# Provider Payment Tool
# Colorado All Payer Claims Database
# Overview and Methodology

December 2024

## Overview

During the 2022 Colorado legislative session, Senate Bill 22-068 was passed to increase health care payment transparency. The bill requires CIVHC, administrator of the Colorado All Payer Claims Database (CO APCD), to create a public report that displays payments made to Colorado health care providers for CPT (Current Procedural Terminology) codes and HCPCS (Healthcare Common Procedure Coding System) codes by county, Division of Insurance (DOI) Region, and statewide. The report includes the following:

- All current (effective in 2022) CPT codes and HCPCS with sufficient volume (statewide claim volume of 30 or more) for 2018, 2019, 2020, 2021,2022, and 2023 .
- Payer breakouts for Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service.
- Total allowed amounts (payer and patient payments combined) at the 25th, 50th, 60$^{th}$, and 75th percentile, and average total allowed amounts.
- Anesthesiology payment calculations (see below for details).

View Senate Bill 22-068 for more information.

**Key considerations**

- The analysis includes all public and private health insurance payers submitting data to the CO APCD, which represents the majority of covered lives (70% of medically insured) in the state. The CO APCD *does not* include roughly half of the self-insured employer covered lives and *does not* include federal programs such as Tricare, Indian Health Services and the VA.
- This analysis is based on fee-for-service payments only and *does not* include supplemental payments, capitated payments or payments made through Alternative Payment Models (APMs).
- The data only includes payments for in-network providers for commercial, Medicaid and Medicare Advantage claims. Medicare FFS data in the CO APCD does not indicate in- vs. out-of-network providers, and therefore may include some out-of-network payments.
- Payments represent total allowed amounts (plan and patient paid) for the professional/provider portion of the claim only. Payments do not include any facility fees or other payments that may have been billed for the service.

## Definitions and Methods

**Defining Professional Claims**

Professional services are those provided by physicians or other health care professionals, such as a nurse practitioner, chiropractor, psychiatrist, or oncologist, and refer primarily to non-facility costs for evaluation and management services (e.g., office visits, specialist consultations, hospital and emergency room visits, home visits, nursing home visits) and procedures (e.g., major and minor surgical procedures, ambulatory procedures, anesthesia, endoscopies, imaging procedures). These services can be provided in conjunction with an inpatient or outpatient visit across a variety of health care facility types, and often include other fees like facility fees or ancillary service fees that do not go directly to the provider. Professional claims also include additional codes for non-facility providers or suppliers for lab tests, cardiovascular tests, durable medical equipment (e.g., the administration of selected drugs, prosthetic

devices, oxygen and other supplies), ambulance, chemotherapy, vaccinations, and other services and supplies**.**

**Defining Providers and Settings**
Provider specialty categories and settings were determined using the Centers for Medicare & Medicaid Services (CMS) National Plan & Provider Enumeration System (NPPES). Specialties are categorized into the broadest taxonomical level available. For detailed description of the categories, please visit the NPPES website. It is important to note that health care providers often bill under their organization name rather than their specialty. For example, a surgeon might bill under the name of the hospital where they provided services rather than their specialty of "surgery". In this case, the payment for the surgeon has been included in the “hospital provider” category displayed on the tool.

**Defining Outpatient vs. Inpatient Setting**
Outpatient and inpatient settings were determined by the place of service field on the claim. Providers may get paid differently based on the setting where they see a patient, therefore the tool enables users to select either setting type. Pharmacies, emergency departments and stand-alone clinics are considered outpatient settings whereas an inpatient setting indicates the service was provided in a hospital during a hospital admission or in a residential care setting.

**Payments and Cost Category**
The analysis provides payment information in the form of total allowed amounts which are the combined sum of the amount of dollars paid by the health insurance plan and patient (which includes copay, coinsurance and deductibles). This analysis includes 25th, 50th, 60th, and 75th percentile allowed amounts, as well as average allowed amounts. In the interactive report, allowed amounts are described as “payments”.

- **Cost Category: Flat Fee versus Per Unit Fee**. The tool also displays the way the code gets paid. Flat fee codes are payed for using a fixed rate payment while per unit code payments will vary and show the cost of a single unit of the service rendered (units can be time unit or drug dosage unit).

## Telehealth Services

This analysis includes telehealth services. Telehealth services are determined by a combination of billing modifiers and place of serves (POS) codes.

**Billing Modifiers for Telehealth**
Modifiers are two-digit codes added to procedure codes to provide additional information about the service provided. For telehealth, two modifiers are commonly used:

1. **95 Modifier**: Indicates that the service was provided via a real-time audio and video communication system. This modifier is essential for telehealth claims to signify that the visit was conducted virtually.

2. **GT Modifier**: Previously used to denote services provided via interactive audio and video telecommunications systems. However, it has largely been replaced by the 95 modifier under many regulations.

**Place of Service (POS) Codes**

POS codes are used to indicate where the service was provided. For telehealth services, there are two primary codes:

- **POS 02**: Used for telehealth services provided via telecommunication technology, indicating the patient is at a different location than the provider.
- **POS 10**: Used for telehealth services provided in a patient's home, which is becoming increasingly relevant as home-based care models grow.

**Geographical Groupings**

Geographic breakdowns are available in the tool for Colorado counties, Division of Insurance (DOI) commercial insurance geographic rate setting areas, and at the state level. The following is a list of counties in each DOI region, along with the label displayed for each region in this report:

- **Rating Area 1 – Boulder:** Boulder
- **Rating Area 2 – Colorado Springs:** El Paso, Teller
- **Rating Area 3 – Denver:** Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
- **Rating Area 4** – Ft. Collins: Larimer
- **Rating Area 5** – Grand Junction: Mesa
- **Rating Area 6** – Greeley: Weld
- **Rating Area 7** – Pueblo: Pueblo
- **Rating Area 8** – East: Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
- **Rating Area 9** – West: Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat,

## Anesthesia Methodology

Payments to providers for anesthesia services are calculated using a formula that considers the code, any modifiers, and associated units using the following formula and definitions:

**Calculated Reimbursement Rate = Conversion Factor x ((Base Units + Physical Status Units + Time Units) x Price Modifier)**

- **Conversion factor** is determined using data from the CO APCD which is a standard payment for each geography selected. The dashboard shows the anesthesia conversion factor for each of the geographic regions, specialties, settings, and payer types included.
- **Base units** are assigned to each anesthesia code by the Centers for Medicare and Medicaid Services (CMS).
- **Physical status units** are based on the physical status of the patient prior to surgery.
- **Time units** are based on the time the procedure took.
- **Price modifiers** are based on who provided the anesthesia service.

The tool provides the calculated estimated reimbursement rate when each of the factors above are selected by the user. Detailed definitions of each of the modifiers and units are provided below.

**CPT/Base Units:** Common CPT codes used in anesthesia are assigned a base unit by the Centers for Medicare & Medicaid Services. This unit is used in the calculation of payment in addition to Time Units, Physical Status and Price Modifiers.

**Price Modifier:** Pricing modifiers are used to change reimbursement percentages depending on the type of anesthesia provider.

| Price Modifier | Descriptor |
|---|---|
| **AA** | Anesthesia Services performed personally by the anesthesiologist |
| **AD** | Medical Supervision by a physician: more than 4 concurrent anesthesia procedures |
| **QK** | Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals |
| **QS** | Monitored anesthesia care service<br><br>NOTE: The QS HCPCS modifier can be used by a physician or a qualified non-physician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim. |
| **QX** | Qualified nonphysician anesthetist service: With medical direction by a physician |
| **QY** | Medical direction of one qualified nonphysician anesthetist by an anesthesiologist |
| **QZ** | CRNA service: Without medical direction by a physician |
| ***Source: Medicare Claims Processing Manual, Chapter 12, Sections 50I and 140.3.3 as of 6/11/2019*** | |

**Patient Physical Status:** Patient Physical Status indicate the patient's physical status prior to surgery.

| | Patient Physical Status |
|---|---|
| **P1** | A normal healthy patient |
| **P2** | A patient with mild systemic disease |
| **P3** | A patient with severe systemic disease |
| **P4** | A patient with severe systemic disease that is a constant threat to life |
| **P5** | A moribund patient who is not expected to survive without the operation |
| **P6** | A declared brain-dead patient whose organs are being removed for donor purposes |

## Data Caveats

**General**

- Claims without an associated billing provider are not included. This accounts for less than 1% of professional claims from 2018 to 2023.
- This report does not include any supplemental or non-claims-based payments made by any payer to providers outside of the traditional fee-for service system.

**Commercial Ambulance Claims**

- In Colorado, it is estimated that two-thirds of all ambulance claims are out of network. Therefore, commercial claims for in-network ambulance services in the CO APCD account for approximately 20% of all commercial claims for ambulance services.

- Due to the comparatively small volume of data and the nuances of how ambulance payments are calculated, rates for commercial ambulance claims should be interpreted with caution.

**Medicaid**

- Because this tool does not include facility fees, no Medicaid supplemental payments for hospital or nursing facility services were included.

**Medicare Fee-For-Service**

- Centers for Medicare & Medicaid (CMS) provides Medicare FFS data to CIVHC and does not differentiate between in-network and out-of-network claims. In this analysis, all Medicare FFS claims were included and may include some out-of-network payments. However, in most instances, except for urgent or emergency situations, Medicare FFS does not pay for services with out-of-network providers, and therefore is estimated to represent a small number of claims in this analysis.

## Additional Information

**Service Dates Included**

This analysis includes claims data for the following calendar years: 2018, 2019, 2020, 2021, 2022, and 2023.

**Data Suppression**

Following privacy protection standards used by the Centers for Medicare & Medicaid Services (CMS) and the Out-of- Network Analysis methodology, data are suppressed for values based on fewer than 30 claims statewide, and can only be displayed at the county or DOI region if there are 30 or more claims in that particular region.

**Data Vintage**
This report is based off claims data in the CO APCD data warehouse refresh on November, 2024. For more information about number of claims in the CO APCD during a particular reporting year and data discovery information regarding payer submissions, please visit our website at civhc.org.

For more information or additional questions, contact us at info@civhc.org.