Medicare Claims Data: Advanced Imaging-Diagnosis Code Crosstab

Background

In the CY 2016 Physician Fee Schedule Final Rule, CMS included a discussion of priority clinical areas (PCAs). Section 414.94(b) defines priority clinical areas as clinical conditions, diseases or symptom complexes and associated advanced diagnostic imaging services identified by CMS through annual rulemaking and in consultation with stakeholders which may be used in the determination of outlier ordering professionals.

The dataset provided is intended to provide stakeholders with information regarding the volume of advanced imaging services rendered to Medicare beneficiaries and their associated diagnoses. Stakeholders may then be able to use this information to provide informed comments to CMS regarding priority clinical areas.

Methodology

The primary data source for this analysis is CMS's Chronic Conditions Data Warehouse (CCW). The CCW contains 100 percent of Medicare claims for beneficiaries who are enrolled in the fee-for-service (FFS) program.

Data was derived from the CCW's 2014 Part B non-institutional claim line file, which includes services covered by the Part B benefit that were furnished during calendar year 2014. This is the main file containing final action claims data for non-institutional providers, including physicians, physician assistants, clinical social workers, nurse practitioners, independent clinical laboratories, and freestanding ambulatory surgical centers.

The Part B non-institutional claim line file contains the individual line level information from the claim and includes Healthcare Common Procedure Coding System (HCPCS) code(s), diagnosis code(s), service dates, and line Medicare payment amount. The analysis focused on non-institutional claims data for a group of advanced imaging HCPCS codes provided by CCSQ and excluded claims reporting the place of service as inpatient hospital.

A given imaging service can appear in multiple lines within the claim line file. In order to avoid counting a single service more than once, claim lines with the same beneficiary identifier, HCPCS code, and service date were combined into a single record. In these cases, the Medicare payment amount for each line were summed to produce a total payment amount for all the claim lines for that service.

The analysis provides a cross-tabulation of diagnosis codes and a selected group of HCPCS codes. A non-institutional claim can have up to 25 diagnosis codes. This analysis used the Line Diagnosis Code variable, which is the diagnosis code that supports the procedure on the claim. The top 300 most frequently reported diagnosis codes are shown.

For each HCPCS code, the Service variable indicates the total count of unduplicated services furnished by non-institutional providers that had the indicated line diagnosis code. There are 150 HCPCS codes displayed in the table, representing services with total volume greater than 3000. The corresponding Payment variable indicates the total Medicare payments made to non-institutional providers for those services. Cells containing service counts of less than 11 have been suppressed. Columns representing total services and total Medicare payments do not include suppressed values.