AHIP

America's Health Insurance Plans

Survey of Charges Billed by Out-of-Network Providers:

A Hidden Threat to Affordability

JANUARY 2013

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SUMMARY

To make health care coverage more affordable, the nation must address the soaring cost of medical care that continues to rise at an unsustainable rate. Research shows that higher health care spending is a result of higher health care prices.

For consumers who choose to seek care out-of-network, our latest survey shows that the charges billed by some out-of-network providers can exceed several hundred or several thousand percent of what Medicare would reimburse for the same service in the same area.

For example,

- **$34,366** for knee arthroscopy/surgery (New Jersey). **Medicare fee = $718**. Billed charge was 48 times the Medicare fee.
- **$115,625** for lumbar spine fusion (New York). **Medicare fee = $1,867**. Billed charge was 62 times the Medicare fee.
- **$5,520** for an MRI of the brain (physician fee) (Texas). **Medicare fee = $118**. Billed charge was 47 times the Medicare fee.
- **$73,848** for neck spine disk surgery (New York). **Medicare fee = $1,616**. Billed charge was 46 times the Medicare fee.
- **$48,983** for total hip replacement (New Jersey). **Medicare fee = $1,544**. Billed charge was 32 times the Medicare fee.
- **$44,000** for removal of gallbladder using a laparoscope (New York). **Medicare fee = $849**. Billed charge was 52 times the Medicare fee.
- **$42,800** for partial removal of colon (New York). **Medicare fee = $1,522**. Billed charge was 28 times the Medicare fee.

Protecting consumers from runaway charges billed by some out-of-network physicians is an important policy issue at a time of major economic challenges and a national debate surrounding the affordability of health care. This report provides a snapshot, state-by-state, of exorbitant charges billed by some out-of-network physicians in the 30 largest states by population. Our survey further indicated that health plans and their members routinely receive bills from physicians that are 10 to 20, or sometimes nearly 100 times higher than Medicare would allow. It illustrates the value of provider networks and a pressing problem faced by consumers who want affordable, meaningful access to out-of-network providers.

“Protecting consumers from runaway charges billed by some out-of-network physicians is an important policy issue at a time of major economic challenges and a national debate surrounding the affordability of health care.”

Consumers incur very high expenses when out-of-network physicians “balance bill.” As is oftentimes the case when out-of-network physicians charge the difference back to the consumer, the cost can be enormous and further limits consumers’ access to affordable care. This detracts from the ability of health plans to offer affordable access to out-of-network providers for those consumers who want the advantages of a network, but also wish to have a coverage option for out-of-network providers they may wish to use.

TOP 20 HIGHEST REPORTED CHARGES AS A PERCENT OF MEDICARE FEE (2011)

CPT Code	CPT Description	Amount Billed	2011 Medicare Fee	Amount Billed as % of Medicare Fee	State
99233	Subsequent Hospital Care	$9,470.90	$100.06	9,465%	TX
88305	Tissue Exam by Pathologist	$12,000.00	$128.70	9,324%	NY
99291	Critical Care, First 30–74 Minutes	$27,309.56	$293.60	9,302%	NJ
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$9,600.00	$104.72	9,167%	NY
99233	Subsequent Hospital Care	$9,800.00	$109.00	8,991%	NJ
99233	Subsequent Hospital Care	$10,000.00	$111.97	8,931%	NY
15734	Muscle-Skin Graft Trunk	$150,500.00	$1,766.57	8,519%	NY
88305	Tissue Exam by Pathologist	$8,500.00	$112.35	7,566%	IL
88305	Tissue Exam by Pathologist	$8,040.00	$106.29	7,564%	TX
43239	Upper GI Endoscopy Biopsy	$29,998.00	$409.18	7,331%	NY
26055	Tendon Sheath Incision	$39,450.00	$547.06	7,211%	TX
88305	Tissue Exam by Pathologist	$7,298.00	$104.52	6,982%	FL
99285	Emergency Department Visit	$12,000.00	$187.38	6,404%	NY
99291	Critical Care, First 30–74 Minutes	$19,200.00	$303.62	6,324%	NY
88305	Tissue Exam by Pathologist	$8,100.00	$128.46	6,305%	CA
22612	Lumbar Spine Fusion	$115,625.00	$1,866.71	6,194%	NY
88305	Tissue Exam by Pathologist	$6,000.00	$103.49	5,798%	MO
99285	Emergency Department Visit	$10,289.85	$181.76	5,661%	FL
88305	Tissue Exam by Pathologist	$5,480.00	$100.37	5,460%	KY
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$4,740.00	$86.84	5,458%	TX

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC. Notes: Highest billed charges for selected services received by responding health plans from out-of-network providers in 2011, and Medicare fee applicable for the service in the corresponding locality. Only one example per state per CPT code shown above.

One tool that health insurance plans use to improve quality and make health care more affordable for consumers is the establishment of high quality provider networks. By selectively contracting with credentialed providers, health plans ensure consumers affordable access to a wide choice of high-quality doctors and hospitals. Nationally, approximately 88 percent of all claims were paid on an in-network basis in 2011.[1]

Consumers see measurable savings when they visit contracted providers because in-network physicians are generally prohibited from charging patients the difference between billed charges and a negotiated rate. Also, consumers who receive services from in-network providers typically have lower cost-sharing obligations. Over the decades, this has saved consumers billions of dollars in out-of-pocket costs and premiums.

[1] AHIP Center for Policy and Research. (*Forthcoming*—2013, January). *Update: A Survey of Health Insurance Claims Receipt and Processing Times*, 2011.

SURVEY METHODOLOGY

In 2012, AHIP asked Dyckman & Associates, LLC (Dyckman) for assistance in conducting a survey of AHIP member health plans regarding maximum billed charges from non-participating or out-of-network providers for selected physician services. The plans were asked to provide the three highest billed charges in 2011 and their corresponding zip codes from non-participating providers for each of the 24 CPT procedure codes within the 30 most populous states. The new survey updates a similar survey done by AHIP and Dyckman in 2009.[2]

Responding companies included national plans that operate in most of the 30 survey states, as well as regional plans that operate in one or several states. Billed charges were reported based on only "clean" claims — that is, complete claims that are ready for adjudication and for which no additional information is required. Dyckman computed the ratios of billed charges to the applicable Medicare fee in the same Medicare payment locality, aggregated the results, and reported them to AHIP at the state level.

In analyzing the response data, Dyckman took measures to try and exclude any claims that could possibly have been billed or reported in error. For example, Dyckman excluded claims where the reported out-of-network charge was more than 2,000 percent of the Medicare fee and at least 50 percent (1.5 times) greater than the next highest reported charge-to-Medicare fee ratio in the same locality for the procedure code.

RESULTS

In 2011, the maximum reported charge billed by a non-participating provider as a percent of the Medicare fee in the same locality was 9,465 percent, based on a billed charge received by a health plan from an out-of-network provider of $9,471 for "subsequent hospital care." The applicable Medicare fee for that service in the same locality was $100. Therefore, the billed charge was **nearly 95 times the corresponding Medicare fee**.

Of the highest maximum out-of-network charge-to-Medicare fee ratios for each of the 24 CPT codes reported:

- 12 were in New York;
- 5 were in Texas;
- 3 were in New Jersey;
- and there was 1 each in California, Illinois, Massachusetts and Wisconsin (see Table 1 on page 9).

Overall, among the top 20 highest charges as a percent of Medicare billed in 2011:

- 8 were in New York;
- 4 were in Texas;
- 2 were in Florida;
- 2 were in New Jersey;
- and there was 1 each in California, Illinois, Kentucky, and Missouri (see Table on page 3).

In some instances, the sheer magnitude of the out-of-network charges was astounding. For example, a billed charge for a hernia repair with a torso muscle-skin graft (CPT Code 15734) in New York was submitted by an out-of-network physician that exceeded the Medicare reimbursement by nearly $149,000. Yet this was only the eighth highest overall out-of-network billed charge-to-Medicare fee ratio reported.

Out-of-network charge extremes varied widely across the country. For example, the maximum billed out-of-network charge for CPT code

[2] America's Health Insurance Plans (2009, August). *The Value of Provider Networks And the Role of Out-of-Network Charges In Rising Health Care Costs: A Survey of Charges Billed By Out-of-Network Physicians*. Retrieved from America's Health Insurance Plans (AHIP): *http://www.ahip.org/Value-of-Provider-Networks/*

TOP FIVE HIGHEST REPORTED CHARGES AS PERCENT OF MEDICARE FEE (2011)

1

Subsequent Hospital Care, TX
(CPT Code 99233)

The billed charge was nearly 9,500 percent—**95 times**—the Medicare fee for this service in the same locality.

2

Tissue Exam by Pathologist, NY
(CPT Code 88305)

The billed charge was more than 9,300 percent—**93 times**—the Medicare fee for this service in the same locality.

3

Critical Care, First 30–74 Minutes, NJ
(CPT Code 99291)

The billed charge was more than 9,300 percent—**93 times**—the Medicare fee for this service in the same locality.

4

Debridement of Subcutaneous Tissue 20 sq cm/<, NY
(CPT Code 11042)

The billed charge was nearly 9,200 percent—**92 times**—the Medicare fee for this service in the same locality.

5

Subsequent Hospital Care, NJ
(CPT Code 99233)

The billed charge was 9,000 percent—**90 times**—the Medicare fee for this service in the same locality.

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC. Notes: Highest billed charges for selected services received by responding health plans from out-of-network providers in 2011, and Medicare fee applicable for the service in the corresponding locality. Only one example per state per CPT code shown above.

43239 (upper GI endoscopy and biopsy) ranged from $29,998 in New York to $781 in Iowa. The highest charge as a percent of the Medicare fee for CPT 43239 was in New York (7,331 percent—more than **seventy-three times the Medicare fee**). While the lowest maximum billed charge was more than twice the Medicare fee in the same locality in Iowa (243 percent), the average of all reported maximum out-of-network charge-to-Medicare fee ratios for CPT code 43239 in the 30 states surveyed was 1,325 percent, or **more than 13 times** the Medicare fee. Maximum billed out-of-network charges for CPT code 43239 exceeded ten times the Medicare fee in 19 of the 30 states included in the survey.

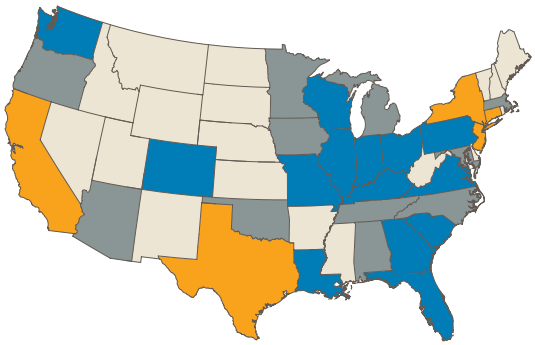
Similarly, the highest reported maximum out-of-network charge as a percent of the Medicare fee for the first 30–74 minutes of critical care (CPT code 99291) was 9,302 percent in New Jersey—**more than 93 times** the Medicare fee; the lowest was 219 percent in Minnesota. The reported charges were $27,310 (New Jersey) and $559 (Minnesota), when Medicare would have paid $294 and $255, respectively. The average of all reported maximum out-of-network charge-to-Medicare fee ratios for CPT code 99291 was 1,766 percent, **or nearly 18 times the Medicare fee**. Maximum billed out-of-network charges for CPT code 99291 exceeded ten times the Medicare fee in 22 of the 30 states included in the survey.

The geographic distribution of the maximum billed out-of-network charge-to-Medicare fee ratio varied by procedure. For example, a map of the maximum ratios for CPT code 88305 (tissue exam by pathologist) shows that only one state had a maximum billed charge-to-Medicare fee ratio of under 1,000 percent of Medicare. Eleven (11) states had maximum ratios between 1,000 and 3,000 percent of Medicare, and 18 of the 30 states included in the survey had ratios of more than 3,000 percent. The highest billed charge as a percent of Medicare for CPT code 88305 was 9,324 percent in New York; the lowest was 765 percent in Minnesota.

HIGHEST BILLED CHARGES AS A PERCENT OF MEDICARE FEE FOR SAME SERVICE AND LOCALITY

FIGURE 1.

Comparison of Highest Billed Charge as a Percent of Medicare Fee for Debridement of Subcutaneous Tissue 20 sq cm/< (CPT Code 11042), 2011

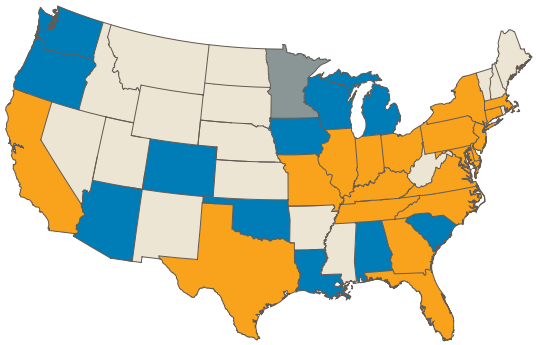


Below 1,000% | 1,000% to 3,000% | 3,000% and Above | State Data Not Collected

Source: AHIP Center for Policy and Research (2012). Note: Eleven (11) states had maximum billed charge-to-Medicare fee ratios under 1,000 percent of Medicare; 14 states between 1,000 and 3,000 percent of Medicare; and 5 states more than 3,000 percent of Medicare. The highest billed charge as a percent of Medicare for CPT code 11042 was 9,167 percent in NY; the lowest was 412 percent in MN.

FIGURE 2.

Comparison of Highest Billed Charge as a Percent of Medicare Fee for Tissue Exam by Pathologist (CPT Code 88305), 2011

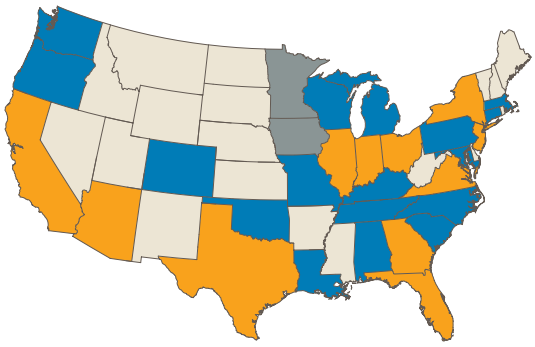


Below 1,000% | 1,000% to 3,000% | 3,000% and Above | State Data Not Collected

Source: AHIP Center for Policy and Research (2012). Note: One (1) state had a maximum billed charge-to-Medicare fee ratio under 1,000 percent of Medicare; 11 states between 1,000 and 3,000 percent of Medicare; and 18 states more than 3,000 percent of Medicare. The highest billed charge as a percent of Medicare for CPT code 88305 was 9,324 percent in NY; the lowest was 765 percent in MN.

FIGURE 3.

Comparison of Highest Billed Charge as a Percent of Medicare Fee for Subsequent Hospital Care (CPT Code 99233), 2011

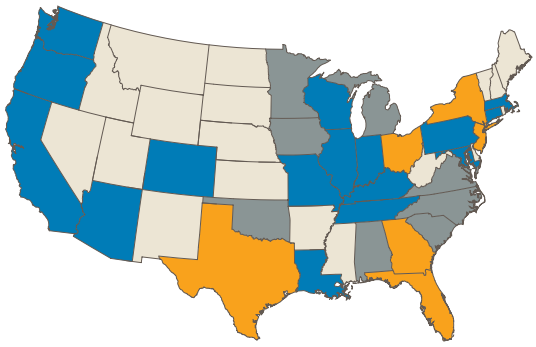


Below 1,000% | 1,000% to 3,000% | 3,000% and Above | State Data Not Collected

Source: AHIP Center for Policy and Research (2012). Note: Two (2) states had maximum billed charge-to-Medicare fee ratios under 1,000 percent of Medicare; 17 states between 1,000 and 3,000 percent of Medicare; and 11 states more than 3,000 percent of Medicare. The highest billed charge as a percent of Medicare for CPT code 99233 was 9,465 percent in TX; the lowest was 321 percent in MN.

FIGURE 4.

Comparison of Highest Billed Charge as a Percent of Medicare Fee for Critical Care, First 30–74 Minutes (CPT Code 99291), 2011



Below 1,000% | 1,000% to 3,000% | 3,000% and Above | State Data Not Collected

Source: AHIP Center for Policy and Research (2012). Note: Eight (8) states had maximum billed charge-to-Medicare fee ratios under 1,000 percent of Medicare; 16 states between 1,000 and 3,000 percent of Medicare; and 6 states more than 3,000 percent of Medicare. The highest billed charge as a percent of Medicare for CPT code 99291 was 9,302 percent in NJ; the lowest was 542 percent in MN.

ACKNOWLEDGEMENTS

Kelly Buck, Deputy Director in the AHIP Center for Policy and Research, performed the final data analysis and prepared this report for publication with assistance from Cameron Lloyd, Research Analyst.

Data collection, aggregation and preliminary analysis were conducted by Zach Dyckman and Peggy Hess of Dyckman & Associates, LLC.

For more information please contact Jeff Lemieux, Senior Vice President for AHIP's Center for Policy and Research, at 202.778.3200, or visit www.ahip.org/ahipresearch.

APPENDIX

TABLE 1. Highest Reported Out-of-Network Charges as Percent of Medicare Fee for 24 CPT Codes in the Survey (2011)

CPT Code	CPT Description	Amount Billed	2011 Medicare Fee	Amount Billed as % of Medicare Fee	State
99233	Subsequent Hospital Care	$9,470.90	$100.06	9,465%	TX
88305	Tissue Exam by Pathologist	$12,000.00	$128.70	9,324%	NY
99291	Critical Care, First 30–74 Minutes	$27,309.56	$293.60	9,302%	NJ
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$9,600.00	$104.72	9,167%	NY
15734	Muscle-Skin Graft Trunk	$150,500.00	$1,766.57	8,519%	NY
43239	Upper GI Endoscopy Biopsy	$29,998.00	$409.18	7,331%	NY
26055	Tendon Sheath Incision	$39,450.00	$547.06	7,211%	TX
99285	Emergency Department Visit	$12,000.00	$187.38	6,404%	NY
22612	Lumbar Spine Fusion	$115,625.00	$1,866.71	6,194%	NY
47562	Removal of Gallbladder Using a Laparoscope	$44,000.00	$848.57	5,185%	NY
29881	Knee Arthroscopy/Surgery	$34,366.00	$717.84	4,787%	NJ
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$5,520.00	$117.88	4,683%	TX
63075	Neck Spine Disk Surgery	$73,847.50	$1,615.54	4,571%	NY
99215	Office/Outpatient Visit, Established Patient	$6,205.93	$152.60	4,067%	MA
19120	Removal of Breast Lesion	$18,500.00	$546.18	3,387%	NY
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$24,000.00	$720.05	3,333%	TX
45380	Colonoscopy and Biopsy	$19,000.00	$571.41	3,325%	NY
27130	Total Hip Replacement	$48,983.00	$1,543.70	3,173%	NJ
36471	Injection Therapy of Veins	$6,525.00	$212.23	3,074%	NY
70553	MRI of the Brain, with and without Dye Contrast	$20,540.18	$724.26	2,836%	TX
44140	Partial Removal of Colon	$42,800.00	$1,521.80	2,812%	NY
57288	Repair Bladder Defect	$19,272.00	$777.68	2,478%	CA
17311	Mohs Micrographic Surgery, First Stage	$13,900.00	$730.10	1,904%	IL
33533	Coronary Artery Bypass (CABG), Single Arterial Graft	$31,490.00	$1,820.39	1,730%	WI

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC. Notes: Highest billed charges for selected services received by responding health plans from out-of-network providers in 2011, and Medicare fee applicable for the service in the corresponding locality.

TABLE 2. Various Out-of-Network Physician Claims Submitted in the State of **Alabama** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$2,832.00	$99.91	2,835%
99285	Emergency Department Visit	$2,784.67	$161.79	1,721%
99233	Subsequent Hospital Care	$1,118.00	$95.47	1,171%
99215	Office/Outpatient Visit, Established Patient	$1,441.00	$130.75	1,102%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$7,000.00	$689.78	1,015%
99291	Critical Care, First 30–74 Minutes	$2,432.00	$251.18	968%
29881	Knee Arthroscopy/Surgery	$5,430.00	$589.06	922%
43239	Upper GI Endoscopy Biopsy	$2,732.00	$321.03	851%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$920.00	$113.07	814%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$570.00	$80.85	705%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 3. Various Out-of-Network Physician Claims Submitted in the State of **Arizona** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99233	Subsequent Hospital Care	$4,447.20	$98.73	4,504%
99291	Critical Care, First 30–74 Minutes	$5,700.00	$261.63	2,179%
88305	Tissue Exam by Pathologist	$2,148.00	$104.59	2,054%
15734	Muscle-Skin Graft Trunk	$29,720.00	$1,495.24	1,988%
43239	Upper GI Endoscopy Biopsy	$6,656.02	$339.99	1,958%
99285	Emergency Department Visit	$3,000.00	$167.81	1,788%
36471	Injection Therapy of Veins	$2,900.00	$175.18	1,655%
99215	Office/Outpatient Visit, Established Patient	$2,100.00	$136.15	1,542%
47562	Removal of Gallbladder Using a Laparoscope	$9,000.00	$719.97	1,250%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$7,718.00	$731.92	1,054%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 4. Various Out-of-Network Physician Claims Submitted in the State of **California** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$8,100.00	$128.46	6,305%
47562	Removal of Gallbladder Using a Laparoscope	$30,000.00	$778.16	3,855%
29881	Knee Arthroscopy/Surgery	$23,360.00	$640.24	3,649%
99233	Subsequent Hospital Care	$3,800.00	$107.12	3,547%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$3,000.00	$99.09	3,028%
43239	Upper GI Endoscopy Biopsy	$12,000.00	$396.39	3,027%
99291	Critical Care, First 30–74 Minutes	$8,375.00	$289.06	2,897%
99215	Office/Outpatient Visit, Established Patient	$4,170.00	$152.53	2,734%
26055	Tendon Sheath Incision	$17,000.00	$638.35	2,663%
57288	Repair Bladder Defect	$19,272.00	$777.68	2,478%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 5. Various Out-of-Network Physician Claims Submitted in the State of **Colorado** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$3,096.00	$105.60	2,932%
99285	Emergency Department Visit	$4,302.00	$166.61	2,582%
99233	Subsequent Hospital Care	$2,205.00	$98.47	2,239%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,710.00	$85.64	1,997%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$13,166.00	$727.61	1,809%
99291	Critical Care, First 30–74 Minutes	$4,701.00	$261.19	1,800%
47562	Removal of Gallbladder Using a Laparoscope	$9,916.00	$710.04	1,397%
99215	Office/Outpatient Visit, Established Patient	$1,749.00	$136.25	1,284%
63075	Neck Spine Disk Surgery	$16,300.00	$1,321.10	1,234%
43239	Upper GI Endoscopy Biopsy	$4,184.00	$340.99	1,227%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 6. Various Out-of-Network Physician Claims Submitted in the State of **Connecticut** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$5,000.00	$97.25	5,141%
29881	Knee Arthroscopy/Surgery	$25,434.36	$702.51	3,620%
88305	Tissue Exam by Pathologist	$3,920.00	$120.28	3,259%
22612	Lumbar Spine Fusion	$48,000.00	$1,738.10	2,762%
63075	Neck Spine Disk Surgery	$34,000.00	$1,499.51	2,267%
99285	Emergency Department Visit	$3,500.00	$179.27	1,952%
99233	Subsequent Hospital Care	$2,080.00	$106.70	1,949%
27130	Total Hip Replacement	$30,000.00	$1,571.18	1,909%
99215	Office/Outpatient Visit, Established Patient	$2,550.00	$150.59	1,693%
15734	Muscle-Skin Graft Trunk	$24,000.00	$1,672.90	1,435%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 7. Various Out-of-Network Physician Claims Submitted in the State of **Florida** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$7,298.00	$104.52	6,982%
99285	Emergency Department Visit	$10,289.85	$181.76	5,661%
99233	Subsequent Hospital Care	$4,254.00	$105.21	4,043%
47562	Removal of Gallbladder Using a Laparoscope	$28,303.20	$779.07	3,633%
99291	Critical Care, First 30–74 Minutes	$9,183.00	$294.45	3,119%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$24,000.00	$818.21	2,933%
43239	Upper GI Endoscopy Biopsy	$9,820.00	$348.66	2,816%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$2,400.00	$97.42	2,464%
22612	Lumbar Spine Fusion	$50,000.00	$2,055.75	2,432%
45380	Colonoscopy and Biopsy	$9,970.00	$480.21	2,076%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 8. Various Out-of-Network Physician Claims Submitted in the State of **Georgia** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$4,560.00	$106.56	4,279%
99291	Critical Care, First 30–74 Minutes	$9,000.00	$264.58	3,402%
99233	Subsequent Hospital Care	$3,248.00	$97.48	3,332%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$14,000.00	$716.69	1,953%
43239	Upper GI Endoscopy Biopsy	$6,422.00	$345.62	1,858%
29881	Knee Arthroscopy/Surgery	$10,000.00	$636.57	1,571%
45380	Colonoscopy and Biopsy	$6,544.00	$473.15	1,383%
99285	Emergency Department Visit	$2,258.00	$169.04	1,336%
26055	Tendon Sheath Incision	$7,193.00	$547.75	1,313%
27130	Total Hip Replacement	$16,776.00	$1,431.99	1,172%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 9. Various Out-of-Network Physician Claims Submitted in the State of **Illinois** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$8,500.00	$112.35	7,566%
99285	Emergency Department Visit	$6,697.00	$184.92	3,622%
99233	Subsequent Hospital Care	$3,440.00	$107.26	3,207%
47562	Removal of Gallbladder Using a Laparoscope	$25,127.60	$842.74	2,982%
57288	Repair Bladder Defect	$16,148.50	$802.25	2,013%
17311	Mohs Micrographic Surgery, First Stage	$13,900.00	$730.10	1,904%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$13,837.68	$738.34	1,874%
15734	Muscle-Skin Graft Trunk	$30,764.00	$1,718.16	1,791%
27130	Total Hip Replacement	$26,934.00	$1,641.83	1,640%
19120	Removal of Breast Lesion	$8,000.00	$513.60	1,558%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 10. Various Out-of-Network Physician Claims Submitted in the State of **Indiana** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99233	Subsequent Hospital Care	$3,570.00	$96.75	3,690%
88305	Tissue Exam by Pathologist	$3,288.00	$102.30	3,214%
22612	Lumbar Spine Fusion	$39,136.00	$1,484.74	2,636%
99215	Office/Outpatient Visit, Established Patient	$2,250.00	$133.09	1,691%
27130	Total Hip Replacement	$22,468.00	$1,358.56	1,654%
99285	Emergency Department Visit	$2,564.00	$163.87	1,565%
99291	Critical Care, First 30–74 Minutes	$3,834.00	$255.45	1,501%
29881	Knee Arthroscopy/Surgery	$8,612.00	$604.22	1,425%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,136.00	$82.88	1,371%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,560.00	$114.59	1,361%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 11. Various Out-of-Network Physician Claims Submitted in the State of **Iowa** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$1,015.17	$100.36	1,012%
99233	Subsequent Hospital Care	$758.00	$95.46	794%
99285	Emergency Department Visit	$1,271.00	$161.55	787%
26055	Tendon Sheath Incision	$3,630.00	$508.23	714%
43239	Upper GI Endoscopy Biopsy	$1,862.00	$321.85	579%
99291	Critical Care, First 30–74 Minutes	$1,453.00	$251.31	578%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$586.00	$113.07	518%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$380.00	$81.05	469%
47562	Removal of Gallbladder Using a Laparoscope	$3,027.05	$668.23	453%
17311	Mohs Micrographic Surgery, First Stage	$2,775.00	$623.28	445%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 12. Various Out-of-Network Physician Claims Submitted in the State of **Kentucky** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$5,480.00	$100.37	5,460%
99233	Subsequent Hospital Care	$1,752.00	$96.46	1,816%
15734	Muscle-Skin Graft Trunk	$25,200.00	$1,430.36	1,762%
43239	Upper GI Endoscopy Biopsy	$5,352.00	$325.06	1,646%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,132.00	$81.81	1,384%
99285	Emergency Department Visit	$2,258.00	$164.12	1,376%
99291	Critical Care, First 30–74 Minutes	$3,200.00	$254.09	1,259%
70553	MRI of the Brain, with and without Dye Contrast	$7,492.00	$682.56	1,098%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,058.00	$114.23	926%
47562	Removal of Gallbladder Using a Laparoscope	$5,300.00	$689.47	769%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 13. Various Out-of-Network Physician Claims Submitted in the State of **Louisiana** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$3,000.00	$100.77	2,977%
99233	Subsequent Hospital Care	$2,788.00	$99.77	2,794%
99285	Emergency Department Visit	$4,000.00	$165.41	2,418%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,440.00	$82.43	1,747%
99291	Critical Care, First 30–74 Minutes	$4,149.00	$255.82	1,622%
27130	Total Hip Replacement	$17,504.00	$1,440.47	1,215%
99215	Office/Outpatient Visit, Established Patient	$1,505.00	$132.82	1,133%
29881	Knee Arthroscopy/Surgery	$6,470.00	$610.52	1,060%
47562	Removal of Gallbladder Using a Laparoscope	$6,747.76	$700.16	964%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,040.00	$114.91	905%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 14. Various Out-of-Network Physician Claims Submitted in the State of **Maryland** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$5,208.00	$113.30	4,597%
99215	Office/Outpatient Visit, Established Patient	$3,172.00	$154.76	2,050%
99233	Subsequent Hospital Care	$1,920.00	$99.76	1,925%
99285	Emergency Department Visit	$2,542.00	$175.67	1,447%
43239	Upper GI Endoscopy Biopsy	$3,652.00	$347.43	1,051%
99291	Critical Care, First 30–74 Minutes	$3,040.00	$294.39	1,033%
22612	Lumbar Spine Fusion	$17,103.15	$1,689.09	1,013%
36471	Injection Therapy of Veins	$1,800.00	$190.05	947%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$6,930.00	$743.45	932%
63075	Neck Spine Disk Surgery	$12,676.00	$1,366.97	927%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 15. Various Out-of-Network Physician Claims Submitted in the State of **Massachusetts** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99215	Office/Outpatient Visit, Established Patient	$6,205.93	$152.60	4,067%
88305	Tissue Exam by Pathologist	$4,248.00	$114.09	3,723%
99233	Subsequent Hospital Care	$2,535.00	$106.61	2,378%
99291	Critical Care, First 30–74 Minutes	$6,150.00	$288.73	2,130%
47562	Removal of Gallbladder Using a Laparoscope	$16,000.00	$779.98	2,051%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$2,399.84	$126.36	1,899%
29881	Knee Arthroscopy/Surgery	$12,018.00	$700.72	1,715%
19120	Removal of Breast Lesion	$8,090.00	$516.78	1,565%
99285	Emergency Department Visit	$2,247.50	$171.20	1,313%
63075	Neck Spine Disk Surgery	$14,641.00	$1,460.18	1,003%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 16. Various Out-of-Network Physician Claims Submitted in the State of **Michigan** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$3,634.00	$116.94	3,108%
88305	Tissue Exam by Pathologist	$2,590.00	$102.86	2,518%
99233	Subsequent Hospital Care	$2,400.00	$105.72	2,270%
43239	Upper GI Endoscopy Biopsy	$6,000.00	$336.93	1,781%
70553	MRI of the Brain, with and without Dye Contrast	$12,230.00	$702.46	1,741%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$11,658.00	$733.43	1,590%
99285	Emergency Department Visit	$2,476.00	$168.77	1,467%
36471	Injection Therapy of Veins	$2,240.00	$174.45	1,284%
15734	Muscle-Skin Graft Trunk	$14,800.00	$1,439.21	1,028%
22612	Lumbar Spine Fusion	$17,000.00	$1,813.15	938%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 17. Various Out-of-Network Physician Claims Submitted in the State of **Minnesota** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,543.00	$114.19	1,351%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$9,142.50	$699.04	1,308%
88305	Tissue Exam by Pathologist	$804.00	$105.03	765%
33533	Coronary Artery Bypass (CABG), Single Arterial Graft	$13,520.00	$1,777.00	761%
70553	MRI of the Brain, with and without Dye Contrast	$5,335.42	$720.16	741%
99285	Emergency Department Visit	$1,183.00	$161.50	733%
26055	Tendon Sheath Incision	$3,710.00	$530.11	700%
27130	Total Hip Replacement	$9,306.00	$1,329.36	700%
43239	Upper GI Endoscopy Biopsy	$2,091.00	$333.27	627%
57288	Repair Bladder Defect	$3,969.00	$679.24	584%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 18. Various Out-of-Network Physician Claims Submitted in the State of **Missouri** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$6,000.00	$103.49	5,798%
36471	Injection Therapy of Veins	$3,500.00	$175.21	1,998%
57288	Repair Bladder Defect	$14,000.00	$715.95	1,955%
99233	Subsequent Hospital Care	$1,888.00	$98.93	1,908%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$12,834.50	$735.45	1,745%
22612	Lumbar Spine Fusion	$27,122.83	$1,588.73	1,707%
43239	Upper GI Endoscopy Biopsy	$4,817.62	$341.81	1,409%
99285	Emergency Department Visit	$2,258.00	$166.64	1,355%
45380	Colonoscopy and Biopsy	$6,042.00	$469.50	1,287%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$3,236.00	$261.88	1,236%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 19. Various Out-of-Network Physician Claims Submitted in the State of **New Jersey** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99291	Critical Care, First 30–74 Minutes	$27,309.56	$293.60	9,302%
99233	Subsequent Hospital Care	$9,800.00	$109.00	8,991%
29881	Knee Arthroscopy/Surgery	$34,366.00	$717.84	4,787%
22612	Lumbar Spine Fusion	$83,543.22	$1,770.94	4,717%
88305	Tissue Exam by Pathologist	$4,913.76	$116.83	4,206%
63075	Neck Spine Disk Surgery	$64,000.00	$1,526.64	4,192%
47562	Removal of Gallbladder Using a Laparoscope	$32,000.00	$809.40	3,954%
15734	Muscle-Skin Graft Trunk	$60,000.00	$1,639.03	3,661%
99285	Emergency Department Visit	$6,000.00	$182.73	3,284%
27130	Total Hip Replacement	$48,983.00	$1,543.70	3,173%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 20. Various Out-of-Network Physician Claims Submitted in the State of **New York** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$12,000.00	$128.70	9,324%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$9,600.00	$104.72	9,167%
99233	Subsequent Hospital Care	$10,000.00	$111.97	8,931%
15734	Muscle-Skin Graft Trunk	$150,500.00	$1,766.57	8,519%
43239	Upper GI Endoscopy Biopsy	$29,998.00	$409.18	7,331%
99285	Emergency Department Visit	$12,000.00	$187.38	6,404%
99291	Critical Care, First 30–74 Minutes	$19,200.00	$303.62	6,324%
22612	Lumbar Spine Fusion	$115,625.00	$1,866.71	6,194%
47562	Removal of Gallbladder Using a Laparoscope	$44,000.00	$848.57	5,185%
63075	Neck Spine Disk Surgery	$73,847.50	$1,615.54	4,571%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 21. Various Out-of-Network Physician Claims Submitted in the State of **North Carolina** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$4,824.00	$102.58	4,703%
99233	Subsequent Hospital Care	$1,690.50	$97.08	1,741%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,924.00	$114.98	1,673%
99215	Office/Outpatient Visit, Established Patient	$2,150.01	$133.56	1,610%
47562	Removal of Gallbladder Using a Laparoscope	$10,500.00	$693.29	1,515%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$10,416.00	$710.39	1,466%
99285	Emergency Department Visit	$2,258.00	$164.58	1,372%
26055	Tendon Sheath Incision	$6,428.00	$523.41	1,228%
22612	Lumbar Spine Fusion	$18,102.00	$1,499.40	1,207%
27130	Total Hip Replacement	$15,994.00	$1,369.12	1,168%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 22. Various Out-of-Network Physician Claims Submitted in the State of **Ohio** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$4,945.00	$103.05	4,799%
99291	Critical Care, First 30–74 Minutes	$10,511.22	$263.10	3,995%
99233	Subsequent Hospital Care	$3,500.00	$99.42	3,520%
29881	Knee Arthroscopy/Surgery	$16,644.00	$641.58	2,594%
15734	Muscle-Skin Graft Trunk	$37,814.00	$1,522.62	2,483%
99215	Office/Outpatient Visit, Established Patient	$3,280.00	$136.31	2,406%
99285	Emergency Department Visit	$3,500.00	$170.38	2,054%
70553	MRI of the Brain, with and without Dye Contrast	$13,870.00	$703.89	1,970%
43239	Upper GI Endoscopy Biopsy	$5,964.00	$339.38	1,757%
26055	Tendon Sheath Incision	$9,266.00	$534.60	1,733%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 23. Various Out-of-Network Physician Claims Submitted in the State of **Oklahoma** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$3,509.77	$113.93	3,081%
88305	Tissue Exam by Pathologist	$2,817.00	$99.95	2,818%
99233	Subsequent Hospital Care	$1,440.00	$96.20	1,497%
99285	Emergency Department Visit	$2,224.00	$163.67	1,359%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$9,372.00	$699.93	1,339%
70553	MRI of the Brain, with and without Dye Contrast	$7,500.00	$679.20	1,104%
99291	Critical Care, First 30–74 Minutes	$2,524.00	$253.24	997%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$800.00	$81.43	982%
15734	Muscle-Skin Graft Trunk	$11,557.00	$1,422.75	812%
99215	Office/Outpatient Visit, Established Patient	$884.00	$131.57	672%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 24. Various Out-of-Network Physician Claims Submitted in the State of **Oregon** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$2,616.00	$103.14	2,536%
99233	Subsequent Hospital Care	$1,896.30	$96.80	1,959%
29881	Knee Arthroscopy/Surgery	$11,260.00	$618.44	1,821%
99291	Critical Care, First 30–74 Minutes	$4,504.00	$261.10	1,725%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$11,652.00	$723.04	1,612%
99285	Emergency Department Visit	$2,040.00	$163.58	1,247%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$760.00	$83.29	912%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$965.00	$114.66	842%
70553	MRI of the Brain, with and without Dye Contrast	$5,514.56	$704.88	782%
22612	Lumbar Spine Fusion	$10,630.00	$1,478.24	719%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 25. Various Out-of-Network Physician Claims Submitted in the State of **Pennsylvania** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$4,800.00	$102.72	4,673%
99285	Emergency Department Visit	$6,000.00	$168.98	3,551%
99233	Subsequent Hospital Care	$3,150.00	$105.41	2,988%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,800.00	$93.86	1,918%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$2,144.00	$116.99	1,833%
99291	Critical Care, First 30–74 Minutes	$4,668.00	$261.31	1,786%
43239	Upper GI Endoscopy Biopsy	$5,760.00	$375.10	1,536%
99215	Office/Outpatient Visit, Established Patient	$1,900.00	$135.52	1,402%
45380	Colonoscopy and Biopsy	$6,477.00	$462.66	1,400%
57288	Repair Bladder Defect	$9,908.00	$715.41	1,385%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 26. Various Out-of-Network Physician Claims Submitted in the State of **South Carolina** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99233	Subsequent Hospital Care	$2,877.00	$96.12	2,993%
88305	Tissue Exam by Pathologist	$2,100.00	$101.82	2,062%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$12,238.00	$697.56	1,754%
29881	Knee Arthroscopy/Surgery	$10,233.72	$595.80	1,718%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,200.00	$82.19	1,460%
63075	Neck Spine Disk Surgery	$15,758.70	$1,242.12	1,269%
99285	Emergency Department Visit	$2,056.00	$162.49	1,265%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,188.00	$113.85	1,043%
47562	Removal of Gallbladder Using a Laparoscope	$6,681.00	$675.98	988%
99291	Critical Care, First 30–74 Minutes	$2,334.00	$253.56	920%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 27. Various Out-of-Network Physician Claims Submitted in the State of **Tennessee** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$3,380.40	$101.32	3,336%
99233	Subsequent Hospital Care	$1,902.18	$96.27	1,976%
99285	Emergency Department Visit	$2,418.00	$163.13	1,482%
99291	Critical Care, First 30–74 Minutes	$3,592.00	$253.83	1,415%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,212.00	$114.02	1,063%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$7,344.00	$699.96	1,049%
43239	Upper GI Endoscopy Biopsy	$3,252.00	$326.17	997%
99215	Office/Outpatient Visit, Established Patient	$1,250.00	$132.18	946%
45380	Colonoscopy and Biopsy	$3,426.50	$446.59	767%
29881	Knee Arthroscopy/Surgery	$4,452.00	$598.65	744%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 28. Various Out-of-Network Physician Claims Submitted in the State of **Texas** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
99233	Subsequent Hospital Care	$9,470.90	$100.06	9,465%
88305	Tissue Exam by Pathologist	$8,040.00	$106.29	7,564%
26055	Tendon Sheath Incision	$39,450.00	$547.06	7,211%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$4,740.00	$86.84	5,458%
99291	Critical Care, First 30–74 Minutes	$13,654.78	$265.45	5,144%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$5,520.00	$117.88	4,683%
29881	Knee Arthroscopy/Surgery	$25,459.00	$619.45	4,110%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$24,000.00	$720.05	3,333%
43239	Upper GI Endoscopy Biopsy	$9,642.00	$330.98	2,913%
70553	MRI of the Brain, with and without Dye Contrast	$20,540.18	$724.26	2,836%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 29. Various Out-of-Network Physician Claims Submitted in the State of **Virginia** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$3,825.00	$104.04	3,676%
99233	Subsequent Hospital Care	$3,015.00	$97.69	3,086%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$13,504.00	$717.88	1,881%
45380	Colonoscopy and Biopsy	$8,464.00	$459.35	1,843%
22612	Lumbar Spine Fusion	$31,600.00	$1,776.38	1,779%
43239	Upper GI Endoscopy Biopsy	$5,356.80	$335.67	1,596%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,168.00	$100.44	1,163%
99285	Emergency Department Visit	$1,782.00	$165.41	1,077%
47562	Removal of Gallbladder Using a Laparoscope	$8,000.00	$811.51	986%
15734	Muscle-Skin Graft Trunk	$13,982.40	$1,461.74	957%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 30. Various Out-of-Network Physician Claims Submitted in the State of **Washington** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$3,060.00	$105.13	2,911%
99285	Emergency Department Visit	$4,000.00	$166.59	2,401%
99215	Office/Outpatient Visit, Established Patient	$2,450.00	$144.01	1,701%
99233	Subsequent Hospital Care	$1,410.00	$102.73	1,373%
43239	Upper GI Endoscopy Biopsy	$4,200.00	$339.82	1,236%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,084.00	$91.95	1,179%
66984	Cataract Surgery with Intraocular Lens (1 Stage)	$8,716.00	$769.71	1,132%
99291	Critical Care, First 30–74 Minutes	$2,916.00	$260.78	1,118%
45380	Colonoscopy and Biopsy	$4,800.00	$465.02	1,032%
70553	MRI of the Brain, with and without Dye Contrast	$7,133.00	$720.82	990%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 31. Various Out-of-Network Physician Claims Submitted in the State of **Wisconsin** in 2011

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
88305	Tissue Exam by Pathologist	$2,833.00	$102.94	2,752%
22612	Lumbar Spine Fusion	$32,862.00	$1,463.10	2,246%
27130	Total Hip Replacement	$28,936.00	$1,345.04	2,151%
99233	Subsequent Hospital Care	$1,786.74	$96.48	1,852%
33533	Coronary Artery Bypass (CABG), Single Arterial Graft	$31,490.00	$1,820.39	1,730%
70553	MRI of the Brain, with and without Dye Contrast	$11,986.00	$703.26	1,704%
19120	Removal of Breast Lesion	$7,288.00	$438.63	1,662%
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	$1,823.02	$114.29	1,595%
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	$1,226.00	$82.95	1,478%
29881	Knee Arthroscopy/Surgery	$8,820.00	$599.45	1,471%

Source: AHIP Center for Policy and Research (2012). Data collected and prepared by Dyckman & Associates, LLC.

TABLE 32. Short and Detailed Descriptions for CPT Codes Included in the Survey

CPT Code	CPT Code Short Description	CPT Code Long Description
11042	Debridement of Subcutaneous Tissue 20 sq cm/<	Excision - Debridement skin and subcutaneous tissue 20 sq cm/<
15734	Muscle-Skin Graft Trunk	Muscle-skin graft trunk
17311	Mohs Micrographic Surgery, First Stage	Mohs micrographic surgery, first stage
19120	Removal of Breast Lesion	Excision of benign breast legion (e.g., cyst or fibroadenoma)
22612	Lumbar Spine Fusion	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)
26055	Tendon Sheath Incision	Tendon sheath incision
27130	Total Hip Replacement	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
29881	Knee Arthroscopy/Surgery	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)
33533	Coronary Artery Bypass (CABG), Single Arterial Graft	Coronary artery bypass, using arterial graft(s); single arterial graft
36471	Injection Therapy of Veins	Injection of sclerosing solution; multiple veins, same leg
43239	Upper GI Endoscopy Biopsy	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple
44140	Partial Removal of Colon	Colectomy, partial; with anastomosis
45380	Colonoscopy and Biopsy	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
47562	Removal of Gallbladder Using a Laparoscope	Removal of gallbladder using a laparoscope
57288	Repair Bladder Defect	Repair bladder defect
63075	Neck Spine Disk Surgery	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
66984	Cataract Surgery with Intraocular Lens (1 Stage)	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
70553 (global)	MRI of the Brain, with and without Dye Contrast	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
70553-26	MRI of the Brain, with and without Dye Contrast (Physician Fee)	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
88305 (global)	Tissue Exam by Pathologist	Surgical pathology, level 4, gross and microscopic examination
99215	Office/Outpatient Visit, Established Patient	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: comprehensive history; comprehensive examination; medical decision making of high complexity
99233	Subsequent Hospital Care	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of high complexity
99291	Critical Care, First 30–74 Minutes	Critical care, evaluation and management, first 30–74 minutes

Sources: Short CPT code descriptions retrieved from U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.). *Physician Fee Schedule Search* (2012B). Retrieved from *http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx*; Long CPT code descriptions retrieved from Abraham, M., Ahlman J.T., Boudreu A.J., Connelly J., Levreau-Davis, L., Evans D.D., et. al. (2012) *Current Procedural Terminology*, Professional Edition. American Medical Association.