



INFORMAL RULE PROPOSAL:
REIMBURSEMENT RATE DATA
28 TAC CHAPTER 21, SUBCHAPTER KK

APRIL 30, 2015

TEXAS DEPARTMENT OF INSURANCE



AGENDA

- Background
- Data issues
- Informal draft rule
- Proposed data collection
 - Scope of services
 - Methodology
 - Presentation of data
- Next steps



BACKGROUND

- ❑ SB 1731, 80th Legislature sought to increase price transparency in health care services and directed TDI to
 - ❑ collect data from issuers on the reimbursement rates that health plans pay to providers
 - ❑ publish information online that does not reveal individual insurers or providers
- ❑ TDI adopted rules in December 2010
- ❑ Data collection began in 2011
- ❑ A beta website launched in February 2012
- ❑ Following stakeholder feedback, the current version of the website launched in February 2013
- ❑ TDI, in partnership with UT received a grant to support health price transparency in October 2013



DATA ISSUES

- ❑ Use of DRGs produces inconsistent and misleading facility costs
- ❑ Line level data does not capture all services provided for a procedure
- ❑ Scope does not include facility, surgeon, and anesthesiology codes for each procedure
- ❑ Scope does not include facility, professional, and technical component costs for imaging
- ❑ Lack of summary statistics prevents TDI from illustrating a typical range of costs a consumer may experience
- ❑ Single aggregated data point incorporates outliers and limits ability to audit data



INFORMAL DRAFT RULE

- ❑ Issuers subject to reporting: 10k lives → 20K lives
- ❑ Reporting period: 6 months → 12 months
- ❑ Geographic regions: DSHS health service regions
→ 3-digit ZIP codes
- ❑ Data collection methodology
 - ❑ Data collection form and instructions
 - ❑ Scope of medical services
 - ❑ Scope of data elements
 - ❑ Instructions



PROPOSED DATA COLLECTION

- Inpatient procedures (13)
 - Facility costs
 - Professional costs: surgeon, anesthesiologist, radiologist, as applicable
- Outpatient procedures (10)
 - Facility costs
 - Professional costs: surgeon, anesthesiologist, radiologist, as applicable
- Imaging – in office or outpatient facility (23)
 - Facility costs, if applicable
 - Professional costs
 - Technical component, if applicable
- Office visits – professional services (10)
- Pathology – professional services (10)



INPATIENT PROCEDURES

□ Facility Fees and Professional Fees for Surgery and Anesthesia Services

- Coronary Bypass (CABG) without Cardiac Catheterization
- C-Section Delivery
- Vaginal Delivery
- Back Surgery – Laminectomy
- Inguinal Hernia Repair
- Laparoscopic Cholecystectomy
- Appendectomy
- Tonsillectomy
- Adenoidectomy
- Cardiac Angioplasty – with Drug Eluting Stent *
- Hip Replacement *
- Knee Replacement *
- Hysterectomy**

* Also includes Professional Fees for Radiology

** Also includes Professional Fees for Pathology



INPATIENT METHODOLOGY

□ Facility

- Filter: Facility claims
- Filter: [in-network, out-of-network]
- Filter: bill type institution = hospital AND bill type classification = inpatient
- Filter by 3-digit ZIP code
- Identify hospital stay with one or more of the target ICD-9 procedure codes, derive the totals for the hospital stay

□ Professional

- Filter: Professional claims
- Filter: [in-network, out-of-network]
- Filter: Place of service = inpatient hospital
- Filter by 3-digit ZIP code
- Identify claims with one or more of the CPT target codes, derive the totals for the claim



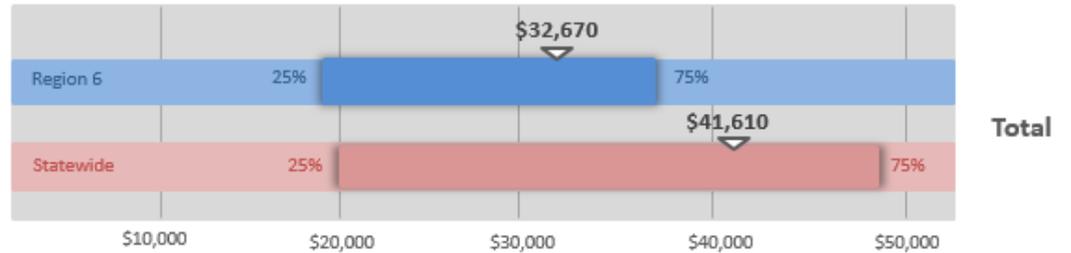
Inpatient procedures: Hip Replacement

- In-Network
- Out-of-Network

Hip Replacement: In-Network					
		Facility	Surgery	Anesthesiology	Total
Allowed amount	Region 6	\$29,300	\$1,900	\$1,470	\$32,670
	Statewide	\$37,700	\$2,200	\$1,710	\$41,610
Billed amount	Statewide	\$62,000	\$4,000	\$3,100	\$69,200

- Billed Amount
- Allowed Amount

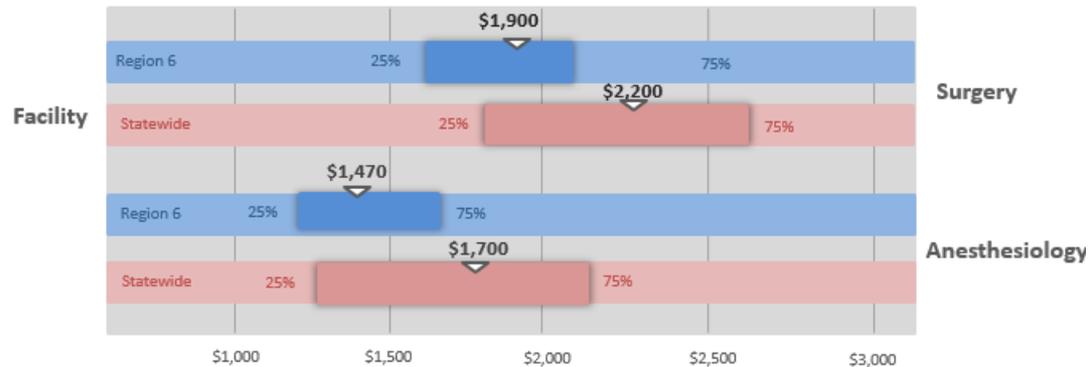
Total Fees: Allowed Amount



Facility Fees: Allowed Amount



Professional Fees: Allowed Amount





- **Facility Claim** is a claim that was sent by the facility (inpatient hospital/outpatient hospital) where the medical care services were rendered.
- **Surgery claim** is professional claim that was sent by provider (Surgeon) who rendered medical care to the patient.
- **Anesthesia claim** is professional claim that was sent by provider (Anesthesiologist) who rendered medical care to the patient.
- **Radiology claim** is professional claim that was sent by provider (Radiologist) who rendered medical care to the patient.



- **Region 6** – fee estimations are based on claims data from Region 6 - Gulf Coast, including Houston and Huntsville.
- **Statewide** – fee estimations are based on claims from entire Texas state.



- **Allowed amount** - the maximum reimbursement the member's health policy allows for a specific service. Allowed amounts are based on the rate specified by the insurance.
- **Billed amount** is the amount charged for each service performed by the provider. It is the total charge value of the claim.



Hip replacement



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Definition

By Mayo Clinic Staff



During hip replacement, a surgeon removes the damaged sections of your hip joint and replaces them with parts usually constructed of metal and very hard plastic. This artificial joint (prosthesis) helps reduce pain and improve function.

Also called total hip arthroplasty, hip replacement surgery may be an option for you if your hip pain interferes with daily activities and more-conservative treatments haven't helped. Arthritis damage is the most common reason to need hip replacement.



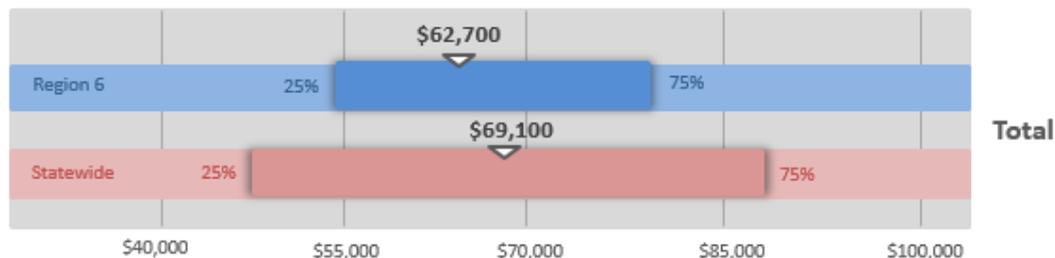
Inpatient procedures: Hip Replacement

- In-Network
- Out-of-Network

Hip Replacement: In-Network					
		Facility	Surgery	Anesthesiology	Total
Billed amount	Region 6	\$56,000	\$3,800	\$2,900	\$62,700
	Statewide	\$62,000	\$4,000	\$3,100	\$69,100
Allowed amount	Statewide	\$37,700	\$2,200	\$1,710	\$41,610

- Billed Amount
- Allowed Amount

Total Fees: Billed Amount



Facility Fees: Billed Amount



Professional Fees: Billed Amount





OUTPATIENT PROCEDURES

❑ Facility Fees and Professional Fees for Surgery and Anesthesia Services

- ❑ Myringotomy
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ Cardiac catheterization (left, right, or both)
- ❑ Rotator cuff repair
- ❑ Bunion Repair
- ❑ Upper GI Endoscopy
- ❑ Colonoscopy
- ❑ Colonoscopy with Upper Gastrointestinal Endoscopy
- ❑ Anterior cruciate ligament (ACL) Repair*

* *Also includes Professional Fees for Radiology*



Outpatient Methodology

□ Facility

- Filter: Facility claims
- Filter: [in-network, out-of-network]
- Filter: bill type institution = [hospital, special facility] AND bill type classification = [outpatient, ambulatory surgical center]
- Filter by 3-digit ZIP code
- Identify claim with one or more of the target ICD-9 procedure codes, derive the totals for the claim

□ Professional

- Filter: Professional claims
- Filter: [in-network, out-of-network]
- Filter: Place of service = outpatient hospital OR ambulatory surgical center
- Filter by 3-digit ZIP code
- Identify claims with one or more of the CPT target codes, derive the totals for the claim



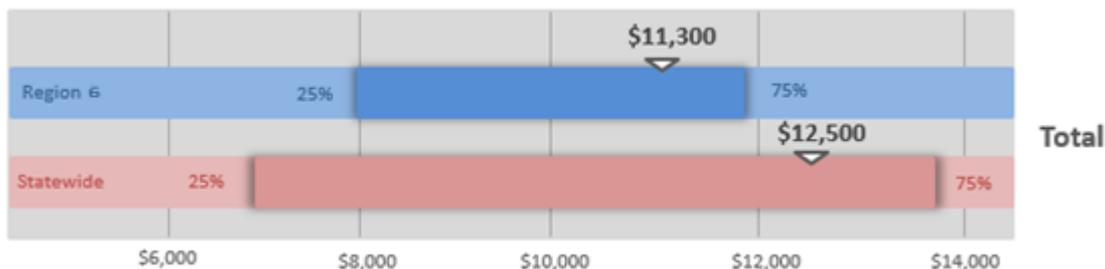
Outpatient Procedures: Cardiac catheterization

- In-Network
- Out-of-Network

Cardiac Catheterization – left: In-Network					
		Facility	Surgery	Anesthesiology	Total
Allowed amount	Region 6	\$9,000	\$1,200	\$1,100	\$11,300
	Statewide	\$9,800	\$1,490	\$1,210	\$12,500
Billed amount	Statewide	\$21,000	\$3,200	\$2,700	\$26,900

- Billed Amount
- Allowed Amount

Total Fees: Allowed Amount



Facility Fees: Allowed Amount



Professional Fees: Allowed Amount





Cardiac catheterization



- Basics
- Care at Mayo Clinic
- In-Depth
- Expert Answers
- Multimedia
- Resources
- News From Mayo Clinic

Definition

Why it's done

Risks

How you prepare

What you can expect

Results

Definition

By Mayo Clinic Staff

Cardiac catheterization (kath-uh-tur-ih-ZAY-shun) is a procedure used to diagnose and treat cardiovascular conditions. During cardiac catheterization, a long thin tube called a catheter is inserted in an artery or vein in your groin, neck or arm and threaded through your blood vessels to your heart. Using this catheter, doctors can then do diagnostic tests as part of a cardiac catheterization. Some heart disease treatments, such as coronary angioplasty, also are done using cardiac catheterization.

Usually, you'll be awake during cardiac catheterization, but given medications to help you relax. Recovery time for a cardiac catheterization is quick, and there's a low risk of complications.





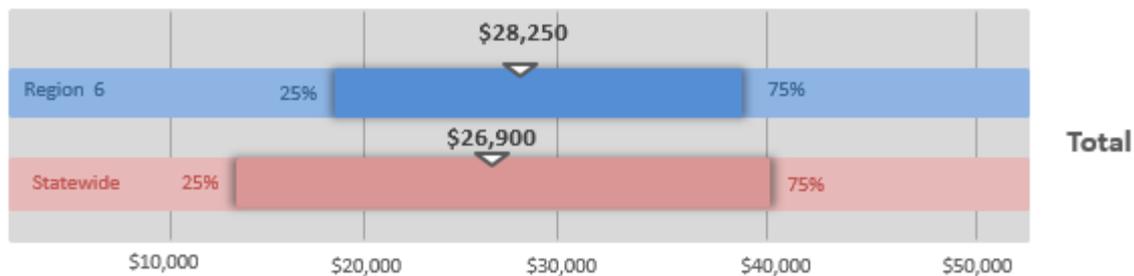
Outpatient Procedures: Cardiac catheterization

- In-Network
- Out-of-Network

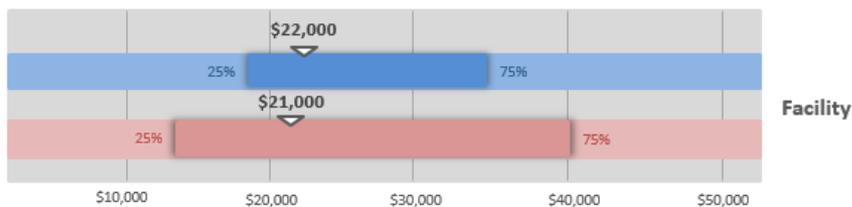
Hip Replacement: In-Network					
		Facility	Surgery	Anesthesiology	Total
Billed amount	Region 6	\$22,000	\$3,450	\$2,800	\$28,250
	Statewide	\$21,000	\$3,200	\$2,700	\$26,900
Allowed amount	Statewide	\$9,800	\$1,490	\$1,210	\$12,500

- Billed Amount
- Allowed Amount

Total Fees: Billed Amount



Facility Fees: Billed Amount



Professional Fees: Billed Amount





IMAGING SERVICES

- ❑ Outpatient hospital: Facility Fees and Professional Fees (26)
- ❑ Office: Professional Fees (26, TC, null/missing)*
- ❑ All Other Places: Professional Fees (26, TC, null/missing)*
- * Modifiers (26, TC, and null/missing) will be used to generate overall fees by place of service
 - ❑ CT Abdomen and Pelvis
 - ❑ CT Scan Abdomen
 - ❑ CT Scan Pelvis
 - ❑ CT Scan Head/Brain
 - ❑ CT Scan of Mouth, Jaw, and Neck
 - ❑ CT Soft Tissue Neck
 - ❑ CT Scan Chest
 - ❑ CT Scan of Lumbar Lower Spine
 - ❑ CT Lower Extremity
 - ❑ Mammogram, Analog
 - ❑ Mammogram, Digital
 - ❑ MRI Brain
 - ❑ MRI Head (Orbit/Face/Neck)
 - ❑ MRI Angiography Head
 - ❑ MRI Neck Spine
 - ❑ MRI Spine
 - ❑ MRI Lumbar Spine
 - ❑ MRI Lower Limb
 - ❑ MRI Lower Limb (other than joint)
 - ❑ MRI Lower Limb (with joint)
 - ❑ MRI Abdomen
 - ❑ MRI Breast
 - ❑ MRI Pelvis



IMAGING METHODOLOGY

- ❑ Facility (where applicable)
 - ❑ Filter: Facility claims
 - ❑ Filter: [in-network, out-of-network]
 - ❑ Filter: bill type institution = hospital AND bill type classification = outpatient
 - ❑ Filter by 3-digit ZIP code
 - ❑ Identify claim lines with the following combination of revenue codes and CPT codes
- ❑ Professional
 - ❑ Filter: Professional claims
 - ❑ Filter: [in-network, out-of-network]
 - ❑ Filter: Place of service = [outpatient hospital, office, all other]
 - ❑ Filter: CPT modifier [26, TC, missing or null]
 - ❑ Filter: units of service = 1
 - ❑ Filter by 3-digit zip code
 - ❑ Identify claim lines with any one of the CPT target codes



Imaging Services: MRI Brain without and with contrast

- In-Network
- Out-of-Network

MRI Brain without and with contrast (CPT 70553)				
		Outpatient Hospital	Physician Office	FSF or other
Allowed amount	Region 6	\$2,550	\$1,140	\$1,250
	Statewide	\$2,630	\$1,300	\$1,450
Billed amount	Statewide	\$3,200	\$2,200	\$2,350

- Billed Amount
- Allowed Amount

Service Fees: Allowed Amount





Imaging Services: MRI Brain without and with contrast

- In-Network
- Out-of-Network

MRI Brain without and with contrast (CPT 70553)				
		Outpatient Hospital	Physician Office	FSF or other
Billed amount	Region 6	\$3,100	\$2,100	\$2,250
	Statewide	\$3,200	\$2,200	\$2,350
Allowed amount	Statewide	\$2,630	\$1,300	\$1,450

- Billed Amount
- Allowed Amount

Service Fees: Billed Amount





OFFICE VISITS

- ❑ Professional Fees only
 - ❑ Preventive checkup – age 1-4, 5-11, 12-17 (existing patient, new patient)
 - ❑ Preventive checkup for an adult – age 18-39, 40-64 (existing patient, new patient)
 - ❑ Physician care (existing patient, new patient)
 - ❑ Specialist office consultation
 - ❑ Annual gynecological exam (existing patient, new patient)
 - ❑ Screening pap smear by physician and cytology



OFFICE VISIT METHODOLOGY

- Professional
 - Filter: Professional claims
 - Filter: [in-network, out-of-network]
 - Filter: Place of service = office or rural health clinic
 - Filter by 3-digit ZIP code
 - Identify claims with the CPT target code
 - Derive the average amount per unit: divide the amount by the unit count for the line on which the target code appears



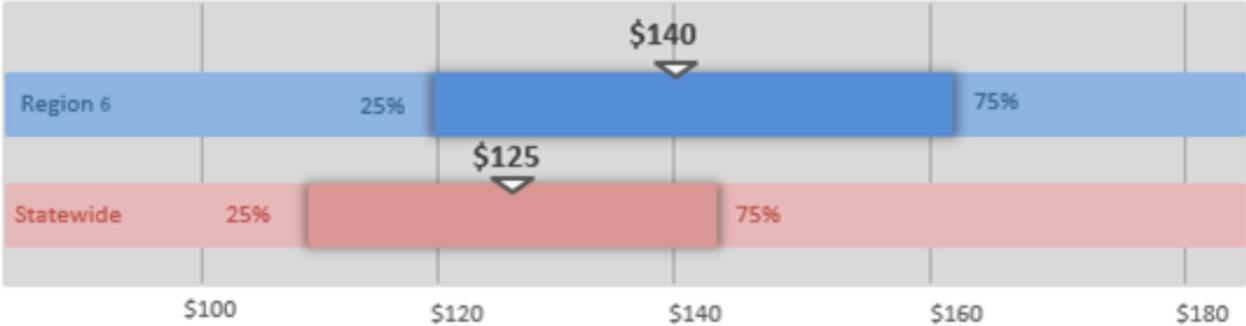
Office Visits: Annual gynecological examination, new patient

Annual gynecological examination, new patient (CPT S0610)		
	No Modifier	
Allowed amount	Region 6	\$140
	Statewide	\$125
Billed amount	Statewide	\$320

- In-Network
- Out-of-Network

- Billed Amount
- Allowed Amount

Professional Fees: Allowed Amount





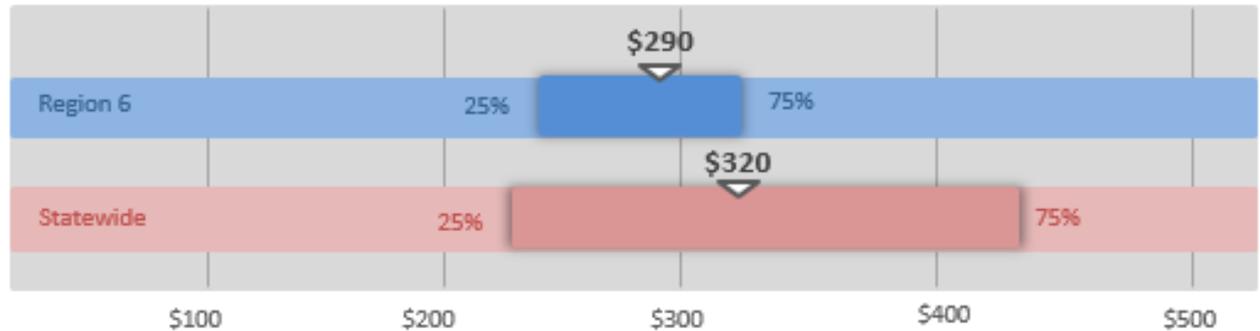
Office Visits: Annual gynecological examination, new patient

Annual gynecological examination, new patient (CPT S0610)		
	No Modifier	
Billed amount	Region 6	\$290
	Statewide	\$320
Allowed amount	Statewide	\$125

- In-Network
- Out-of-Network

- Billed Amount
- Allowed Amount

Professional Fees: Billed Amount





- Professional Fees Only
 - Organ or Disease Panels
 - Evocative Suppression Testing
 - Urinalysis
 - Chemistry
 - Hematology-Coagulation
 - Immunology
 - Microbiology
 - Anatomic Pathology
 - Screening Cytopathology
 - Complete Blood Count



PATHOLOGY METHODOLOGY

- Professional
 - Filter: Professional claims
 - Filter: [in-network, out-of-network]
 - Filter: Place of service = independent lab
 - Filter by 3-digit ZIP code
 - Identify claims with the CPT target code and modifier as applicable
 - Derive the average amount per unit: divide the amount by the unit count for the line on which the target code appears



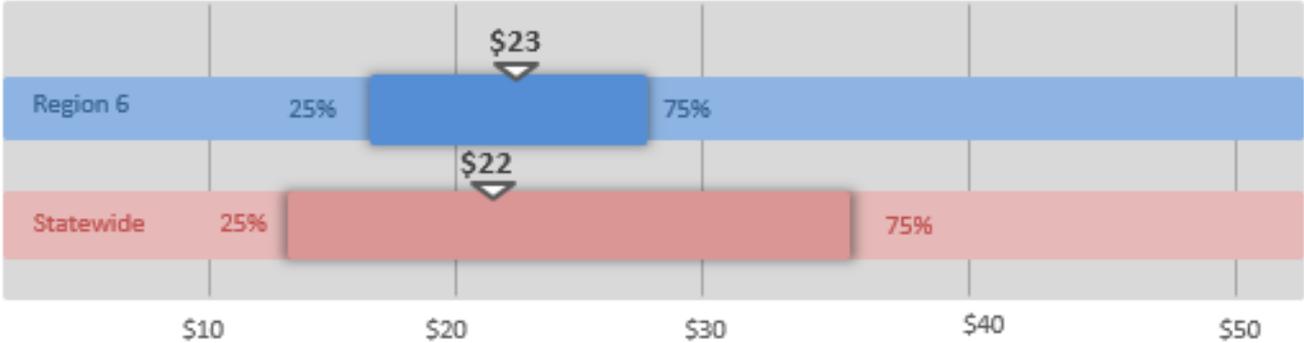
Pathology: Lipid Panel

Lipid Panel (CPT 80061)		
	No Modifier	
Allowed amount	Region 6	\$23
	Statewide	\$22
Billed amount	Statewide	\$45

- In-Network
- Out-of-Network

- Billed Amount
- Allowed Amount

Professional Fees: Allowed Amount





Pathology: Lipid Panel

Lipid Panel (CPT 80061)		
		No Modifier
Billed amount	Region 6	\$48
	Statewide	\$45
Allowed amount	Statewide	\$22

- In-Network
- Out-of-Network

- Billed Amount
- Allowed Amount

Professional Fees: Billed Amount





NEXT STEPS

- ❑ Comment period through *May 15*
 - ❑ HealthPriceTransparency@tdi.texas.gov
 - ❑ Need an extension? Please let us know.
- ❑ Issuer testing of data collection instructions
 - ❑ We're available to work with issuers one-on-one to answer questions and provide clarification as needed
- ❑ Formal rule proposal will reflect comments received during this informal comment period
- ❑ Aim to adopt rules this year and collect data in spring 2016