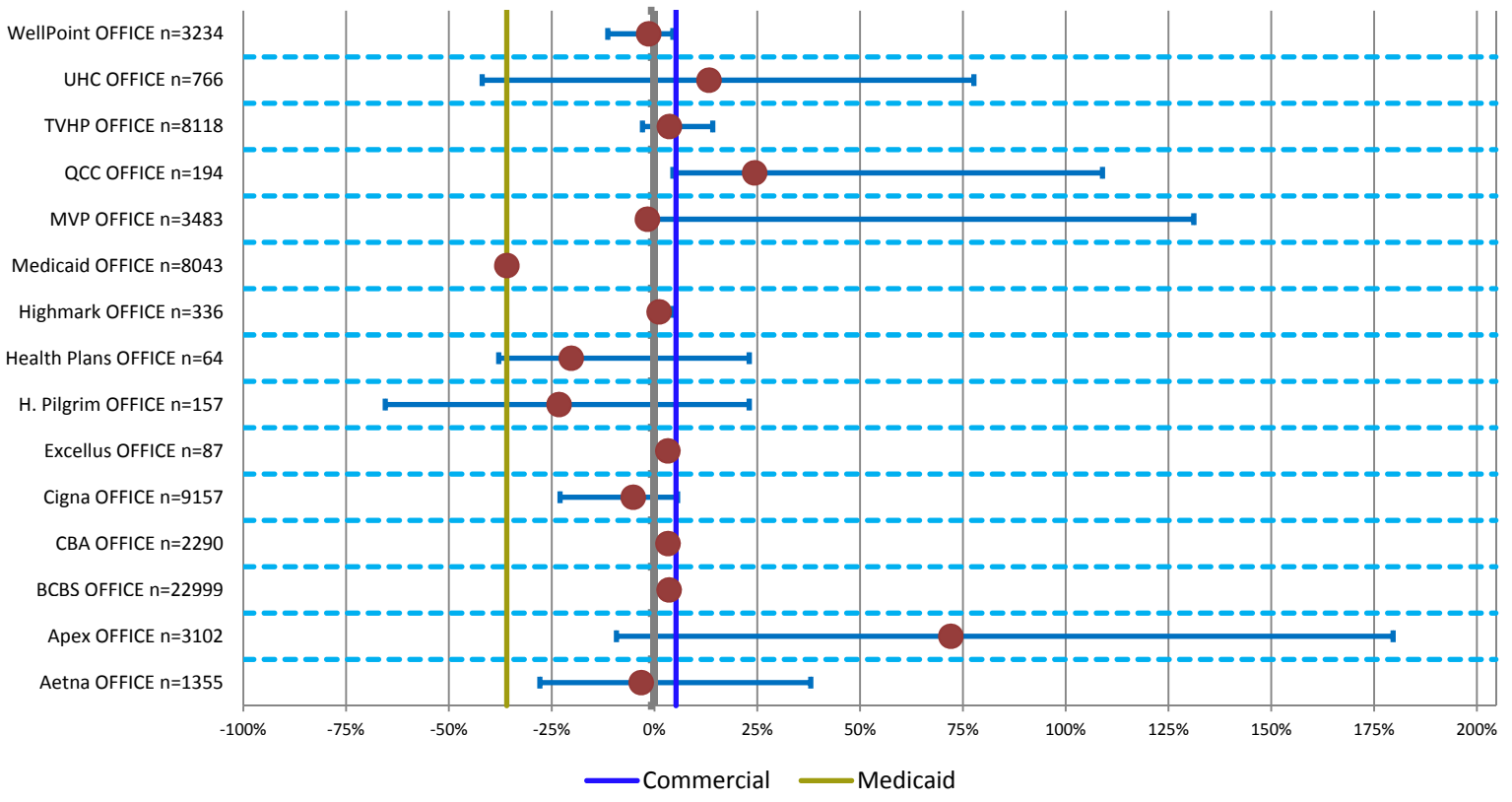
FY2012 Office Professional 90807 - PSYTX- OFF- 45-50 MIN W/E&M Allowed Payment Amount Variation



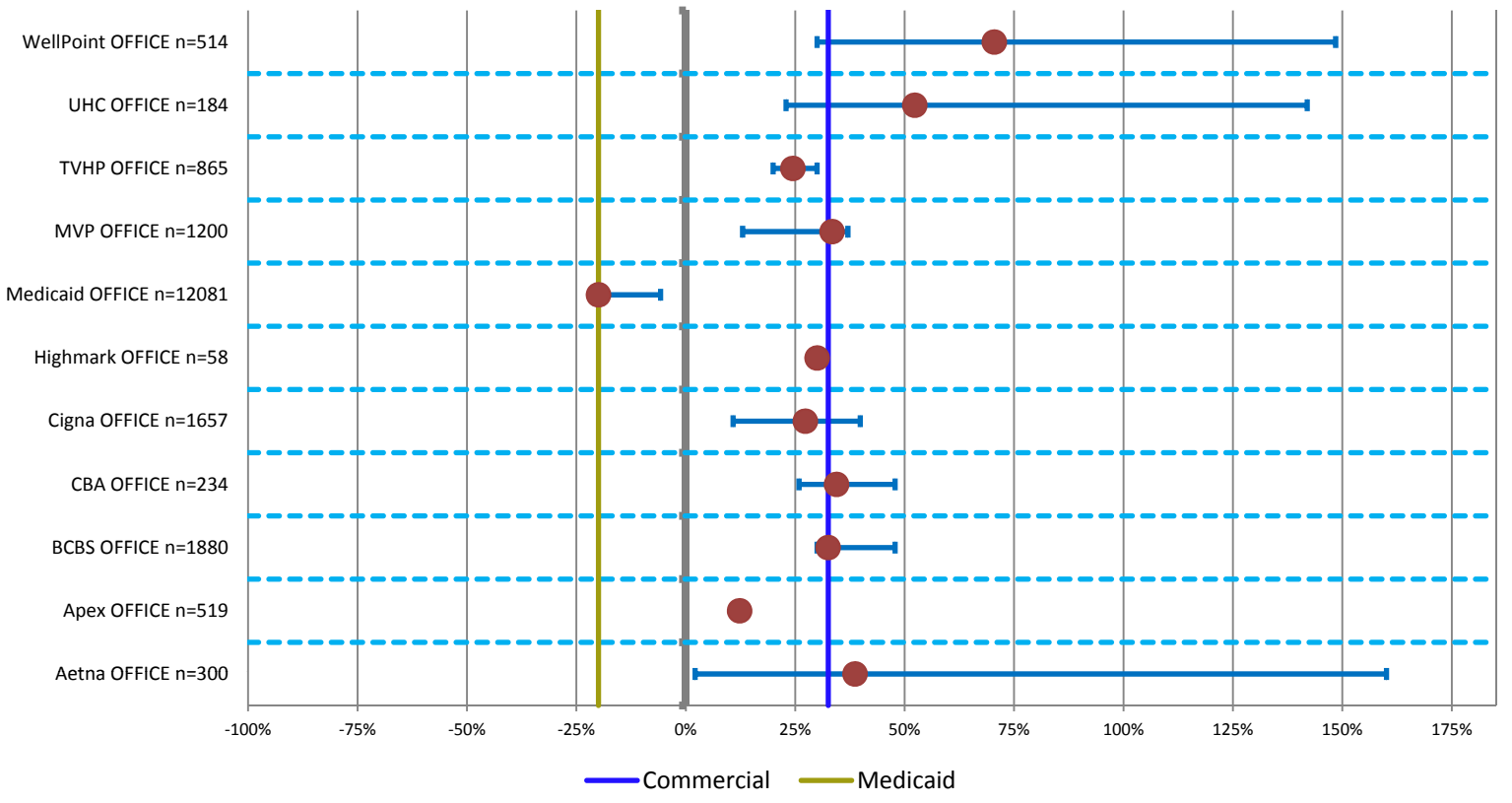
FY2012 Office Professional 90471 - IMMUNIZATION ADMIN Allowed Payment Amount Variation



FY2012 Office Professional 97110 - THERAPEUTIC EXERCISES Allowed Payment Amount Variation

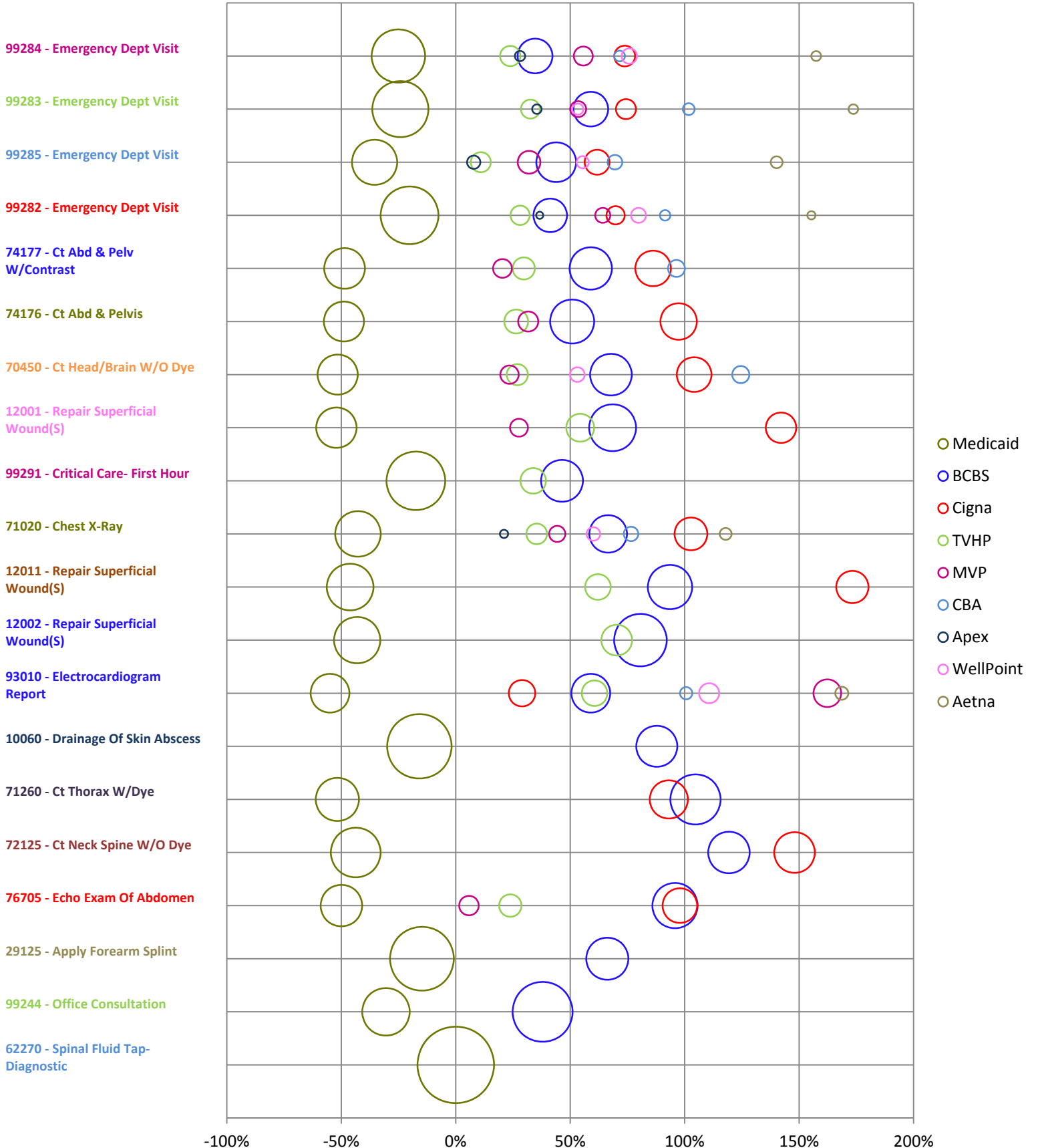


FY2012 Office Professional 99392 - PREV VISIT- EST- AGE 1-4 Allowed Payment Amount Variation

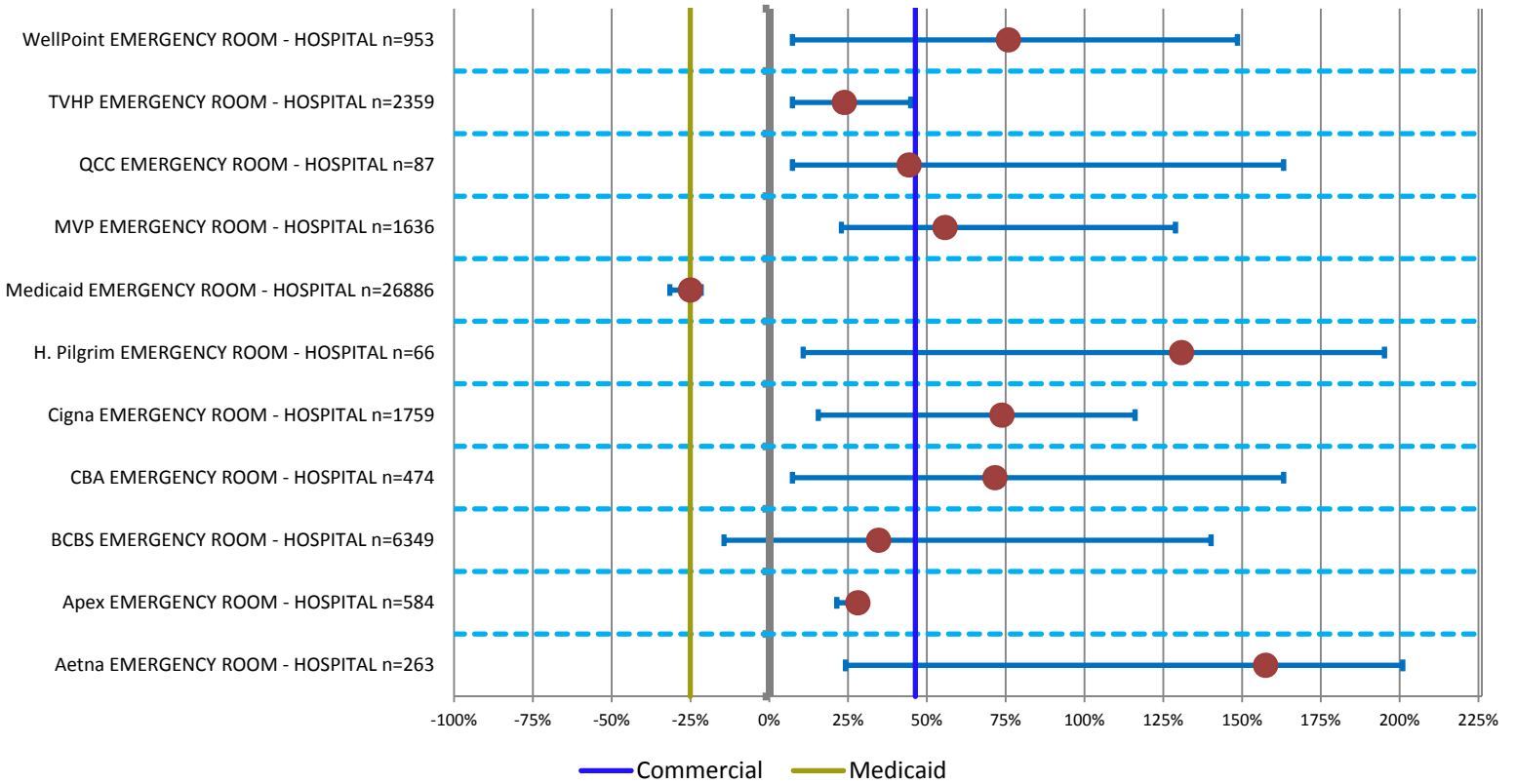


FY2012 Emergency Room - Hospital Professional Allowed Payment Amount Variation

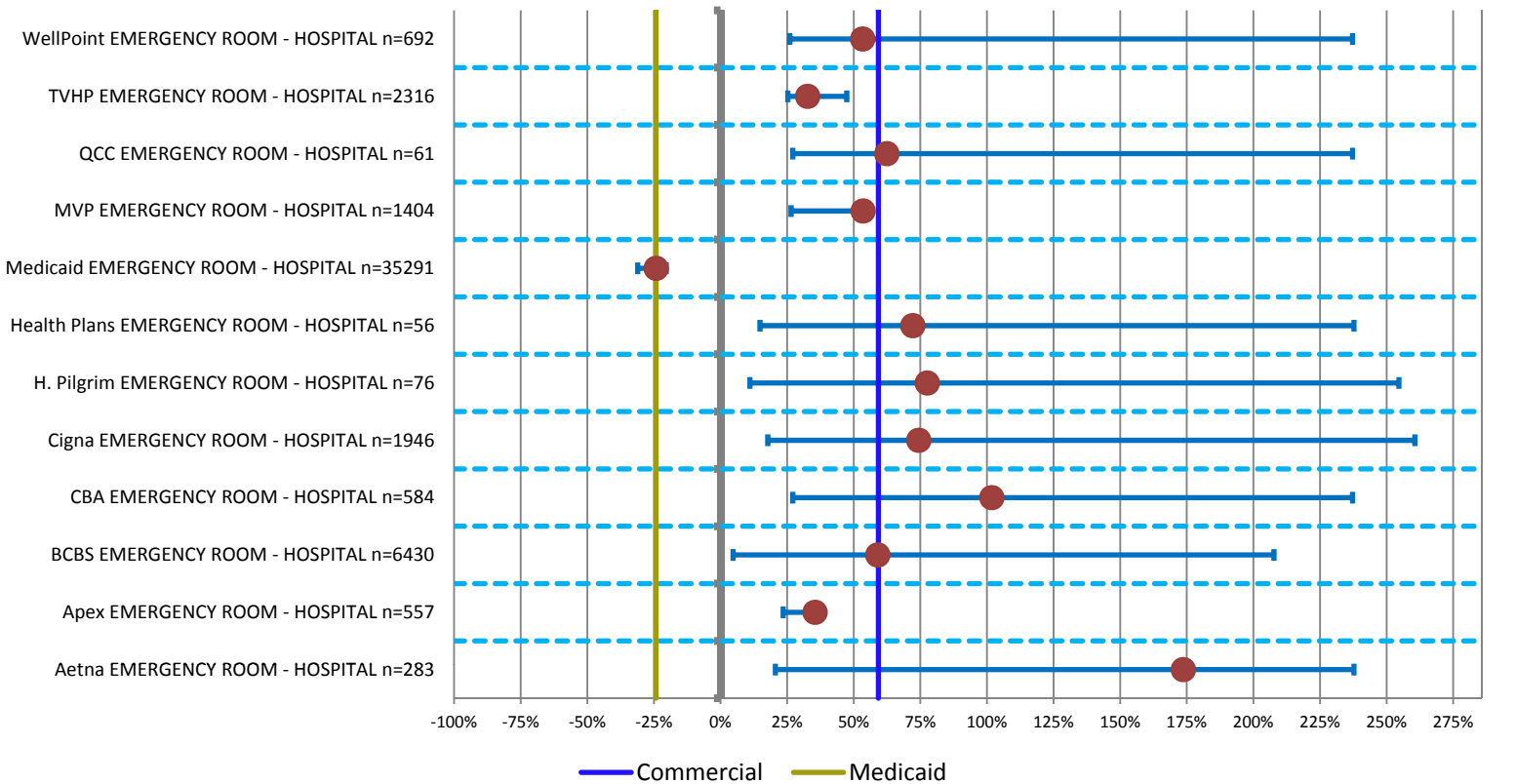
FY2012 Emergency Room - Hospital Professional Allowed Payment Amount Variation (Min 50 Visits)



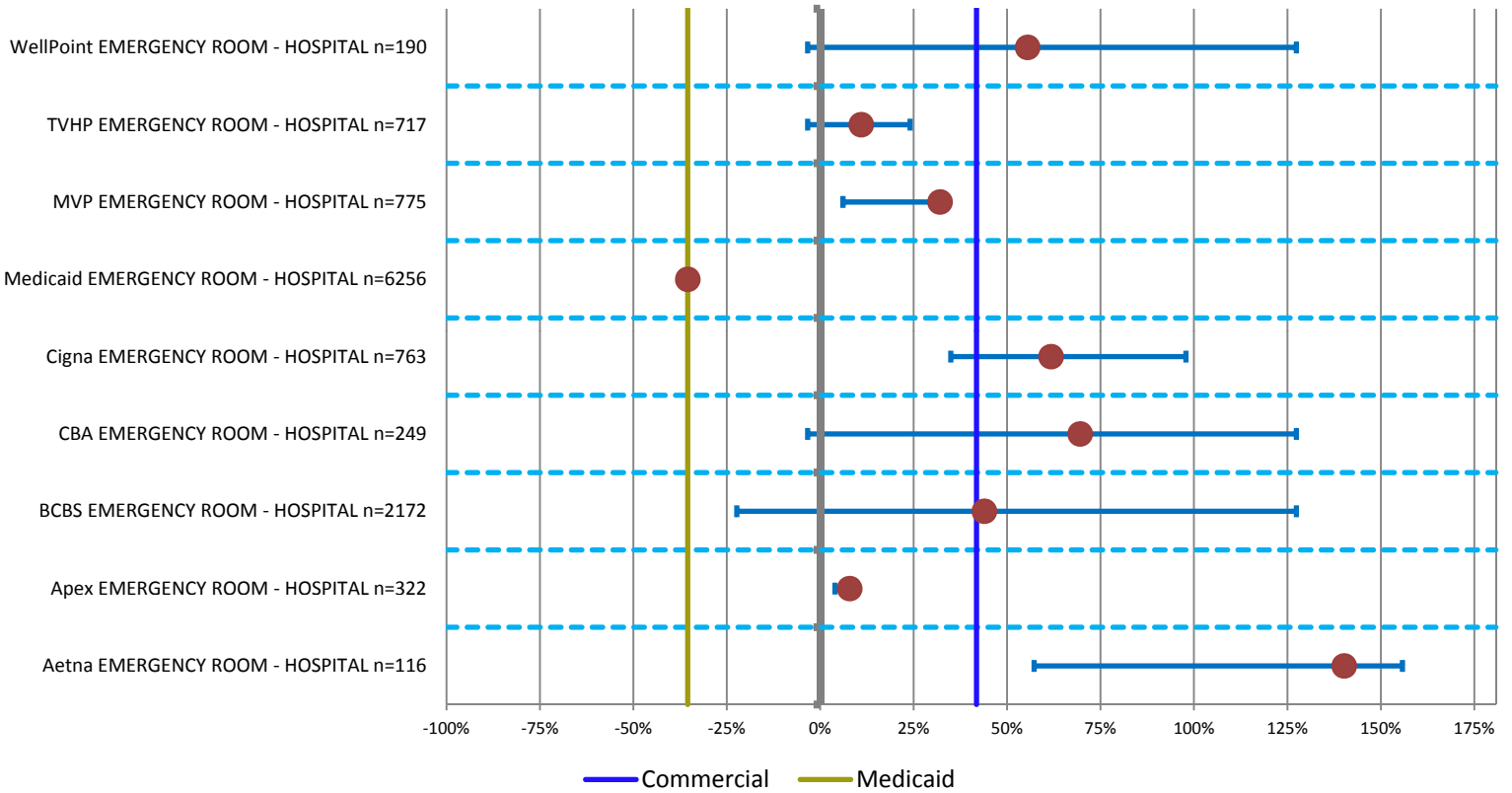
FY2012 ER Professional 99284 - EMERGENCY DEPT VISIT Allowed Payment Amount Variation



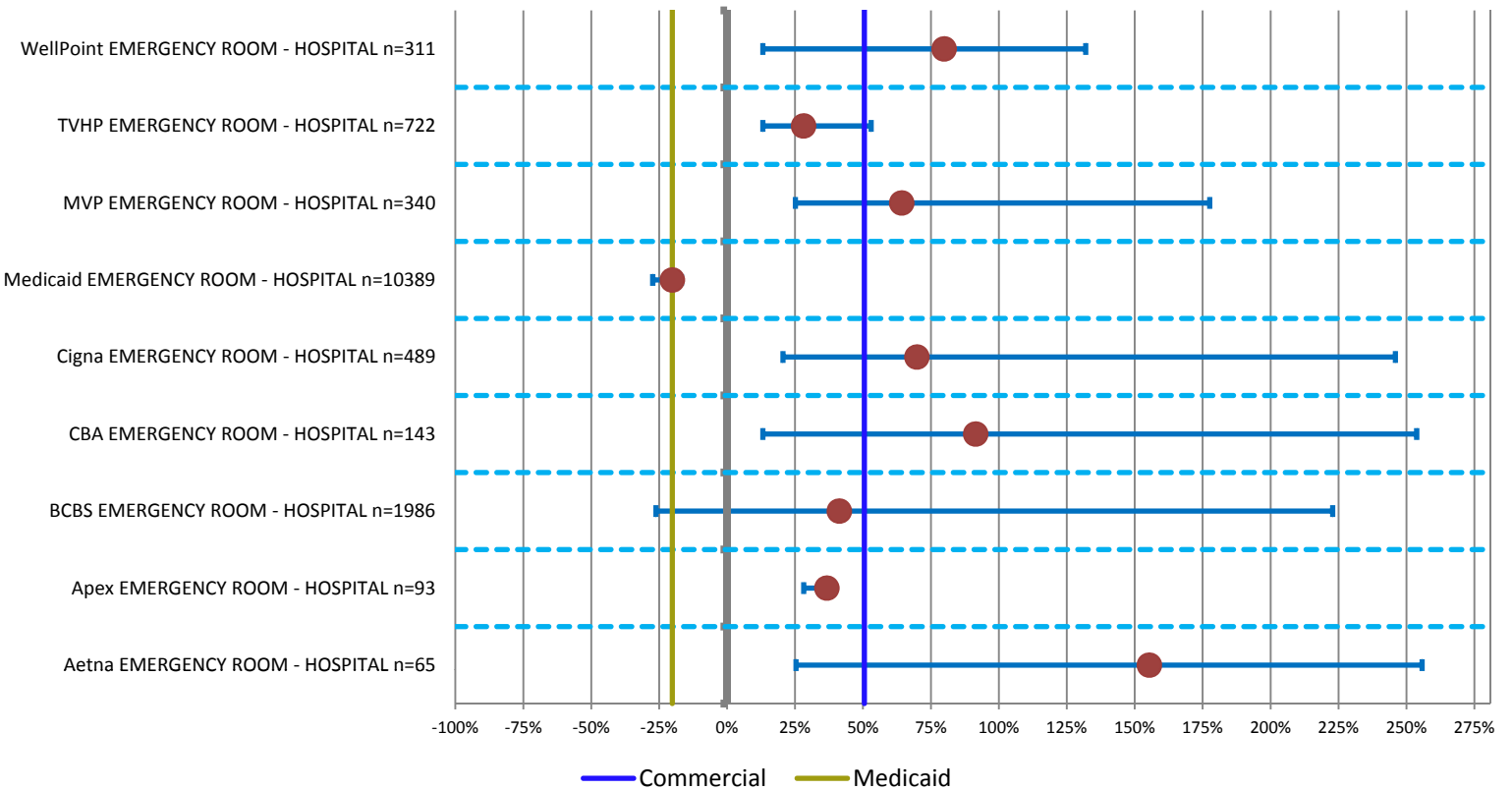
FY2012 ER Professional 99283 - EMERGENCY DEPT VISIT Allowed Payment Amount Variation



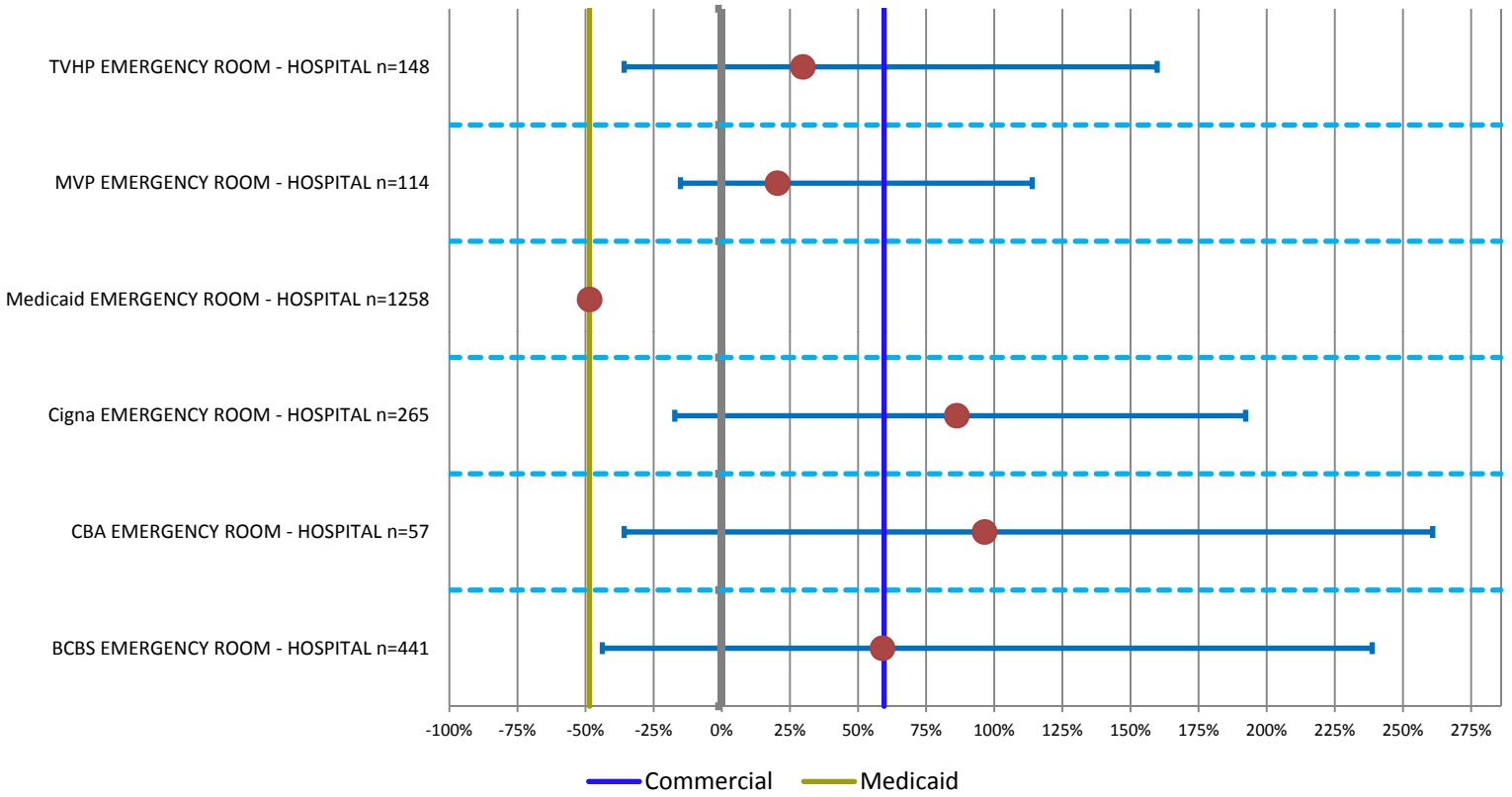
FY2012 ER Professional 99285 - EMERGENCY DEPT VISIT Allowed Payment Amount Variation



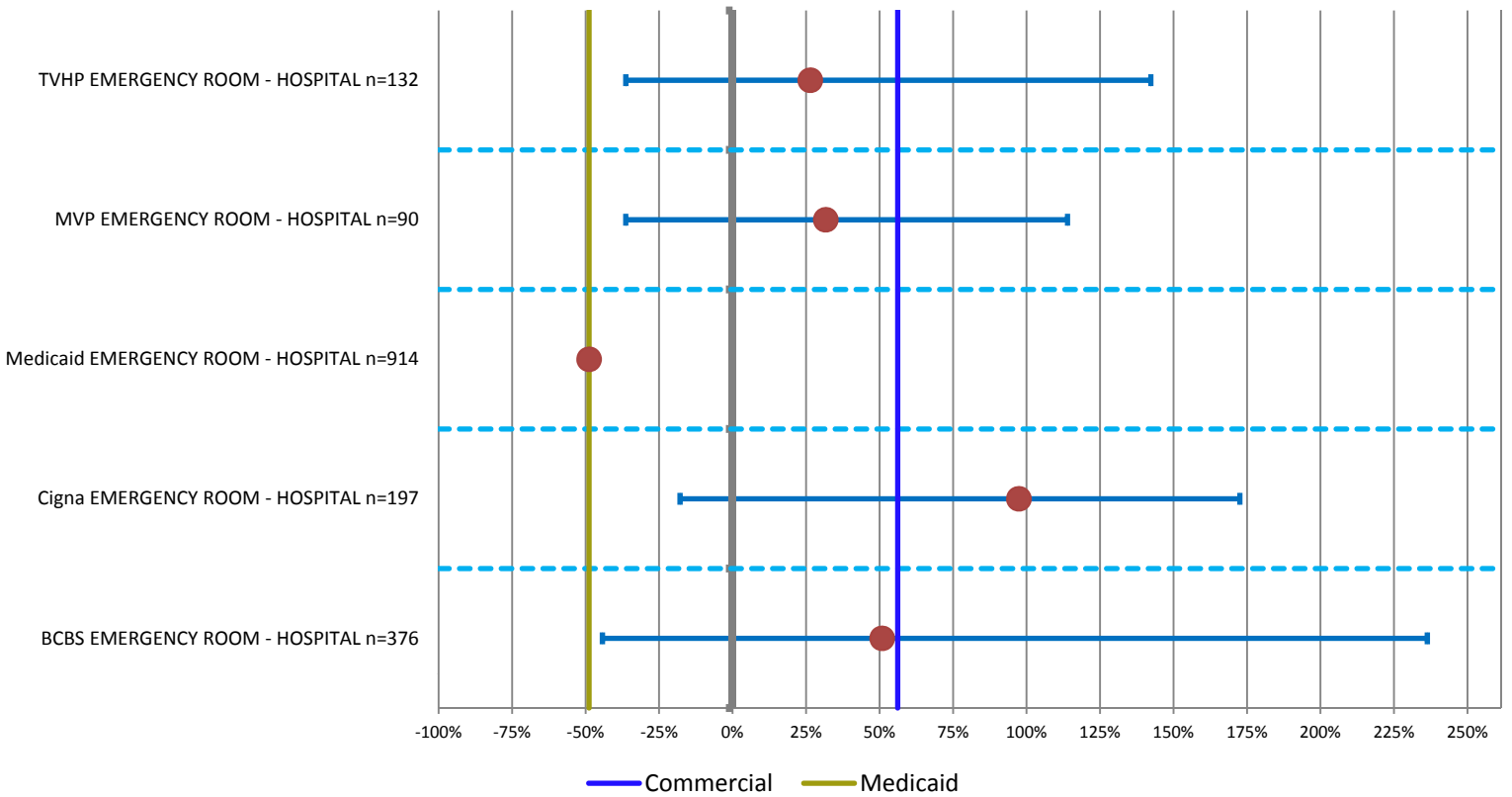
FY2012 ER Professional 99282 - EMERGENCY DEPT VISIT Allowed Payment Amount Variation



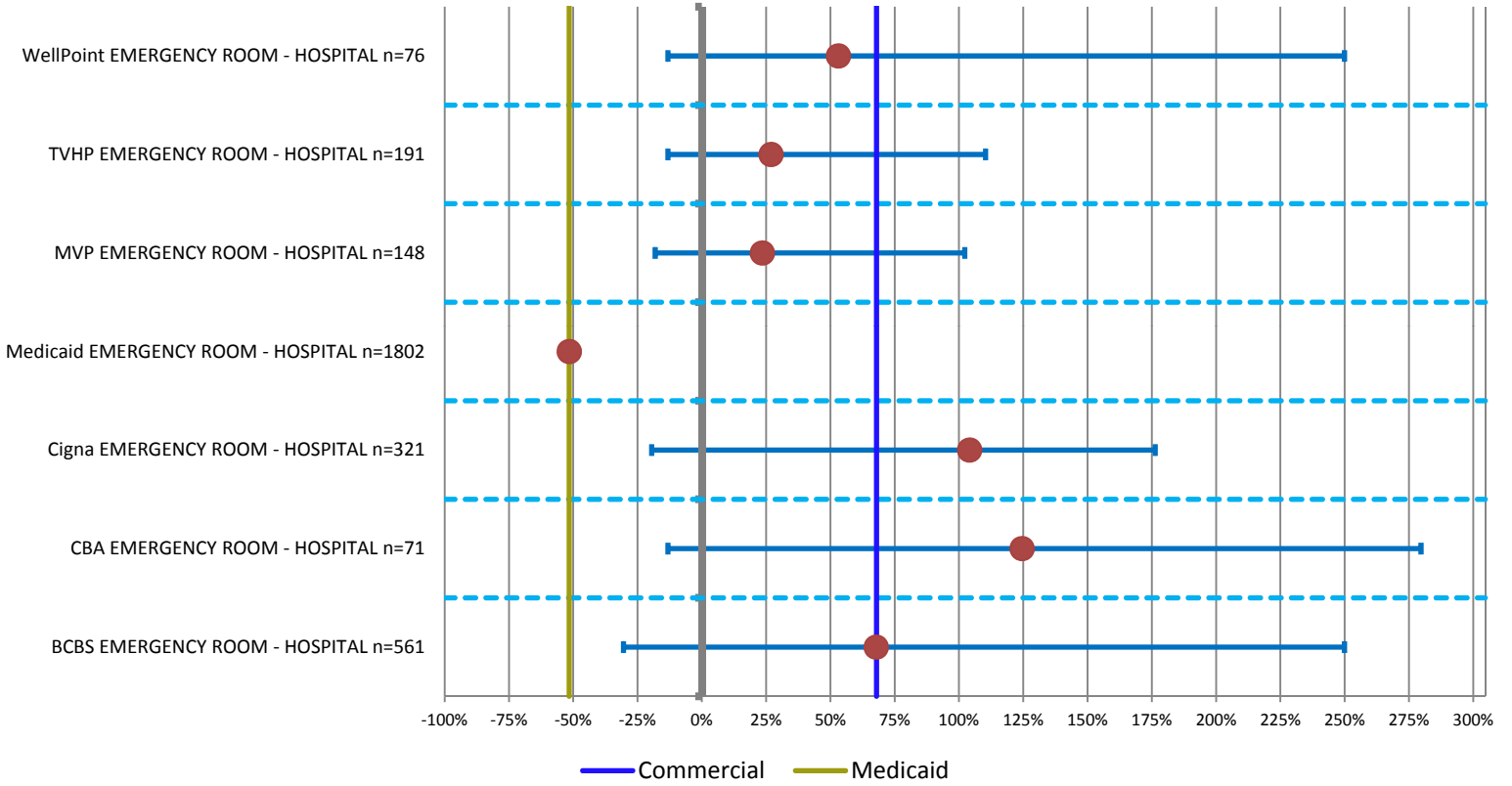
FY2012 ER Professional 74177 - CT ABD & PELV W/CONTRAST Allowed Payment Amount Variation



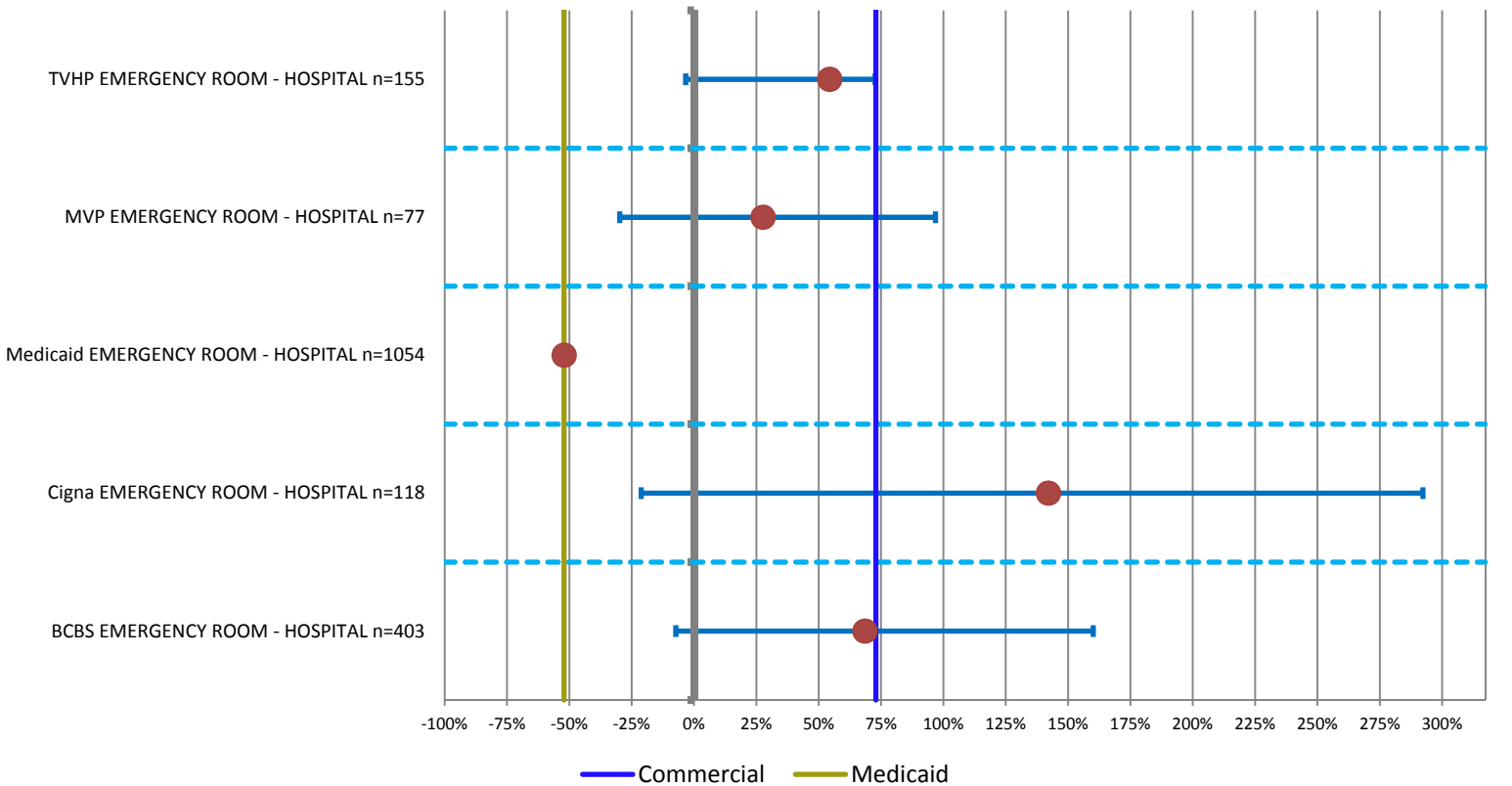
FY2012 ER Professional 74176 - CT ABD & PELVIS Allowed Payment Amount Variation



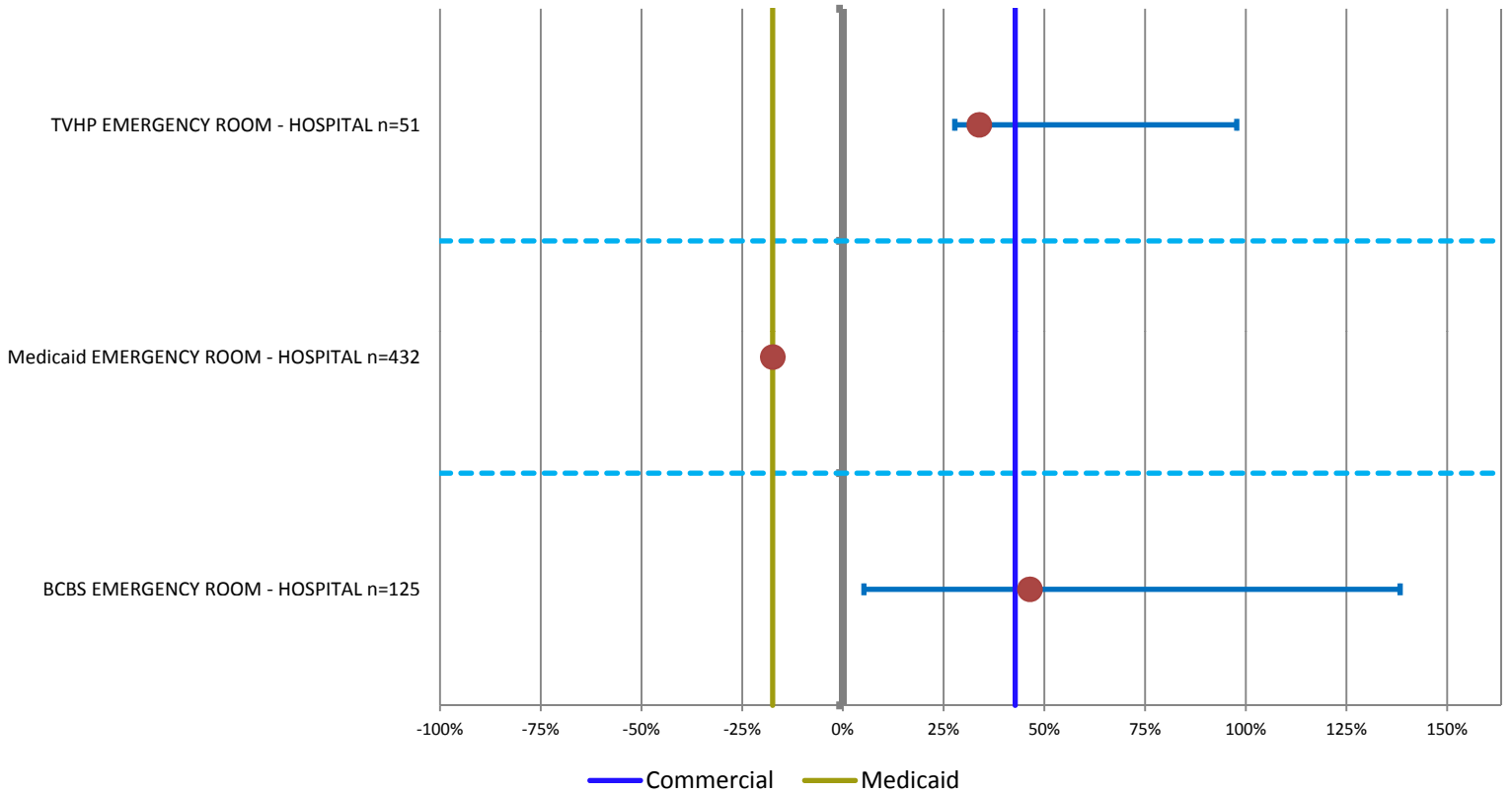
FY2012 ER Professional 70450 - CT HEAD/BRAIN W/O DYE Allowed Payment Amount Variation



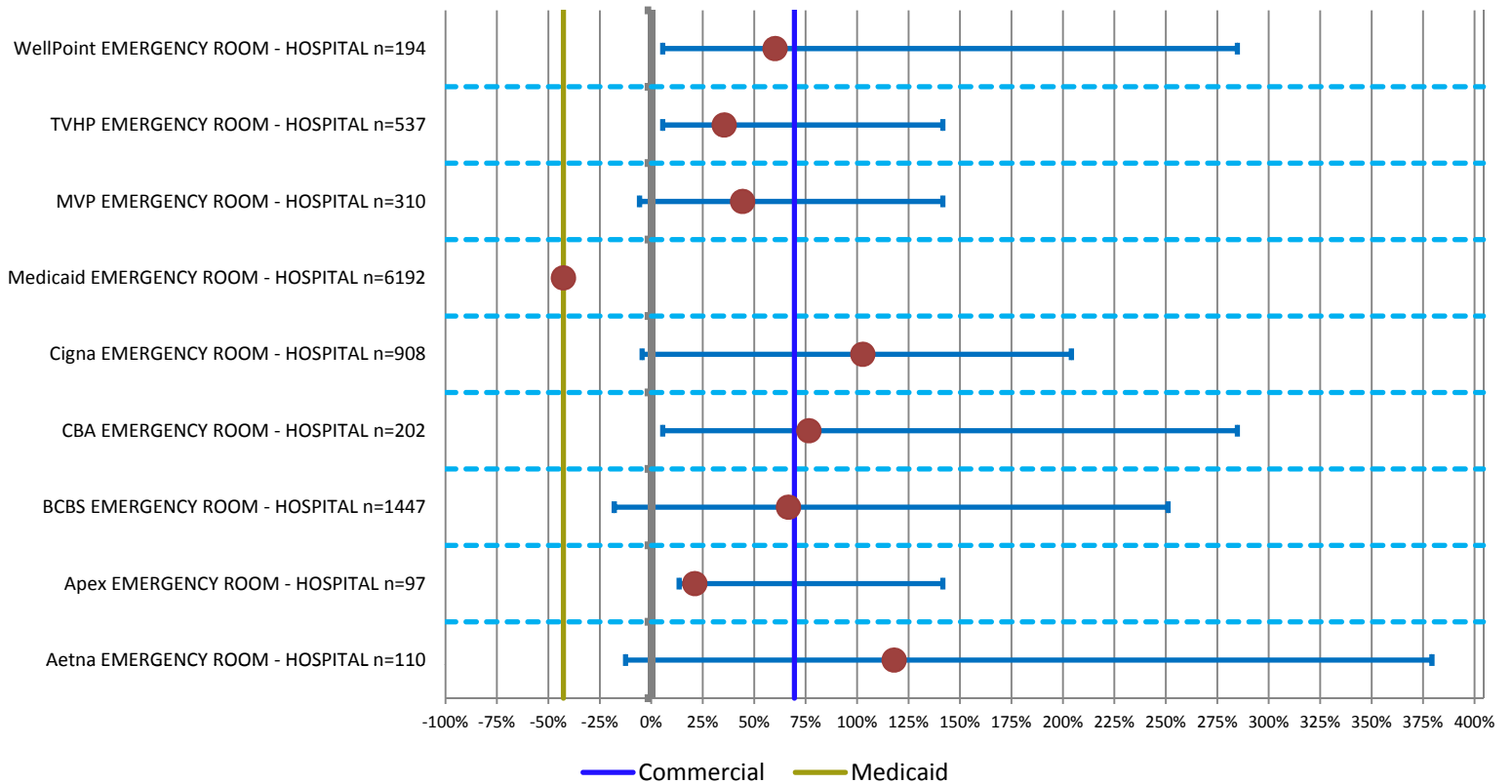
FY2012 ER Professional 12001 - REPAIR SUPERFICIAL WOUND(S) Allowed Payment Amount Variation



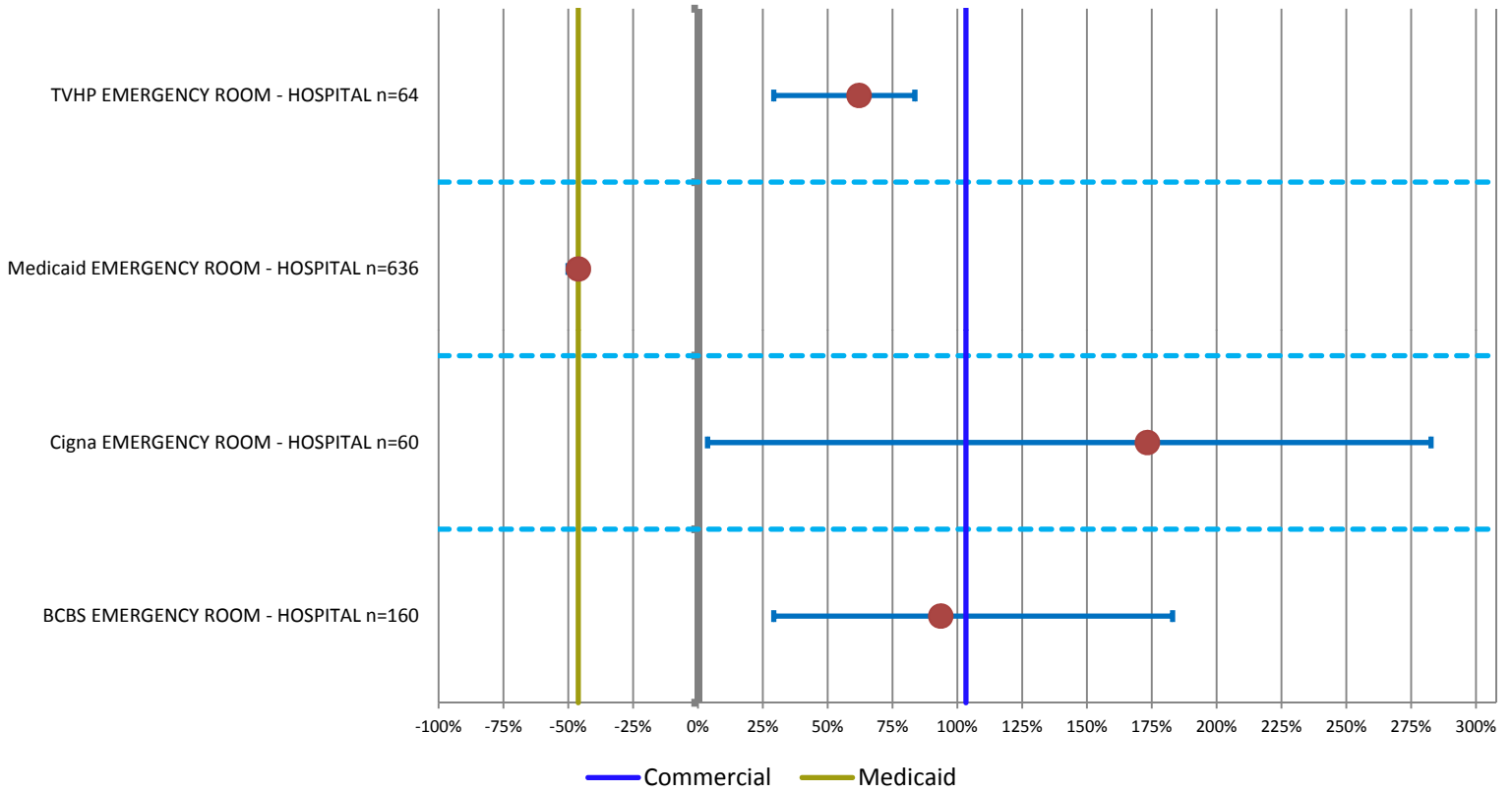
FY2012 ER Professional 99291 - CRITICAL CARE- FIRST HOUR Allowed Payment Amount Variation



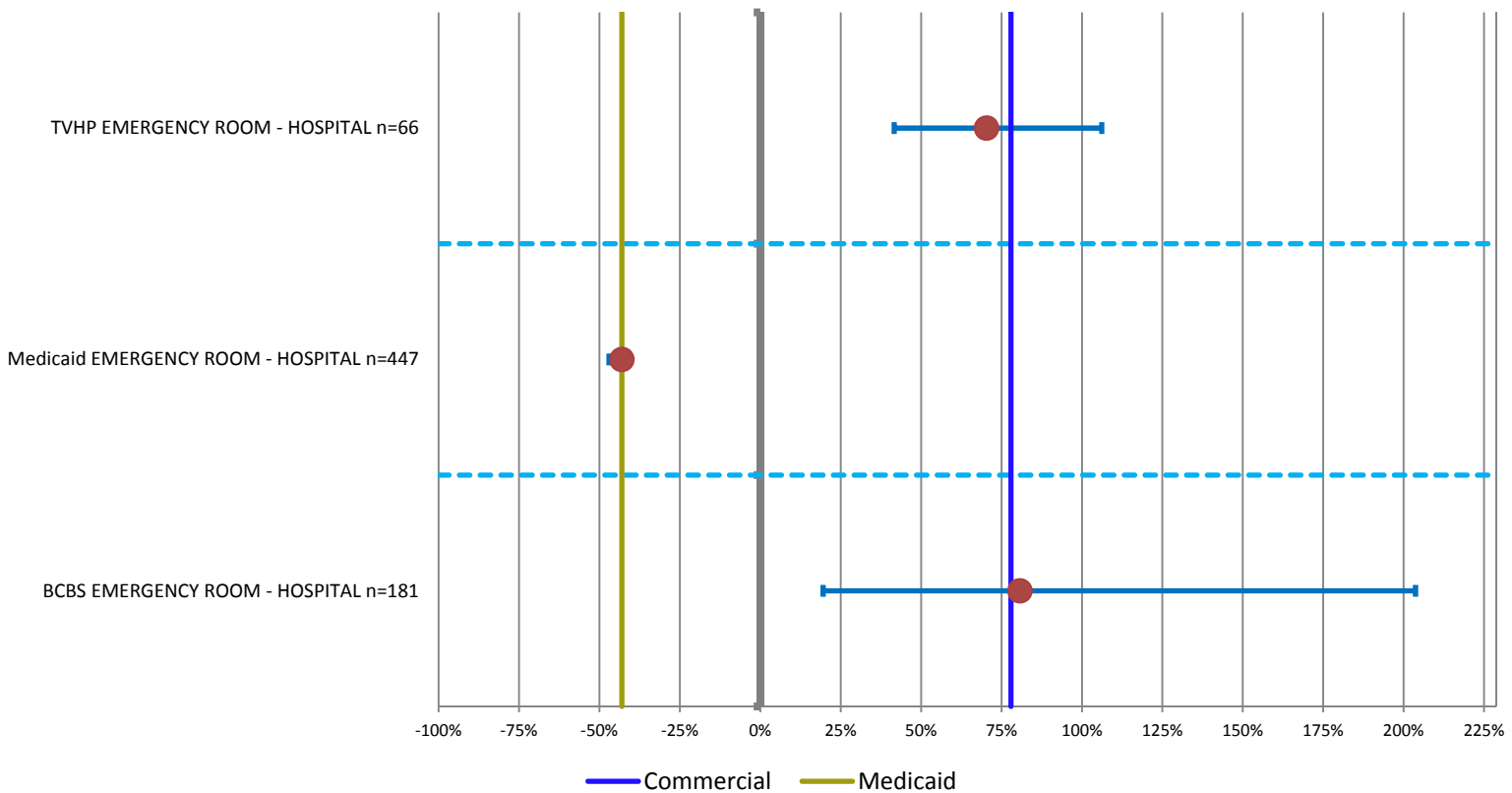
FY2012 ER Professional 71020 - CHEST X-RAY Allowed Payment Amount Variation



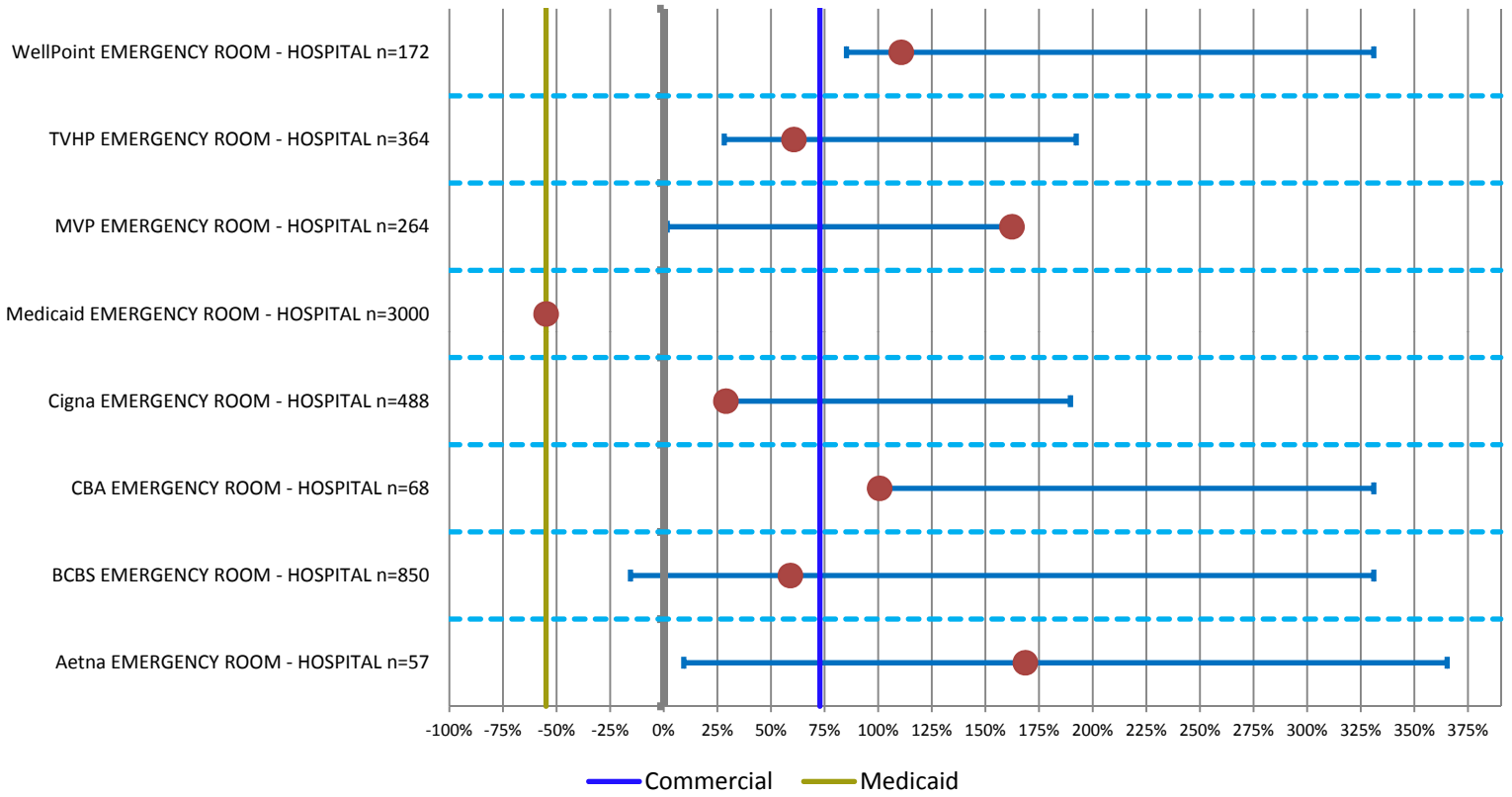
FY2012 ER Professional 12011 - REPAIR SUPERFICIAL WOUND(S) Allowed Payment Amount Variation



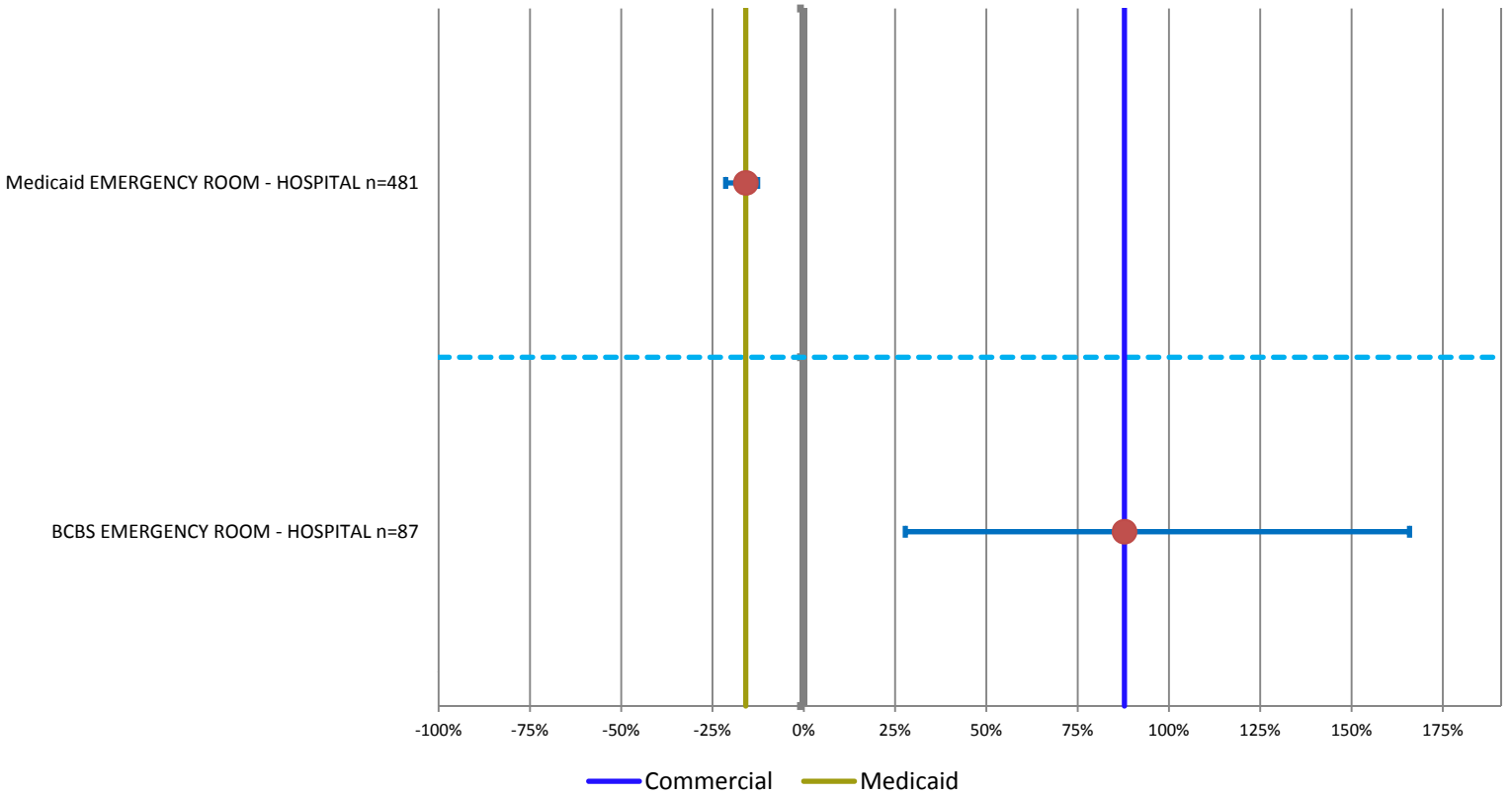
FY2012 ER Professional 12002 - REPAIR SUPERFICIAL WOUND(S) Allowed Payment Amount Variation



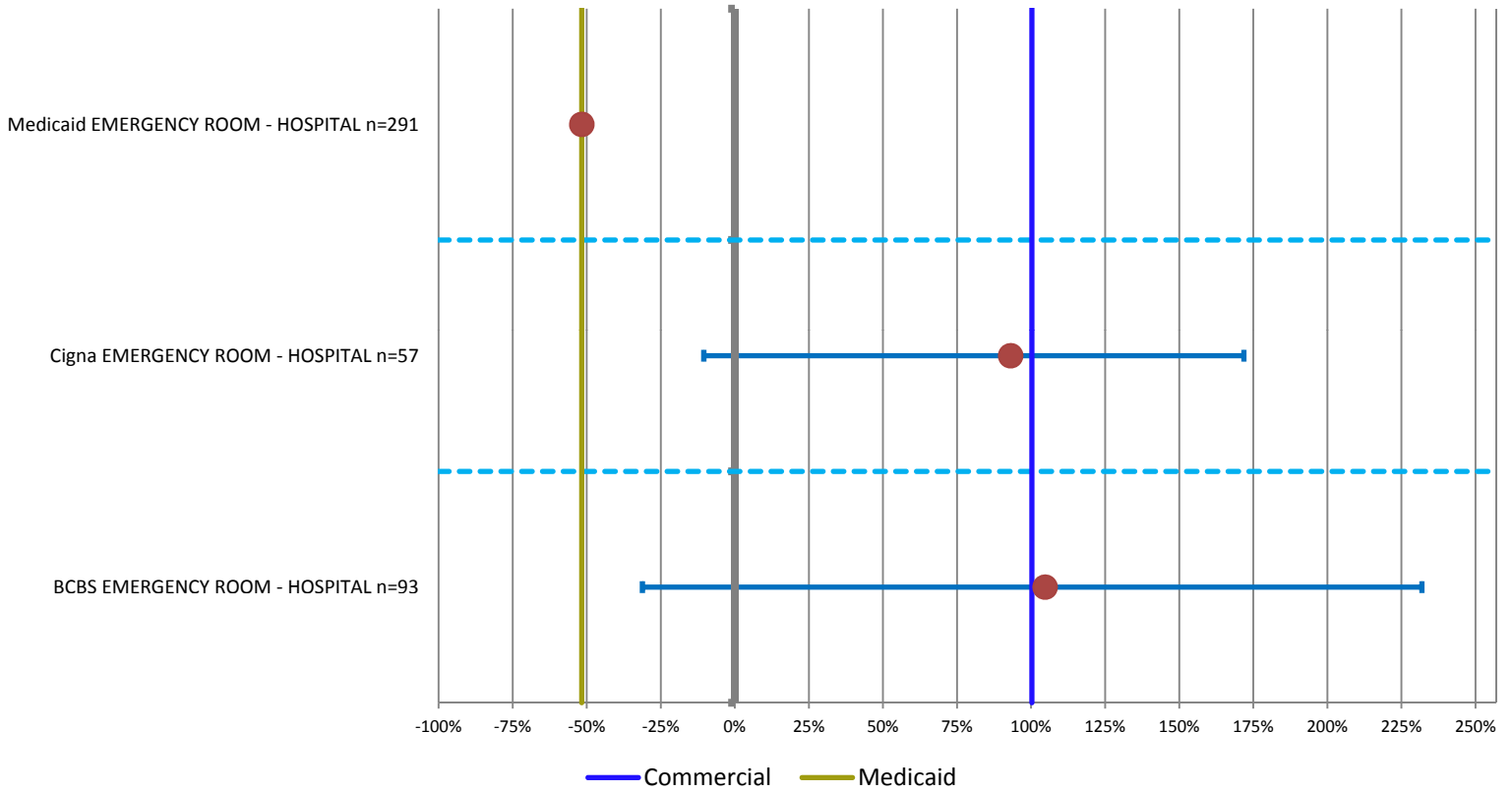
FY2012 ER Professional 93010 - ELECTROCARDIOGRAM REPORT Allowed Payment Amount Variation



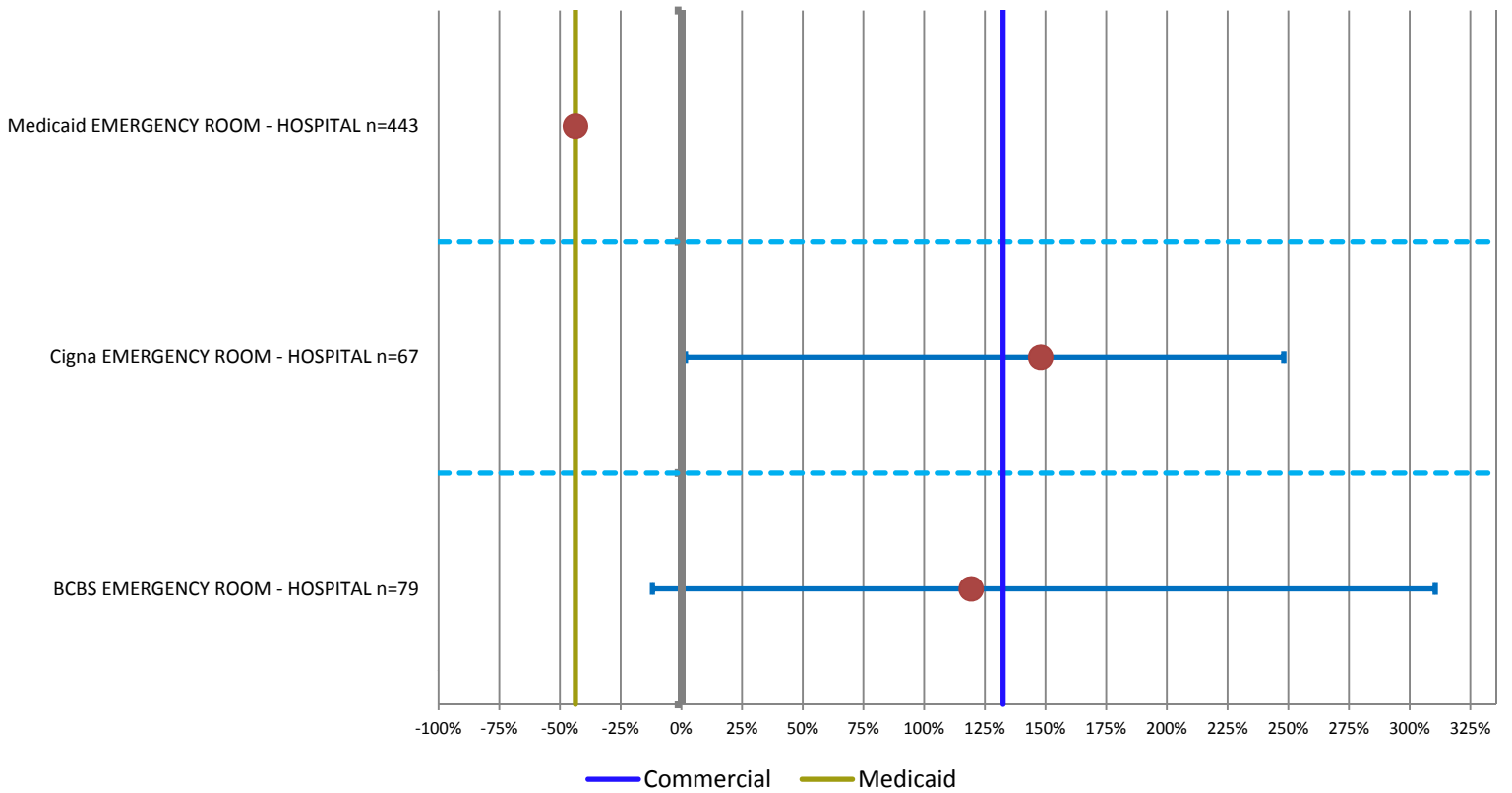
FY2012 ER Professional 10060 - DRAINAGE OF SKIN ABSCESS Allowed Payment Amount Variation



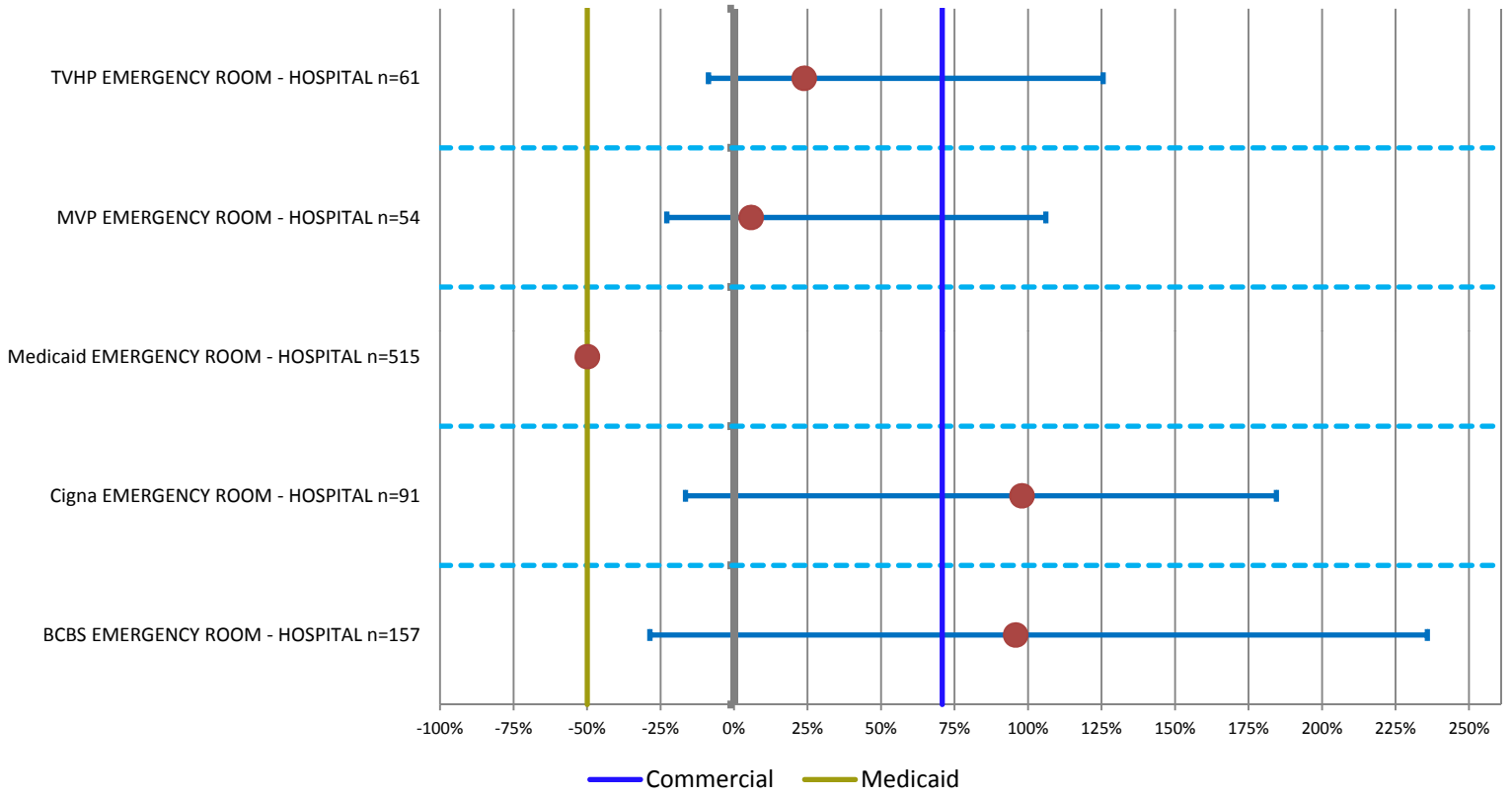
FY2012 ER Professional 71260 - CT THORAX W/DYE Allowed Payment Amount Variation



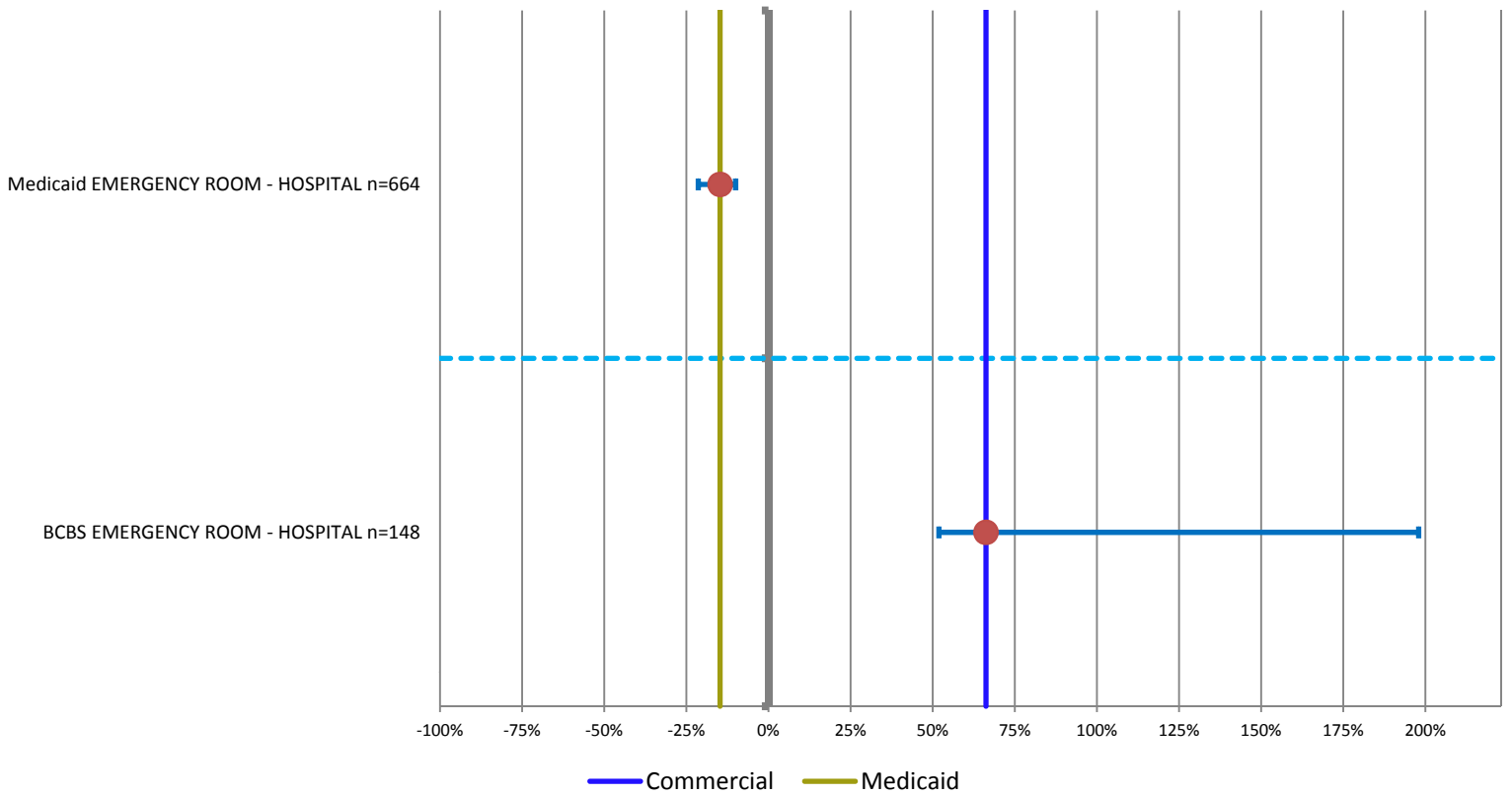
FY2012 ER Professional 72125 - CT NECK SPINE W/O DYE Allowed Payment Amount Variation



FY2012 ER Professional 76705 - ECHO EXAM OF ABDOMEN Allowed Payment Amount Variation



FY2012 ER Professional 29125 - APPLY FOREARM SPLINT Allowed Payment Amount Variation



FY2012 ER Professional 99244 - OFFICE CONSULTATION Allowed Payment Amount Variation

