Oregon Hospital Payment Report: 2015

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Oregon Health Authority
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Oregon Health Authority

About this report

The Oregon Hospital Payment Report, mandated by Senate Bill 900 and codified into Oregon Revised Statutes (ORS) 442.466, is an annual report of the median dollar amounts paid by commercial insurance companies for common procedures performed by Oregon hospitals. This report provides a source of transparency and public accountability for hospital prices. The state's efforts were recently recognized in the national Report Card on State Price Transparency Laws, an annual assessment conducted by Catalyst for Payment Reform. Due largely to this report, Oregon was ranked fourth in the nation for its performance in health care price transparency.

The data source is Oregon's All Payer All Claims (APAC) database, which is a database of health care insurance claims submitted to the state by entities identified as mandatory reporters according to ORS 442.464 and Oregon Administrative Rules (OAR) 409-025-0100 to 409-025-0170. This report includes procedures that occurred in calendar years 2014 – 2015, and only includes payments to hospital inpatient and outpatient facilities. Payments to free-standing Ambulatory Surgical Centers (ASCs) are not included. The OHA plans to build on this report in future years to incorporate other health care provider types.

The report uses the median paid amount. A median represents the point where half the observations are below and half the observations are above the paid amount. Averages are not used because a handful of very high priced cases, or outliers, can greatly affect an average. Median amounts are not as affected by outlier data and more accurately represent the typical paid amount.

Paid amounts represent what a commercial insurance company paid to the hospital performing the procedure, as well as patient-paid amounts such as co-pays, deductibles or co-insurance amounts. In the case of outpatient procedures, the paid amount is inclusive of all elements related to the procedure with the exception of professional fees, which are billed separately. In the case of inpatient procedures, the paid amount is intended to represent the amount paid for the entire hospitalization event. If the attending physician or specialists were not employed by the hospital, the paid amount does not include their professional fees.

Variation in median paid amount from hospital to hospital can be attributed to a variety of factors. Geography often plays a role due to the variation in the cost of doing business. There may also be significant variation in overall patients' health status or severity of illness upon admission that may require higher intensity of care at one hospital compared to another. The contracting and discount arrangements between insurers and hospitals – whether based on volume, on types of procedures performed or specific savings targets – all play a role in the final paid amount. Quality of care, patient satisfaction, and patient outcome are not collected in APAC, making it difficult to link these factors to the paid amount.

Oregon's health system is in the midst of significant changes as it implements both state and federal reforms. Policies to expand insurance coverage, improve health, provide better care and reduce costs affect the lives of all Oregonians.

The Oregon Health Authority is committed to transforming the health care system in Oregon by:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

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Oregon Hospital Payment Report 2015

In 2015, the Oregon Legislature passed Senate Bill 900, mandating the annual reporting of median payments from commercial insurers to hospitals for common inpatient and outpatient procedures. This is the second edition in an annual series using Oregon's All Payer All Claims (APAC) database to provide that information.

The second year of reporting hospital payment data includes important updates and improvements. New for the 2015 report is the inclusion of patient-paid amounts in the calculation of amount paid. The 2014 edition only included amounts paid by insurers. Including patient contributions is more transparent and represents a complete picture of amounts paid. Reporting methodology has also been improved to more accurately capture complex hospital services and eliminate outlier data. Procedure categories have been expanded, resulting in the reporting of more procedures and more narrowly defined procedure categories.

Changes to APAC are also represented in this latest edition of the report. Due to the U.S. Supreme Court's March 2016 ruling in *Gobeille v. Liberty Mutual Insurance Company*, the Oregon Health Authority may no longer require self-insured Employment Retirement Income Security Act (ERISA) covered health plans to submit claims. This has resulted in the loss of thousands of reported procedures.

Highlights of this report include:

- Most procedures show sizable variations in paid amounts, both within and between hospitals.
- Among common outpatient procedures, heart electrophysiology studies were reported to have the highest median paid amount at $36,900.
- Among common inpatient procedures, heart valve replacement surgeries were reported to have the highest median paid amount at $84,700.
- Among common diagnostic and imaging services, nuclear medicine evaluations of the cardiovascular system were reported to have the highest median paid amount at $2,200.
- The procedure with the largest increase in median paid amount from 2014 was coronary bypass surgeries, increasing by $8,700.
- The procedure with the largest percent increase in median paid amount from 2014 was guidance procedures for radiation therapy, increasing 80%.

Procedure list

Procedures for 2015 are broken into several smaller reports. All procedures are listed below in their associated sub-report.

Outpatient surgical procedures

- Abdominal drainage
- Appendectomy
- Arthrocentesis
- Arthrography
- Big toe surgeries
- Breast biopsy
- Breast reconstruction
- Carpal tunnel
- Cataract
- Colonoscopy
- Central venous catheter
- Cystoscopy lithotripsy
- Gallbladder surgery
- Heart catheterization
- Heart electrophysiology
- Hernia repair
- Hysterectomy
- Hysteroscopy
- Knee arthroscopy
- Lesion removal
- Liver biopsy
- Mastectomy
- Nasal endoscopy
- Nerve block
- Shoulder arthroscopy
- Spinal injection Spinal
- Laminectomy
- Subcutaneous drainage
- Thyroidectomy
- Tonsillectomy
- Tympanostomy
- Upper endoscopy

Inpatient procedures

- Abdominal drainage
- Appendectomy
- Blood transfusion
- Bowel removal
- Brain excision
- Central venous catheter
- Chemotherapy
- Coronary bypass
- Colonoscopy
- Hemodialysis
- Closed fracture repair
- Disc removal
- Gallbladder surgery
- Heart catheterization
- Heart valve surgery
- Hernia repair
- Hip replacement
- Hysterectomy
- Kidney removal
- Knee replacement
- Open fracture repair
- PTCA
- Subcutaneous drainage
- Spinal decompression
- Spinal fusion
- Spinal tap
- Upper endoscopy

Diagnostic imaging and testing

- Bone study
- CT scan: Abdomen
- CT scan: Chest
- CT scan: Extremities
- CT scan: Head and neck
- CT scan: Spine
- Echocardiography
- Electrocardiography
- Heart stress test
- Mobile heart monitoring
- MRI scan: Abdomen
- MRI scan: Extremities
- MRI scan: Head and neck
- MRI scan: Spine
- Nuclear medicine: Heart
- Nuclear medicine: Endocrine
- Nuclear medicine: Digestive
- Nuclear medicine: Muscular
- Ultrasound
- X-ray: Abdomen
- X-ray: Chest
- X-ray: Extremities
- X-ray: Head and neck
- X-ray: Spine

Radiology and chemotherapy

- Chemotherapy: Injection
- Chemotherapy: Infusion
- Radiation: Devices
- Radiation: Guidance
- Radiation: Consultation
- Radiation: Delivery
- Radiation: Dosimetry
- Radiation: IMRT
- Radiation: Simulation

Pregnancy related procedures

- Obstetrical ultrasound
- Normal delivery without complication
- Normal delivery with complication
- Cesarean delivery without complication
- Cesarean delivery with complication
- Newborn care without complication
- Newborn care with complication

About amounts paid

Amounts presented in this report are median amounts paid from private insurance companies — that are also a mandatory report to APAC — to one of Oregon's 60 acute care general hospitals. Payments to a hospital from a payer that is not an APAC mandatory reporter — like small carriers or uninsured individuals — will not be reflected in this report. The median paid amounts now include patient contributions, such as co-pays, deductibles and co-insurance. It is important to remember that amounts paid reflect the total payment a hospital received, and not the price a patient actually paid for the service.

Similar to 2014, amounts paid for procedures performed in Oregon's hospitals showed high levels of variation in 2015. This was seen both among hospitals for the same service and within the same hospital for the same service. The reasons for high levels of variation in paid amounts are complex. They generally relate to a few key reasons: hospital location, patient volume, patient case mix and negotiated rates with a given patient's insurance company.

The location of a hospital influences amounts paid for procedures. Hospitals located in areas with higher costs of living, higher utility costs and higher rent costs have greater operating expenses relative to hospitals located in areas with lower costs of living. High costs of living, and the associated need for higher employee wages, is one of the larger factors. Payroll expenses generally make up approximately 50% of a hospital's total operating expenses at any given time. When operating expenses for a hospital increase, paid amounts for services provided must also rise to cover costs. Competition is also an influencing factor determined by location. Hospitals that are located in exclusive service areas generally have higher associated paid amounts than hospitals working in close proximity to other hospitals.

Patient volume is closely related to hospital location. Hospitals that have high volumes of patients for particular services generally can accept lower paid amounts than hospitals with lower patient volumes. High volume hospitals are able to accept a lower price per procedure due to economies of scale. High volume hospitals can make up for accepting lower payments on infrequent procedures by charging slightly more for procedures in which they do higher volumes. Hospitals with low overall patient counts have less flexibility to determine what they must charge for each service, and less flexibility to offset losses on some procedures by charging more for other procedures.

Paid amounts are also affected by patient case mix. Patient case mix refers to the types of services a hospital is most likely to perform, based on the types of patients that populate its service area. It also refers to patient acuity, or the level of severity of patient illness the hospital generally serves. Some hospitals serve populations that are overall sicker or have a higher burden of chronic disease than other hospitals. Some hospitals service a higher proportion of older people and more likely need to provide higher cost procedures such as joint replacements and bypass surgeries. Hospitals that have to provide more complex procedures to patients whose conditions are more severe often have higher paid amounts for similar procedures.

The negotiated rates of payment affect the paid amounts. Each hospital in Oregon has individual payment arrangements negotiated with every insurance provider that operates in Oregon. The rate an insurance company pays for a procedure varies from hospital to hospital. Every hospital has different negotiated rates with every insurance provider and every insurance provider has different negotiated rates with every hospital. All the above factors — hospital location, patient volume, patient case mix — influence these rate negotiations.

Findings for 2015

There were 451,105 individual procedures performed by Oregon's hospitals and paid for by a commercial insurance company that reported to APAC in 2015. This is a small increase from the 447,496 procedures reported in 2014. Patient volumes and historic data were affected by the *Gobeille* decision, which held that ERISA-covered health plans are not required to submit claims data to APAC. This resulted in the loss of thousands of claims from Oregon's All Payer All Claims (APAC) database and forced the recalculation of 2014 median paid amounts.

Diagnostic imaging and testing

The table below summarizes information about procedures in the diagnostic imaging and testing category.

Procedures where the median paid amount:	Number of: Procedures	Visits	2014 to 2015 change: Paid amount	Percent
Increased	16	244,468	$21	4.1%
Stayed the same	2	12,635	$0	0.0%
Decreased	16	53,072	($40)	-7.4%
Overall	34	310,175	$0	0.0%

There were 310,175 diagnostic imaging and testing procedures performed in Oregon's hospitals and paid for by a commercial insurance company that reports to APAC. This is a slight decrease from the 310,353 procedures reported in 2014. Diagnostic imaging and testing procedures are the most common type of procedure performed in hospitals.

Patient volumes are an important consideration in evaluating changes in paid amounts. For example, mammography was one of the most frequently performed imaging procedures in 2015 with almost 80,000 performed. The median amount paid for a mammogram increased by $12 from 2014. This $12 increase translates to close to $1 million more in reimbursement paid to hospitals in 2015 for mammography.

Inpatient procedures

The table below summarizes information about procedures in the inpatient procedures category.

Procedures where the median paid amount:	Number of: Procedures	Visits	2014 to 2015 change: Paid amount	Percent
Increased	22	8,820	$1,059	4.1%
Stayed the same	3	1,514	$0	0.0%
Decreased	3	2,360	($681)	-2.4%
Overall	28	12,694	$687	3.9%

There were 12,694 inpatient procedures performed in Oregon's hospitals and paid for by a commercial insurance company that reports to APAC. This is a decrease from the 14,453 inpatient procedures performed in 2014. Inpatient procedures have the lowest volume of visits for any reported procedure and represent the most complex and expensive procedures performed.

For inpatient procedures, two of the highest volume procedures, hip and knee replacements, paid less or did not change from 2014. Hospital also reported lower volumes in 2015 than in 2014. This resulted in an estimated $20 million less in paid amounts. This estimate does not account for any losses due to the *Gobeille* decision.

Findings for 2015 cont.

Outpatient surgical procedures

The table below summarizes information about procedures in the outpatient surgery category.

Procedures where the median paid amount:	Number of: Procedures	Visits	2014 to 2015 change: Paid amount	Percent
Increased	26	42,113	$323	7.1%
Stayed the same	2	1,379	$0	0.0%
Decreased	4	3,406	($56)	-5.3%
Overall	32	46,918	$287	5.3%

There were 46,918 outpatient procedures performed in Oregon hospitals and paid for by a commercial insurance company that reports to APAC. This is a decrease from the 45,898 outpatient procedures performed in 2014. Outpatient procedures are the second most common type of procedure reported.

The two highest volume outpatient procedures both saw sizable increases in median amount paid. Colonoscopies and upper endoscopies are the most common outpatient procedures performed in 2015. The median amounts paid increased $117 for colonoscopies and $263 for upper endoscopies. Between volume increases and paid amount increases for these two procedures, hospitals received an estimated $4 million more in payments in 2015.

Radiology and chemotherapy

The table below summarizes information about procedures in the radiation and chemotherapy category.

Procedures where the median paid amount:	Number of: Procedures	Visits	2014 to 2015 change: Paid amount	Percent
Increased	4	14,856	$81	12.8%
Stayed the same	1	6,503	$0	0.0%
Decreased	4	20,136	($24)	-5.0%
Overall	9	46,918	$0	0.0%

There were 41,495 radiation and chemotherapy procedures performed in Oregon hospitals and paid for by a commercial insurance company that reports to APAC. This is an increase from the 35,141 procedures performed in 2014. The increase in patient volume came in the form of newly approved treatment options for most insurance carriers in Oregon. In 2015, Intensity Modulated Radiation Therapy became an approved treatment for payment for most major insurance carriers in Oregon, opening up treatment options that were previously paid for out of pocket or simply not performed.

Radiation therapy delivery, the procedure that administers a single session of radiation treatment, is the most common procedure reported in this section with 12,854 radiation treatments performed in 2015. The median paid amount for radiation therapy delivery increased by $36 in 2015, a median increase of 7%.

Findings for 2015, cont.

Pregnancy related procedures

The table below summarizes information about procedures in pregnancy related procedures category.

Procedures where the median paid amount:	Number of:		2014 to 2015 change:	
	Procedures	Visits	Paid amount	Percent
Increased	7	39,823	$237	2.9%
Stayed the same	0	0	$0	0.0%
Decreased	0	0	$0	0.0%
Overall	7	39,823	$237	2.9%

There were 39,823 pregnancy related procedures performed in Oregon hospitals and paid for by a commercial insurance company that reports to APAC. This is a decrease from the 40,026 procedures performed in 2014. Delivery of a baby is the most common reason for hospitalization in Oregon.

The median paid amount for delivery of a baby increased. Normal delivery without complications increased $236 from 2014, a median increase of 3.2%. Cesarean Section delivery without complications increased by $247 year over year, a median increase of 1.4%. As a group, all procedures related to pregnancy increased. The median increase for a pregnancy related condition was $236.

Methods

The data source for this report is the Oregon All Payer All Claims (APAC) database. The Oregon Health Authority contracts with Milliman Solutions (Milliman) to manage and maintain the database. Milliman collects, processes, and applies its Health Cost Guidelines (HCG) grouper — proprietary logic that identifies and groups different health care services — to APAC data. This report makes use of the HCG grouper to identify what claims were for hospital inpatient and outpatient services.

Claims data were extracted from the APAC database for services incurred in calendar years 2014 and 2015, and for HCG groupers that identify as a hospital inpatient or outpatient service. All non-commercial payers (Medicare, Medicaid, VA) were removed from this dataset. OHA also removed data from all non-Oregon facilities and all non-hospital facilities, including free-standing Ambulatory Surgical Centers (ASCs). All claims that had a "denied" status were excluded.

Claims within APAC are identified by a unique claim ID. This unique claim ID is used to identify all itemized portions of the claim together as one. Using the unique claim ID, the total paid amount is summed to provide the total paid amount for the entire claim. Claims that had a zero total paid amount were excluded.

After procedures were summed to total amounts, OHA identified the primary procedure. The process for this is different for inpatient and outpatient settings. In the outpatient setting, a single procedure can be billed as multiple individual components. For example, an arthrogram of the shoulder will generally have four billed items: for the dye injection to the shoulder, for the x-ray guidance used to place the dye, for the CT or MRI imaging after the dye was placed, and sometimes, for additional anesthetics used. Milliman has developed a variable to identify unique services in the outpatient setting and OHA finds it performs well at identifying primary procedures. This unique services flag was used to identify the principle procedure performed in the outpatient setting.

Inpatient claims are required to identify the primary procedure performed in the hospitalization. Inpatient procedure coding makes use of the ICD-9-CM coding system, which is considerably less detailed and granular than the Current Procedure Terminology (CPT) coding outpatient facilities use. Procedures in 2015 that were coded using ICD-10 were mapped to relevant ICD-9 codes using the CMS General Equivalence Mapping (GEM) crosswalk.

Radiation therapy and chemotherapy differ in reporting from other outpatient procedures. Radiation therapy and chemotherapy are not reported as a summed total claim. Individually billed component amounts are reported. This is due to the high level of complexity and customization in such therapies. Amounts paid for chemotherapy and radiation therapy are "per delivery" of the service.

After identification of the primary procedure, procedures were grouped into larger, related categories. This was done to present the data in a more accessible fashion. Groupings were made on the following three major criteria: procedures (X-rays, CT scans, MRIs etc.) were similar, median paid amounts were similar, and the individual procedure code was among the most frequently performed procedures in Oregon.

The data are reported as statewide rates and by hospital when possible. A hospital must have performed the procedure ten times to be included. Hospitals that reported paid amounts that varied significantly from the statewide median (three standard deviations or more) were removed to prevent outlier data from affecting median amounts.

Included in this report

A number of factors determined whether data were included in or excluded from this report. The summary table below details these decisions. A hospital facility not meeting the inclusion criteria for a procedure is not listed for that particular procedure. This does not preclude the same facility from being reported under other procedures if it meets the inclusion criteria.

	Included	Excluded
Amounts	Median paid amounts to hospital facilities including patient-paid amounts	Hospital billed amounts Allowed amounts Professional fee amounts
Facilities	Oregon acute care hospitals	Non-Oregon facilities Ambulatory Surgical Centers (ASCs) Specialized clinics not located within the hospital or that bill as a separate entity
Outpatient procedure codes	Codes for the 100 most common outpatient procedures	Codes for procedures performed less than 350 times statewide Codes for outpatient procedures not in top 100
Inpatient procedure codes	Codes for the 50 most common inpatient procedures	Codes for procedures performed less than 100 times at the statewide level Codes for inpatient procedures not in the top 50
Insurance types	Most commercial insurers	Public insurers (Medicare, Medicaid) Veterans Administration Workers Compensation ERISA self-insured plans Commercial insurance with fewer than 5,000 covered lives
Service volumes	Procedure was performed 10 or more times at a particular hospital	Procedure was performed less than 10 times at a particular hospital
Outliers		Individual paid amounts larger than three standard deviations from statewide median for a procedure

Procedure codes

The following tables contain all the individual billing codes included with each reported procedure. Outpatient surgeries and imaging procedures are coded using the Current Procedural Terminology (CPT) coding system and are five digit numbers with no decimals. Inpatient procedures are coded using the ICD-9 PCS codes and are four digit numbers with a decimal or ICD-10 PCS codes which are seven digit alpha-numeric. Pregnancy codes are grouped using MS-DRG codes and are three digit numbers with no decimal.

Procedure	Codes
Bone study	77071, 77072, 77073, 77074, 77075, 77076, 77077, 77080, 77081, 77085
CT scan: Abdomen	74150, 74176, 74261, 74263
CT scan with contrast: Abdomen	74160, 74170, 74174, 74177, 74178, 74262, 74270, 74280
CT scan: Chest	71250
CT scan with contrast: Chest	71260, 71270, 71275
CT scan: Extremities	73200, 73700
CT scan: Head and neck	70450, 70480, 70486, 70490
CT with contrast: Head and neck	70460, 70470, 70481, 70482, 70487, 70488, 70491, 70492, 70496, 70498
CT scan: Spine	72125, 72128, 72131, 72192
CT scan with contrast: Spine	72126, 72127, 72129, 72130, 72132, 72133, 72193, 72194
Cardiovascular: Heart catheterization	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93464, 93503, 93530, 93531, 93533
Cardiovascular: ECG	93000, 93005, 93010
Cardiovascular: ECG stress test	93015, 93016, 93017, 93018
Cardiovascular: Echo	93303, 93304, 93306, 93307, 93308, 93312, 93315, 93317, 93318, 93320, 93321, 93325, 93350, 93351, 93352
Cardiovascular: EPS	93653, 93654, 93655, 93656, 93657
Cardiovascular: Mobile heart monitoring	93225, 93226, 93227
Inpatient procedure: Blood transfusion	99.00, 99.04, 99.05, 99.06, 99.07, 99.09, 30233N1, 30233R1
Inpatient procedure: Chemotherapy	99.25, 3E0D705
Inpatient procedure: Hemodialysis	39.95, 5A1D00Z, 5A1D60Z
Inpatient procedure: Abdominal drainage	54.91, 0W9G3ZX, 0W9G3ZX, 0W9G3ZZ
Inpatient procedure: Appendectomy	47.01, 47.09, 0DTJ0ZZ, 0DTJ4ZZ
Inpatient procedure: Bowel removal	17.33, 17.36, 45.62, 45.73, 45.74, 45.75, 45.76, 0DTF0ZZ, 0DTF4ZZ, 0DTN0ZZ, 0DTN4ZZ
Inpatient procedure: Brain excision	01.51, 01.52, 01.53, 00B00ZZ, 00B70ZZ
Inpatient procedure: Closed fixation	79.02, 79.05, 79.06, 79.11, 79.12, 79.13, 79.14, 79.15, 79.16, 79.17
Inpatient procedure: Central line insertion	38.93, 38.95, 38.97, 02H633Z, 02HV33Z, 05HM33Z
Inpatient procedure: Colonoscopy	45.23, 45.24, 45.25, 0DBE8ZX, 0DBN8ZX
Inpatient procedure: Coronary bypass	36.11, 36.12, 36.13, 36.14, 021009W, 021109W, 021209W, 021309W

Procedure codes, cont.

Procedure	Codes
Inpatient procedure: Disc excision	80.51, 0RB30ZZ, 0SB20ZZ, 0ST20ZZ
Inpatient procedure: Gallbladder surgery	51.22, 51.23, 51.24, 0FT40ZZ, 0FT44ZZ
Inpatient procedure: Heart catheterization	37.21, 37.22, 37.23, 4A023N6, 4A023N7, 4A023N8
Inpatient procedure: Heart valve replacement	35.12, 35.21, 35.22, 35.23, 35.24, 35.25, 02RF08Z, 02RF0JZ
Inpatient procedure: Hernia repair	53.31, 53.59, 53.61, 53.62, 53.63, 53.69, 53.71, 0WUF0JZ, 0WUF4JZ
Inpatient procedure: Hip replacement	81.51, 81.52, 0SR90JA, 0SR90JZ, 0SRB0JA, 0SRB0JZ
Inpatient procedure: Hysterectomy	65.31, 65.39, 65.41, 65.49, 65.61, 68.25, 68.29, 68.31,68.39, 68.41, 68.49, 68.51, 68.59, 68.69, 68.71, 0UB90ZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT9FZZ
Inpatient procedure: Kidney removal	55.51, 55.53, 55.54, 0TT00ZZ, 0TT04ZZ, 0TT14ZZ, 0TT24ZZ
Inpatient procedure: Knee replacement	81.54, 0SRC0J9, 0SRC0JZ, 0SRD0J9, 0SRD0JZ
Inpatient procedure: Open fixation	79.31, 79.32, 79.33, 79.34, 79.35, 79.36, 79.37, 0QSG04Z, 0QSH04Z
Inpatient procedure: PTCA	00.66
Inpatient procedure: Shoulder replacement	81.80, 81.81, 0RRJ0JZ, 0RRK0JZ
Inpatient procedure: Skin incision and drainage	86.01, 86.03, 86.04, 86.07, 86.09
Inpatient procedure: Spinal decompression	03.02, 03.09, 00NW0ZZ, 00NY0ZZ
Inpatient procedure: Spinal fusion	81.02, 81.03, 81.04, 81.05, 81.06, 81.07, 81.08, 0RG10A0, 0RG20A0, 0SG00A0, 0SG00AJ, 0SG10AJ, 0SG30A0, 0SG30A1, 0SG30AJ
Inpatient procedure: Spinal tap	03.31, 009U3ZC, 009U3ZZ
Mammography	77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77062 77063, G0202, G0204, G0206
MRI scan: Abdomen	74181
MRI scan with contrast: Abdomen	74182, 74183, 74185
MRI scan with contrast: Chest	71551, 71552, 71555
MRI scan: Extremities	73218, 73221, 73718, 73721
MRI scan with contrast: Extremities	73219, 73220, 73222, 73223, 73719, 73720, 73722, 73723
MRI scan: Head and neck	70336, 70540, 70544, 70547, 70551
MRI scan with contrast: Head and neck	70542, 70543, 70545, 70546, 70548, 70552, 70553
MRI scan: Spine	72141, 72146, 72148, 72156, 72157, 72158, 72195
MRI scan with contrast: Spine	72142, 72147, 72149, 72159, 72196, 72197, 72198
Nuclear medicine: Cardiovascular system	78445, 78451, 78452, 78466, 78472, 78494, 78496
Nuclear medicine: Endocrine system	78000, 78012, 78013, 78014, 78018, 78020, 78070, 78071, 78072, 78075
Nuclear medicine: Digestive system	78201, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78261, 78264, 78267, 78268, 78278, 78290
Nuclear medicine: Musculoskeletal system	78300, 78305, 78306, 78315, 78320
Outpatient procedure: Abdominal drainage	49000, 49002, 49020, 49082, 49083, 49084
Outpatient procedure: Appendectomy	44950, 44955, 44960, 44970

Procedure codes, cont.

Procedure	Codes
Outpatient procedure: Arthrocentesis	20600, 20605, 20606, 20610, 20611, 20612
Outpatient procedure: Arthrography	23350, 24220, 25246, 27093, 27095, 27096, 27370, 27648
Outpatient procedure: Big toe surgery	28200, 28208, 28210, 28220, 28225, 28232, 28234, 28238, 28240, 28250, 28262, 28270, 28272, 28285, 28286, 28288, 28289, 28290, 28292, 28293, 28294, 28296, 28297, 28298, 28299, 28300, 28305, 28306, 28308, 28309, 28310, 28312, 28313, 28315, 28320, 28322, 28344, 28345
Outpatient procedure: Breast biopsy	19081, 19082, 19083, 19084, 19085, 19100 ,19101, 19110, 19120, 19125, 19260
Outpatient procedure: Breast reconstruction	19316, 19318, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19366, 19370, 19371, 19380, 19499
Outpatient procedure: Carpal tunnel	64702, 64704, 64708, 64712, 64714, 64716, 64718, 64719, 64721, 64722, 64726
Outpatient procedure: Cataract	66982, 66983, 66984, 66985, 66986
Outpatient procedure: Central venous catheter	36556, 36557, 36558, 36560, 36561, 36563, 36568, 36569, 36571
Outpatient procedure: Colonoscopy	45300, 45305, 45308, 45309, 45320, 45330, 45331, 45332, 45333, 45334, 45335, 45338, 45339, 45340, 45341, 45342, 45346, 45349, 45370, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45398, G0104, G0105, G0120, G0121
Outpatient procedure: Cystoscope lithotripsy	52320, 52325, 52327, 52330, 52332, 52341, 52344, 52345, 52346, 52351, 52352, 52353, 52354, 52355, 52356
Outpatient procedure: Gallbladder surgery	47562, 47563, 47564, 47579, 47600, 47605
Outpatient procedure: Hernia repair	49451, 49452, 49465, 49491, 49492, 49495, 49496, 49500, 49501, 49505, 49507, 49520, 49521, 49525, 49540, 49550, 49553, 49557, 49560, 49561, 49565, 49566, 49568, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49650, 49651, 49652, 49653, 49654, 49655, 49656, 49657, 49659
Outpatient procedure: Hysterectomy	58150, 58180, 58260, 58262, 58263, 58270, 58290, 58291, 58292, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58578, 58579, 58660, 58661, 58662, 58670, 58671, 58672, 58673, 58679
Outpatient procedure: Hysteroscopy	58555, 58558, 58559, 58560, 58561, 58562, 58563
Outpatient procedure: Knee arthroscopy	29866, 29867, 29868, 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29882, 29883, 29884, 29886, 29887, 29888, 29889, 29891, 29892, 29893

Procedure codes, cont.

Procedure	Codes
Outpatient procedure: Skin lesion removal	11100, 11200, 11305, 11310, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11450, 11451, 11462, 11470, 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646
Outpatient procedure: Liver biopsy	47000
Outpatient procedure: Mastectomy	19300, 19301, 19302, 19303, 19304, 19305, 19307
Outpatient procedure: Nasal endoscopy	31231, 31237, 31238, 31239, 31240, 31254, 31255, 31256, 31267, 31276, 31287, 31288
Outpatient procedure: Nerve block	64400, 64405, 64413, 64415, 64416, 64420, 64421, 64425, 64430, 64445, 64447, 64448, 64449, 64450, 64479, 64480, 64483, 64484, 64488, 64490, 64491, 64493, 64494, 64495, 64505, 64510, 64520, 64530
Outpatient procedure: Shoulder arthroscopy	29804, 29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828
Outpatient procedure: Spinal injection	62267, 62268, 62269, 62270, 62272, 62273, 62281, 62282, 62284, 62290, 62291, 62302, 62303, 62304, 62305, 62310, 62311, 62318, 62319
Outpatient procedure: Spinal laminectomy	63001, 63003, 63005, 63012, 63015, 63017, 63020, 63030, 63035, 63040, 63042, 63045, 63046, 63047, 63048, 63050, 63055, 63056, 63081, 63082, 63200
Outpatient procedure: Subcutaneous incision and drain	10021, 10022, 10030, 10060, 10061, 10080, 10120, 10120, 10121, 10140, 10160, 10180
Outpatient procedure: Thyroidectomy	60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60300, 60500
Outpatient procedure: Tonsillectomy	42800, 42804, 42806, 42808, 42810, 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42842, 42860, 42870
Outpatient procedure: Tympanostomy	69420, 69421, 69424, 69433, 69436, 69440, 69450
Outpatient procedure: Upper endoscopy	43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43257, 43259
Pregnancy: Ultrasound	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828
Pregnancy: Normal delivery without complication	775
Pregnancy: Normal delivery with complications	774
Pregnancy: Cesarean section without complications	766
Pregnancy: Cesarean section with complications	765
Pregnancy: Newborn care without complications	795
Pregnancy: Newborn care with complications	794

Procedure codes, cont.

Procedure	Codes
X-ray: Abdomen	74000, 74010, 74020, 74022, 74220
X-ray: Chest	71010, 71020, 71021, 71022, 71023, 71030, 71035, 71100, 71101, 71110, 71111, 71120, 71130
X-ray: Extremities	73000, 73010, 73020, 73030, 73040, 73050, 73060, 73070, 73080, 73090, 73092, 73100, 73110, 73115, 73120, 73130, 73140, 73510, 73520, 73525, 73540, 73550, 73560, 73562, 73564, 73565, 73590, 73592, 73600, 73610, 73620, 73630, 73650, 73660
X-ray: Head and Neck	70020, 70030, 70100, 70110, 70140, 70150, 70160, 70200, 70210, 70220, 70250, 70260, 70310, 70328, 70330, 70355, 70360
X-ray: Spine	72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072, 72074, 72080, 72090, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220