Chapter 8: Medicare Supplementary Medical Insurance Benefit for Hospital Outpatient Services

by John T. Petrie

Introduction

The Medicare supplementary medical insurance (SMI) program helps pay for covered hospital outpatient services for the diagnosis or treatment of an illness or injury. Major hospital outpatient services covered by SMI include services in an emergency room or outpatient clinic, including ambulatory surgical procedures, laboratory tests billed by the hospital, mental health care in a hospital outpatient program, X-rays and other radiology services billed by the hospital, medical supplies, drugs and biologicals that cannot be self-administered, and blood transfusions.

Some hospital outpatient services not covered under SMI include routine physical examinations and tests directly related to such examinations (except some pap smears and mammograms), eye or ear examinations to prescribe or fit eyeglasses or hearing aids, immunizations (except pneumococcal pneumonia and hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection), and most routine foot care.

Since the mid-1980s, there have been large increases in Medicare beneficiaries' use of hospital outpatient services relative to other Medicare benefits and a substantial shift in the site of care from the inpatient to the outpatient setting. One major reason for this shift was the implementation of the Medicare prospective payment system (PPS) in fiscal year (FY) 1984. PPS encouraged hospitals to re-examine traditional modes of delivering patient care by providing the incentive to use alternative sites when they were more appropriate and less costly than inpatient care. Hospitals began to expand and substitute outpatient services in an effort to attract more patients to services that were still paid by Medicare under a reasonable cost-based methodology. The increasing use of outpatient surgery is a prime example.

Utilization review policies have also influenced the Medicare patient case mix in hospitals. For example, the pre-admission reviews performed by peer review organizations encourage hospitals to treat patients in the most cost-effective setting consistent with the patient's safety. Public and private insurers have also encouraged the use of outpatient care as a means of containing the growth of health expenditures. Many insurance companies pay 100 percent of the charge for procedures that are performed on an outpatient basis but only 80 percent of those requiring an inpatient stay.

Legislative changes affecting outpatient care

In an effort to control the rapid growth in hospital outpatient payments, Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509), which revised the Medicare "reasonable cost" payment methodology for ambulatory surgery performed in hospital outpatient facilities. Beginning October 1, 1987, OBRA 1986 revised the payment methodology for certain hospital outpatient surgical procedures that are now being paid to ambulatory surgical centers (ASCs) based on a prospective rate. OBRA 1986 mandated that hospital outpatient facility payments for ASC procedures be paid based on a blended rate composed of a hospital's reasonable costs and the ASC prospective rate. Facility payments to hospitals for non-ASC-approved surgical procedures continued to be paid on the traditional reasonable cost basis.

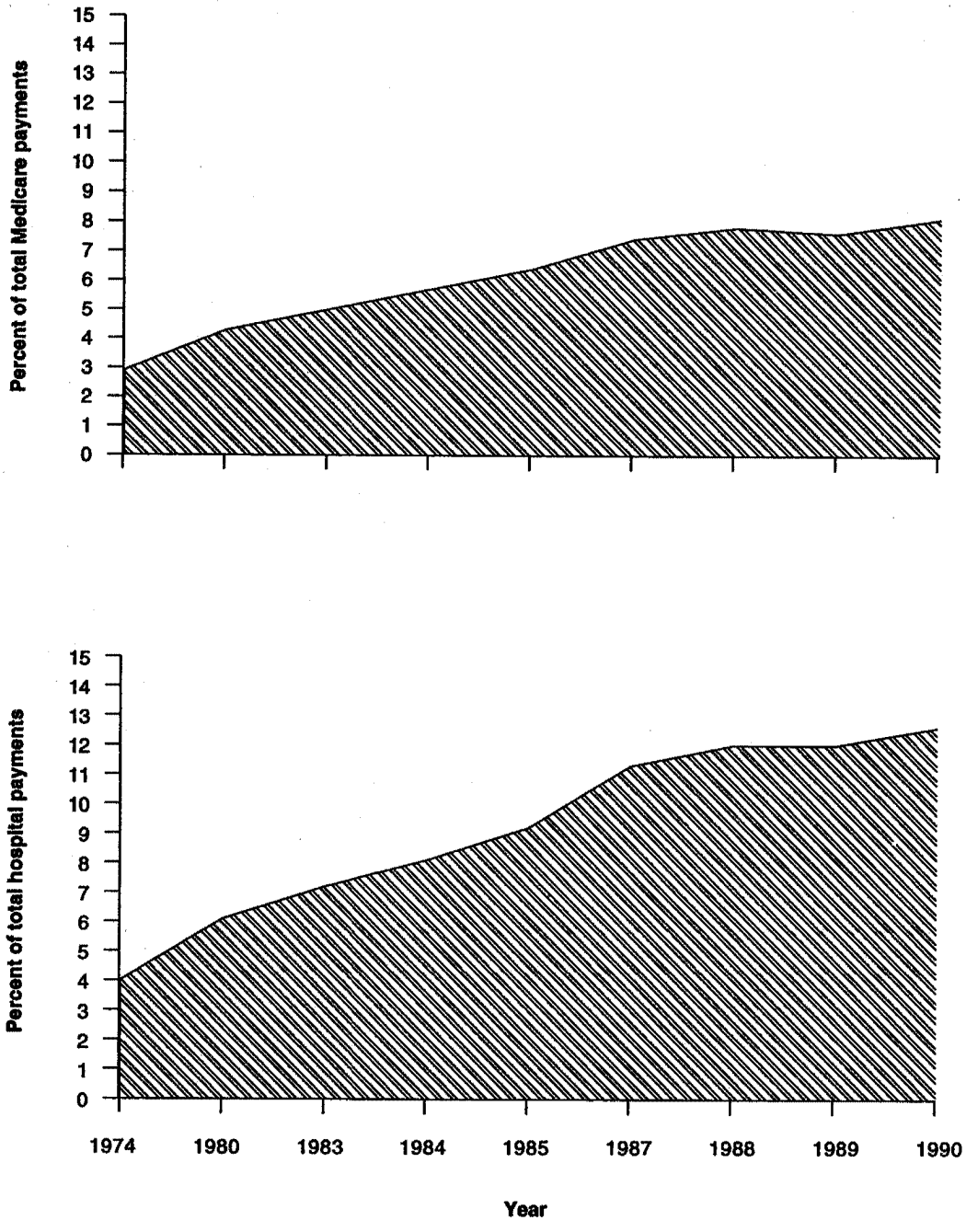
OBRA 1986 also directed the Secretary of the U.S. Department of Health and Human Services (DHHS) to develop recommendations on the feasibility of implementing by April 1989 a full PPS for all Medicare ambulatory surgery performed in hospital outpatient departments, and by January 1991 a full PPS for all other types of hospital outpatient care. To support the development of the new system, hospitals were required to use the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) to report claims for surgery and other designated outpatient services. HCPCS is based on codes found in the American Medical Association's Physicians *Current Procedural Terminology, 4th Edition* (CPT-4) and supplemented by additional HCFA codes that account for physician and non-physician services not included in CPT-4. The HCPCS is intended to standardize the reporting of outpatient services by hospitals, and enable comparisons of services among hospitals and other ambulatory settings.

OBRA 1990 (Public Law 101-508) mandated that the DHHS Secretary develop a proposal by September 1, 1991, to replace the current Medicare payment methods for hospital outpatient services with a PPS for the non-physician components of hospital outpatient services, for example, all surgery, emergency services, and medical visits.

DHHS is continuing to examine prospective payment options for all hospital outpatient services. Congress has enacted a number of new payment methods for specific hospital outpatient services, such as surgery, radiology, other diagnostic procedures, clinical laboratory tests, prosthetics, orthotics, and durable medical equipment (DME). For example, aggregate

Figure 8.1

Medicare hospital outpatient payments as a percent of total Medicare payments and total Medicare hospital payments: Selected calendar years 1974-90



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

payment to hospitals for outpatient services related to procedures approved for ASC facility payment was based on the lowest amount of the hospital's reasonable costs, its customary charges, or a blend of 42 percent of the lowest of the hospital's costs or charges and 58 percent of the prospectively determined ASC payment rates for the same surgical procedures.

Similarly, aggregate payment to a hospital for outpatient radiology services is based on the lowest of the hospital's reasonable costs and customary charges, or a blend of 42 percent of the lowest of the hospital's reasonable costs or customary charges and 58 percent based on the amount that would be paid for the technical (i.e., non-physician) component of the service if it were furnished in a physician's office. Other selected outpatient diagnostic procedures furnished by hospitals are paid under a method similar to that required for outpatient radiology. Clinical laboratory tests, DME, orthotics, and prosthetics are paid based on fee schedules, and outpatient dialysis services are paid under a composite rate. Physical therapy, clinic visits, non-ASC-approved surgical procedures, and certain other services are still paid on a reasonable cost basis.

Because of the different payment methods, the Medicare payment system for hospital outpatient services has become very complex. However, the overall system retains much of its cost-based structure that offers weak incentives for hospitals to become efficient and reduce costs. The spiraling costs of outpatient care and a payment system that lacks the incentive for efficiency found in the inpatient PPS have led policymakers to search for ways to pay for hospital outpatient care under PPS. President Bush's budget for 1992 contained a provision to base Medicare payments for outpatient services such as surgery and radiology on prospectively determined rates, and provisions to change the computation of beneficiary coinsurance for outpatient services and to re-establish a 20-percent coinsurance on laboratory tests. Since this budget was presented, DHHS has continued research in the development of an outpatient PPS.

Hospital outpatient services use: 1990

During 1990, an estimated 15.3 million Medicare beneficiaries used hospital outpatient services. Medicare paid $8.17 billion in hospital outpatient payments, an average of $557 per person served and $250 per enrollee. These hospital outpatient payments comprised an estimated 8.1 percent of total Medicare payments and 12.6 percent of total Medicare hospital payments (Figure 8.1).

The data show that aged Medicare beneficiaries (excluding end stage renal disease [ESRD] patients) accounted for 90 percent (13.8 million) of all persons receiving hospital outpatient services, but 72 percent ($5.9 billion) of all Medicare payments for hospital outpatient services. Beneficiaries with ESRD comprised only 1.0 percent of all persons receiving hospital outpatient services but accounted for nearly 20 percent ($1.6 billion) of all Medicare payments for hospital outpatient services; much of this disparity represents the use of expensive renal dialysis services.

Outpatient versus total program payments

The data shown in Table 8.2, for selected years 1974-90, compare the amount of Medicare payments for total Medicare services, total hospital services, and hospital outpatient services. To illustrate the growth of hospital outpatient payments during the period 1974-90, they are presented as a percent of total Medicare payments and total Medicare hospital payments.

Table 8.2

Trends in the amounts and relative index of total Medicare program payments, total hospital payments, and hospital outpatient payments, by selected calendar years: 1974-90

	Amount of program payments in millions and relative index						Hospital outpatient payments as a percent of:	
	Total Medicare services		Total hospital services		Hospital outpatient services			
Year	Amount	Index	Amount	Index	Amount	Index	Total Medicare payments	Total hospital payments
1974	$11,179	100	$8,160	100	$323	100	2.9	4.0
1980	33,613	301	23,541	288	1,442	446	4.3	6.1
1983	53,438	478	36,999	453	2,661	824	5.0	7.2
1984	59,146	529	41,887	513	3,387	1049	5.7	8.1
1985	63,694	570	44,282	543	4,082	1264	6.4	9.2
1987	75,816	678	49,668	609	5,600	1734	7.4	11.3
1988	81,403	728	53,251	653	6,372	1973	7.8	12.0
1989	93,844	839	59,783	733	7,161	2217	7.6	12.0
1990	101,419	907	64,888	795	8,172	2530	8.1	12.6
				Average annual rate of change				
1974-90	14.8	—	13.8	—	22.4	—	—	—
1974-83	19.0	—	18.3	—	26.4	—	—	—
1984-90	9.4	—	7.6	—	15.8	—	—	—

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Payments for all Medicare-covered services increased from $11.2 billion in 1974 to $53.4 billion in 1983, an average annual rate of growth of 19 percent. Following the implementation of PPS, payments increased from $59.1 billion in 1984 to $101.4 billion in 1990, an average annual rate of growth of only 9.4 percent.

From 1974 to 1983, payments for hospital outpatient services increased from $323 million to $2.7 billion, an average annual rate of growth of 26.4 percent. By 1990, hospital outpatient payments had reached $8.2 billion. Although the annual average rate of growth in hospital outpatient payments increased at a slower rate (15.8 percent) during the post-PPS years, the rate of increase was considerably higher than that for all Medicare services (9.4 percent) during the same period.

As shown in Figure 8.3, the growth in hospital outpatient payments jumped from an index of 100 in 1974 to 2,530 in 1990, or by a factor of more than 25 during the 16-year period. In contrast, the index for total hospital payments (795) increased by a factor of only 8.

Growth in enrollment: 1984-90

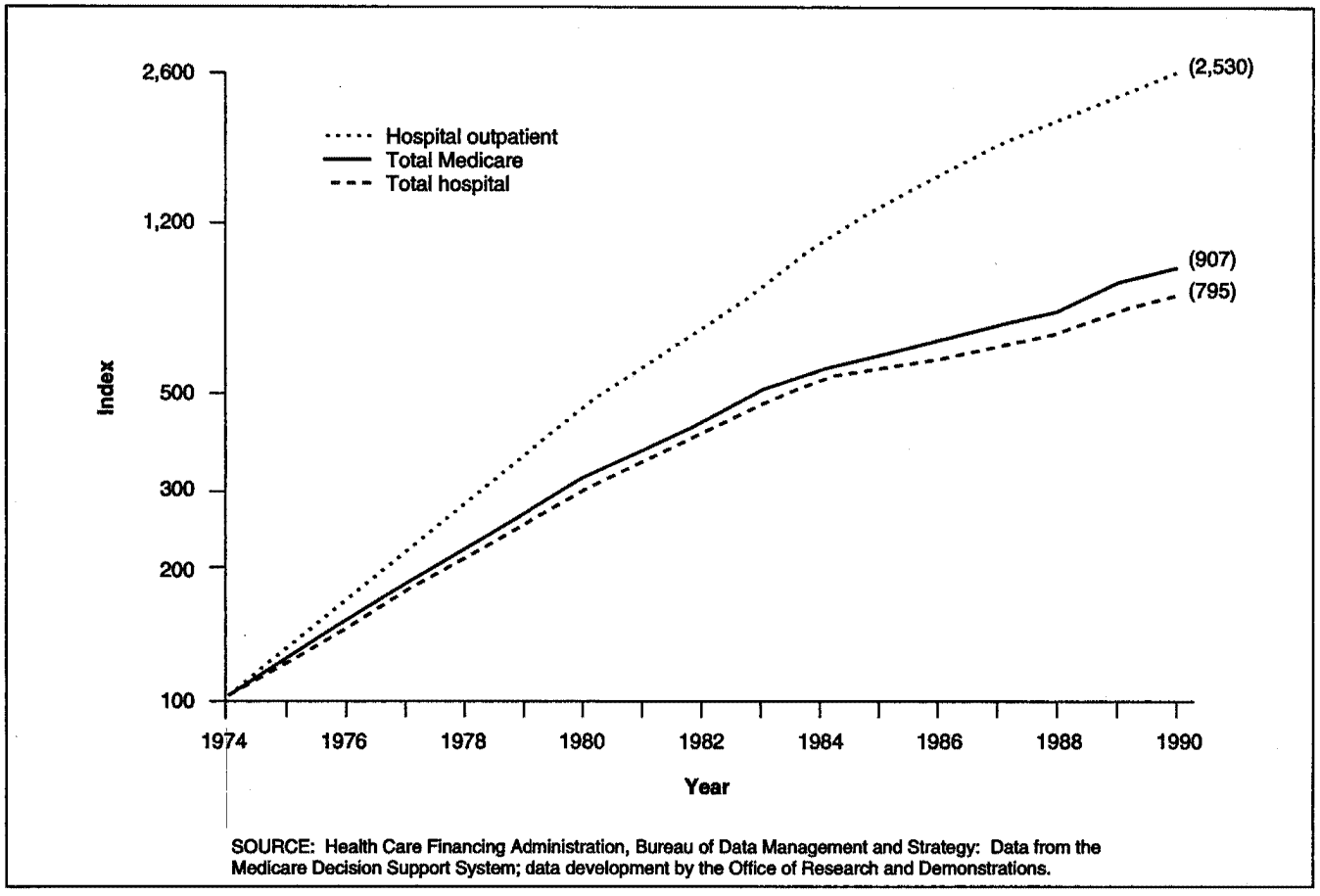
The total number of SMI enrollees increased from 29.4 million in 1984 to 32.6 million in 1990, an average annual rate of change of 1.7 percent (Table 8.4). The average hospital outpatient payment per enrollee jumped from $115 per enrollee in 1984 to $250 in 1990, more than a twofold increase.

In 1990, the average hospital outpatient payment per enrollee was $221 for the aged compared with $546 for the disabled. This largely reflects the higher proportion of disabled ESRD enrollees who use hospital outpatient renal dialysis services.

Distribution of hospital outpatient charges

Figure 8.5 shows the percent distribution of hospital outpatient charges under Medicare by type of service for 1985 and 1990. In 1985, nearly one-half of all Medicare hospital outpatient charges were for three

Figure 8.3
Relative growth in total Medicare payments, total hospital payments, and hospital outpatient payments: Selected calendar years 1974-90 (Semi-logarithmic scale, 1974=100)



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8.4

Supplementary medical insurance (SMI) enrollees, hospital outpatient charges, program payments, and average annual rate of change, by type of enrollee and year: Selected calendar years 1974-90

Type of enrollee and year	Number of SMI enrollees	Covered charges in thousands	Program payments		
			Amount in thousands	Per enrollee	As percent of charges
All SMI					
1974[1]	23,166,564	$535,296	$323,383	$14	60.4
1976	24,614,378	974,708	630,323	26	64.7
1978	26,074,055	1,384,067	923,658	35	66.7
1980	27,399,658	2,076,396	1,441,986	52	69.4
1982	28,412,282	3,164,530	2,203,260	78	69.6
1983	28,974,535	3,813,118	2,661,394	92	69.8
1984	29,415,397	5,129,210	3,387,146	115	66.0
1985	29,988,763	6,480,777	4,082,303	136	63.0
1986	30,589,728	8,115,976	4,881,605	160	60.1
1987	31,169,960	9,794,832	5,690,786	183	58.1
1988	31,617,082	11,833,919	6,371,704	202	53.8
1989	32,098,770	14,195,252	7,160,586	223	50.4
1990	32,635,800	18,346,471	8,171,088	250	44.5
Aged					
1974[1]	21,421,545	394,680	220,742	10	55.9
1976	22,445,911	704,569	432,971	19	61.5
1978	23,530,893	1,005,467	648,249	28	64.5
1980	24,680,432	1,517,183	1,030,896	42	69.9
1982	25,706,792	2,402,462	1,645,064	64	68.5
1983	26,292,124	2,995,784	2,066,207	79	69.0
1984	26,764,150	4,122,859	2,679,571	100	65.0
1985	27,310,894	5,210,762	3,211,744	118	61.6
1986	27,862,737	6,529,273	3,809,992	137	58.4
1987	28,382,203	8,021,167	4,522,841	159	56.4
1988	28,780,154	9,790,273	5,098,546	177	52.1
1989	29,216,027	11,855,127	5,767,589	197	48.7
1990	29,691,180	15,384,510	6,563,454	221	42.7
Disabled					
1974[1]	1,745,019	140,617	102,641	57	73.0
1976	2,168,467	270,139	197,352	91	73.1
1978	2,543,162	378,600	275,409	108	72.7
1980	2,719,226	559,213	411,090	152	73.5
1982	2,705,490	762,068	558,195	206	73.2
1983	2,682,411	817,335	595,187	222	72.8
1984	2,651,247	1,006,351	707,575	267	70.3
1985	2,677,869	1,270,015	870,560	325	68.5
1986	2,726,991	1,586,703	1,071,613	393	67.5
1987	2,787,757	1,773,664	1,167,945	417	65.8
1988	2,836,928	2,043,646	1,273,158	449	62.3
1989	2,882,743	2,340,124	1,392,897	483	59.5
1990	2,944,620	2,961,961	1,607,634	546	54.0
		Average annual rate of change			
All SMI					
1974-90	2.2	24.7	22.4	19.8	—
1974-83	2.5	24.4	26.4	23.3	—
1984-90	1.7	23.7	15.8	13.8	—
Aged					
1974-90	2.1	25.7	23.6	21.1	—
1974-83	2.3	25.3	28.2	25.4	—
1984-90	1.7	24.5	16.1	14.1	—
Disabled					
1974-90	3.3	21.0	18.8	15.2	—
1974-83	4.9	21.6	21.6	16.3	—
1984-90	1.8	19.7	14.7	12.7	—

[1] 1974 is the first full year of coverage for disabled beneficiaries under Medicare.

NOTE: Numbers may not add to totals because of rounding.

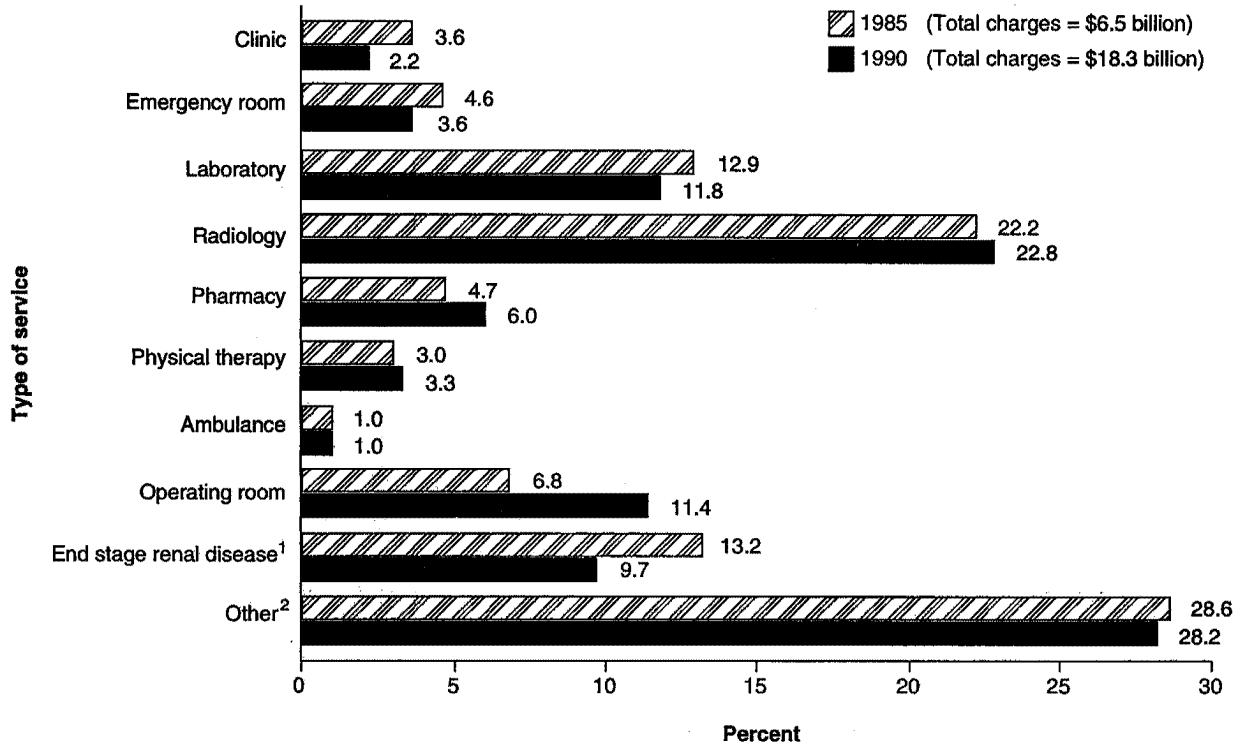
SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

types of services—radiology ($1.4 billion), services to persons with ESRD, primarily renal dialysis ($0.9 billion), and laboratory ($0.8 billion). In 1990, radiology ($4.2 billion) and laboratory ($2.2 billion) were once again the leading hospital outpatient services with respect to covered charges (Table 8.6). Most notable, however, is that hospital outpatient charges for operating room services rose from $0.4 billion (6.8 percent) in 1985 to $2.1 billion (11.4 percent) in 1990. This reflects the increasing number and variety of surgical procedures performed in an outpatient setting. Clearly, hospitals have taken advantage of increasing technical ability to treat more patients on an outpatient basis. This was made possible by relatively recent advances in medical technology, particularly in the areas of anesthesiology, endoscopic techniques, and cataract surgery. Cataract surgery previously required at least a 1-day inpatient stay, but now relatively few cataract removals require an inpatient stay. Technological advances have also allowed complex procedures, such as the insertion of pacemakers and cardiac catheterization, to be performed on an outpatient basis.

Demographic characteristics

By race and type of enrollment, there are substantial differences in the use of hospital outpatient services as measured by the average charge per enrollee (Table 8.6). The average total charge per enrollee for persons of races other than white ($767) was 43 percent higher than that for white persons ($537). The average total charge per disabled enrollee ($1,006) was nearly twice that for the aged ($518). These differences in the average charges per enrollee largely reflect the differences in the proportion of enrollees with ESRD. ESRD enrollees constitute a larger proportion of the races other than white and disabled populations than of the aged and white populations. The costliness of renal dialysis services accounts for the differences in the average incurred charges.

Figure 8.5
Percent distribution of hospital outpatient charges under Medicare, by type of service: Selected calendar years 1985 and 1990



[1]Services to end stage renal disease patients consist primarily of renal dialysis.
[2]Includes charges for computerized axial tomography, durable medical equipment, blood, etc.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8.6

Covered charges, percent distribution, and average charge per enrollee for hospital outpatient services under Medicare supplementary medical insurance, by type of enrollee and demographic characteristics: Calendar year 1990

Type of enrollee and characteristic	Total	Type of service									
		Clinic	Emergency room	Laboratory	Radiology	Pharmacy	Physical therapy	Ambulance	Operating room	Renal dialysis	Other[1]
					Covered charges in thousands						
Total	$18,346,471	$406,208	$668,844	$2,156,509	$4,176,843	$1,100,202	$599,478	$191,495	$2,089,161	$1,779,322	$5,169,183
Sex:											
Male	8,037,440	162,267	286,334	908,139	1,839,863	494,861	199,785	88,560	884,673	881,245	2,287,728
Female	10,309,030	243,940	382,510	1,248,369	2,336,980	605,341	399,693	102,934	1,204,488	898,076	2,881,455
Race:[2]											
White	15,073,015	252,451	540,998	1,811,591	3,629,609	941,089	525,281	166,341	1,837,851	973,276	4,385,955
Other	2,729,955	142,015	109,366	280,021	422,510	125,659	57,256	19,984	188,663	752,735	631,379
Type of enrollee:											
Aged	15,384,510	310,552	546,564	1,845,954	3,832,137	959,815	541,637	172,348	1,943,376	759,745	4,463,711
Disabled	2,961,960	95,656	122,280	310,555	344,705	140,386	57,840	19,147	145,785	1,019,576	705,472
					Percent distribution						
Total	100.0	2.2	3.6	11.8	22.8	6.0	3.3	1.0	11.4	9.7	28.2
Sex:											
Male	100.0	2.0	3.6	11.3	22.9	6.2	2.5	1.1	11.0	11.0	28.5
Female	100.0	2.4	3.7	12.1	22.7	5.9	3.9	1.0	11.7	8.7	28.0
Race:[2]											
White	100.0	1.7	3.6	12.0	24.1	6.2	3.5	1.1	12.2	6.5	29.1
Other	100.0	5.2	4.0	10.3	15.5	4.6	2.1	0.7	6.9	27.6	23.1
Type of enrollee:											
Aged	100.0	2.0	3.6	12.0	24.9	6.2	3.5	1.1	12.6	4.9	29.0
Disabled	100.0	3.2	4.1	10.5	11.6	4.7	2.0	0.6	4.9	34.4	23.8
					Average charge per enrollee						
Total	$562	$12	$20	$66	$128	$34	$18	$6	$64	$55	$158
Sex:											
Male	592	12	21	67	135	36	15	7	65	65	168
Female	541	13	20	66	123	32	21	5	63	47	151
Race:[2]											
White	537	9	19	64	129	34	19	6	65	35	156
Other	767	40	31	79	119	35	16	6	53	212	177
Type of enrollee											
Aged	518	10	18	62	129	32	18	6	65	26	150
Disabled	1,006	32	42	105	117	48	20	7	50	346	240

[1]Includes charges for computerized axial tomography, durable medical equipment, blood, etc.
[2]Excludes unknown race.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8.7

Hospital outpatient clinic and emergency room visits and charges under Medicare supplementary medical insurance (SMI), by type of enrollee and demographic characteristics: Calendar year 1990

Type of enrollee and characteristic	Clinic				Emergency room			
	Visits		Charges[1]		Visits		Charges	
	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit
Total	7,539	231	$406,208	$54	10,419	319	$668,844	$64
Sex:								
Male	3,023	223	162,267	54	4,422	325	286,334	65
Female	4,516	237	243,940	54	5,997	315	382,510	64
Race:								
White	5,082	181	252,451	50	8,647	308	540,998	63
Other	2,247	631	142,015	63	1,477	415	109,366	74
Unknown	210	214	11,742	56	295	300	18,479	63
Type of SMI enrollee:								
Aged	5,900	199	310,552	53	8,510	287	546,564	64
Disabled	1,639	557	95,656	58	1,909	648	122,280	64

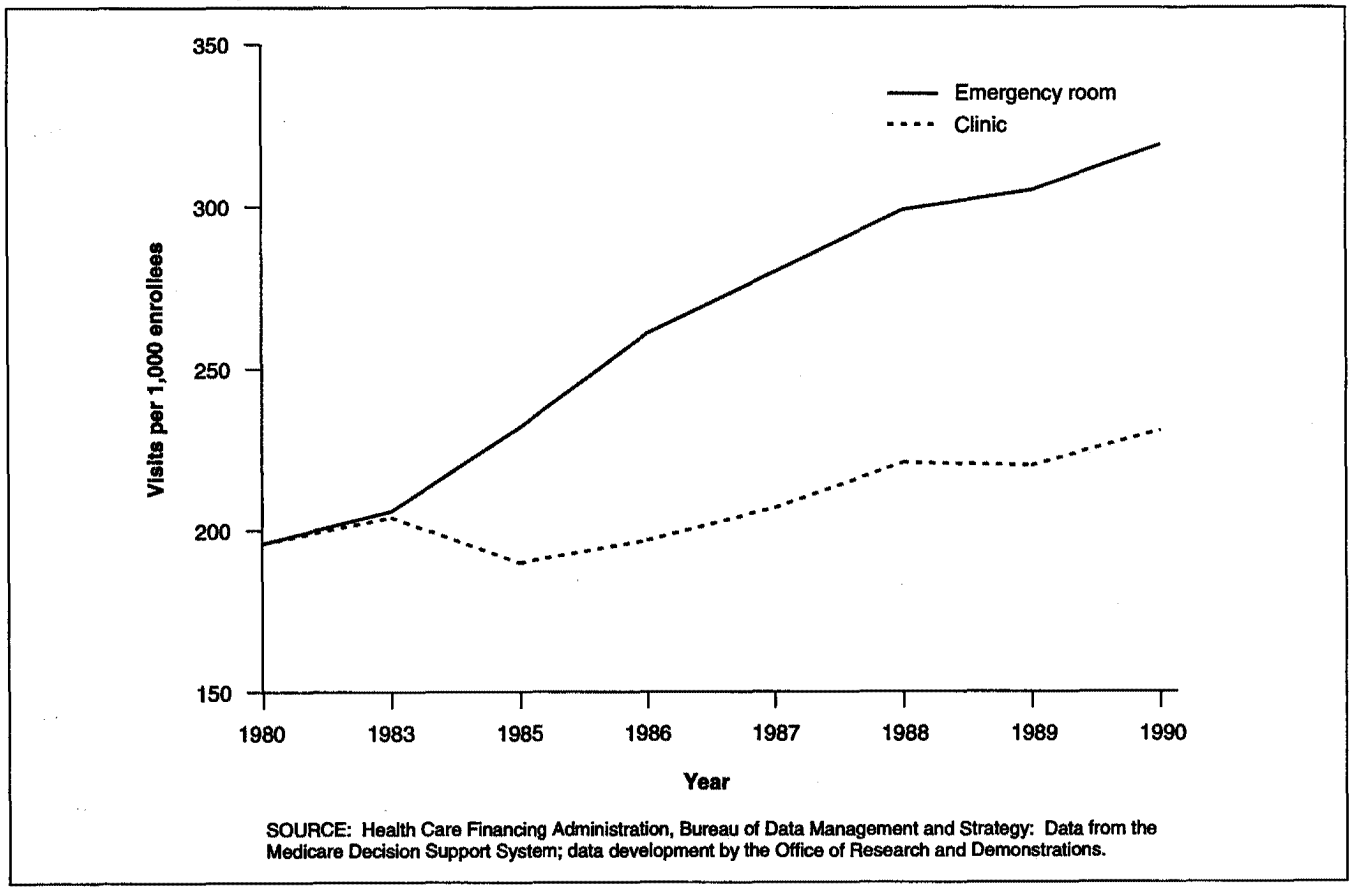
[1]Represents only the routine administrative charges.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Figure 8.8

Medicare hospital outpatient clinic and emergency room visits: Selected calendar years 1980-90



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Renal dialysis accounted for about 34 percent of total hospital outpatient charges among the disabled, but only 5 percent among the aged. Similarly, charges for renal dialysis services represented nearly 27.6 percent of all charges for persons of races other than white, compared with only 6.5 percent of white persons.

Clinic and emergency room use

In 1990, beneficiaries made about 7.5 million clinic visits, an average of 231 per 1,000 enrollees (Table 7.7). There are substantial differences in the utilization rate for clinic services by race and type of entitlement as measured by visits per 1,000 enrollees. Persons whose race was other than white used hospital clinics at a rate 3.5 times greater than white persons. This suggests that persons of races other than white may be using hospital clinics for primary care services to a greater extent than white persons. Disabled beneficiaries used clinic services at a rate 2.8 times greater than aged beneficiaries.

The rate of emergency room use by Medicare beneficiaries also increased steadily over the period 1984-90 and at a rate higher than that of clinic use (Figure 8.8). In 1990, beneficiaries made about 10.4 million emergency room visits, an average of 319 per 1,000 enrollees (Table 8.7). Persons whose race was other than white used emergency room services at a rate 1.3 times higher than white persons. Disabled beneficiaries used emergency room services at a rate 2.3 times greater than aged beneficiaries, suggesting that either they had more emergencies or they used emergency rooms for primary care services to a greater extent than aged persons.

Geographic variation

In 1990, Medicare hospital outpatient program payments in the United States were $8.2 billion; by region, the hospital outpatient payments were highest in the South ($2.7 billion) and lowest in the West ($1.4 billion) (Table 8.9).

The Northeast Region had the lowest average payment per persons served ($528) for all types of enrollees, about 5 percent lower than the national average ($557). The West had the highest average payment per person served ($641), about 15 percent higher than the national average.

By State, California, with the highest number of persons served, had the highest payments ($773 million), and Alaska (with the fewest number of persons served) had the lowest ($8 million). The average payment per person served ranged from a low of $398 in Maine to a high of $1,012 in the District of Columbia. Table 8.9 also shows the average hospital outpatient payment per enrollee by State, which ranged from lows of $177 in Nevada and $179 in Mississippi to highs of $360 in Alaska and $491 in the District of Columbia. The differences in average payments per person served are shown graphically in Figure 8.10.

Visit and procedure data

Table 8.11 provides selected data for the 20 leading reasons for the hospital outpatient visit based on frequency of occurrence in 1990. The table is arrayed by the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) codes. Among all Medicare beneficiaries using hospital outpatient services, the top 20 reasons for the visit accounted for 42 percent (21.6 million) of all hospital outpatient bills (51.5 million) and 48 percent ($3.9 billion) of all hospital outpatient program payments ($8.2 billion). For these 20 reasons for the visit, the average program payment per bill ($191) was about 14 percent higher than the average payment for all reasons for visit ($168).

ICD-9-CM code V72, (special investigations and examinations) was the most frequently reported reason for an outpatient visit, comprising 5.6 percent (2.9 billion) of all bills but only 2.1 percent ($171 million) of all program payments for hospital outpatient services. The average program payment per bill for beneficiaries receiving special investigations and examinations was $61, or about one-third of the average amount for all reasons for the visit.

ICD-9-CM code 585 (chronic renal failure) was the most costly leading reason for an outpatient visit, accounting for 18.6 percent ($1.5 billion) of all hospital outpatient payments. The average payment per bill for chronic renal failure was $920, or more than 5 times higher than the average hospital outpatient payment for all reasons for the visit. ICD-9-CM code 366 (cataract) was another costly reason for an outpatient visit, accounting for 10.1 percent ($826 million) of all hospital outpatient payments. Figure 8.12 summarizes the top six reasons for Medicare hospital outpatient visits.

Table 8.13 shows selected data for the 20 leading hospital outpatient surgical procedures based on frequency of occurrence in 1990 and arrayed by HCPCS codes. Hospital outpatient payments for all surgical procedures amounted to $2.4 billion, an average of $464 per procedure. The top 20 surgical procedures accounted for about 16 percent (833,360) of all hospital outpatient surgical procedures (5.2 million) and about 13 percent ($316 million) of all Medicare payments for hospital outpatient surgical procedures.

The most frequently performed hospital outpatient surgical procedures continue to be cataract procedures. In fact, 4.3 percent (227,300) of Medicare hospital outpatient department surgery visits were for extra capsular cataract removal alone (HCPCS code 66984). This one procedure accounted for 8.7 percent ($0.21 billion) of all Medicare hospital outpatient payments for surgical procedures.

Table 8.9

Number of persons served and program payments for hospital outpatient services received by Medicare beneficiaries, by area of residence: Calendar year 1990

Area of residence	Persons served in thousands				Program payments in millions				Average program payment per person served[5]				Average program payment per enrollee			
	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]
All areas	15,311	13,769	1,396	147	$8,172	$5,919	$628	$1,625	$557	$448	$470	$11,567	$250	$200	$221	$10,663
United States[1]	15,165	13,643	1,377	144	8,124	5,897	624	1,602	559	451	474	11,581	249	199	220	10,515
Northeast	3,594	3,261	302	31	1,801	1,306	140	355	528	422	491	12,193	253	200	257	11,402
North Central	4,213	3,826	354	33	2,204	1,687	157	360	548	462	467	11,291	271	227	233	10,428
South	5,031	4,471	505	54	2,689	1,894	206	590	552	438	421	11,243	241	189	188	10,495
West	2,327	2,086	215	26	1,429	1,011	121	297	641	506	590	11,946	243	188	254	10,594
New England	963	878	78	7	538	422	46	70	568	488	599	10,817	299	255	341	10,044
Connecticut	199	181	16	2	127	93	13	21	655	526	824	12,427	282	221	454	11,003
Maine	114	103	11	1	45	36	4	5	398	357	379	8,275	251	225	237	8,275
Massachusetts	460	421	36	3	270	220	23	27	595	529	645	10,302	330	292	375	9,854
New Hampshire	74	67	6	1	35	27	2	6	480	408	356	10,543	266	225	202	11,386
Rhode Island	74	67	6	1	44	33	3	8	606	494	525	11,296	294	239	251	9,086
Vermont	43	39	4	0	17	13	1	3	412	341	281	10,318	240	199	159	9,711
Middle Atlantic	2,631	2,383	224	24	1,263	884	94	285	513	396	451	12,589	237	181	229	11,796
New Jersey	454	410	38	5	259	182	18	59	590	459	492	11,585	246	187	246	11,102
New York	1,068	955	103	10	508	331	44	133	513	374	465	13,651	213	152	225	12,567
Pennsylvania	1,109	1,017	83	8	496	371	32	93	479	390	413	11,916	263	214	226	11,254
East North Central	2,987	2,703	260	25	1,582	1,198	115	269	553	462	464	11,322	283	236	236	10,573
Illinois	748	679	62	7	375	276	25	75	533	432	420	11,142	254	204	209	10,397
Indiana	402	363	36	3	196	145	14	36	496	409	404	11,637	268	220	216	10,796
Michigan	702	634	63	5	419	322	33	65	637	541	566	12,965	349	298	288	11,132
Ohio	792	717	68	7	423	322	29	73	544	457	431	10,812	285	239	218	10,877
Wisconsin	342	310	30	2	169	133	15	21	512	447	499	9,304	244	211	258	8,612
West North Central	1,226	1,123	94	9	622	489	42	92	536	459	474	11,203	244	208	223	10,026
Iowa	245	227	17	1	120	99	8	13	504	450	467	9,346	269	240	244	9,621
Kansas	181	169	11	1	99	81	5	14	583	508	465	12,714	284	248	218	10,562
Minnesota	219	200	17	2	108	81	7	21	508	413	439	11,729	190	152	194	10,119
Missouri	384	344	37	3	200	154	18	28	564	485	527	11,193	265	226	259	9,904
Nebraska	104	97	6	1	51	40	3	8	511	425	493	10,316	224	186	210	9,836
North Dakota	45	42	3	0	22	19	1	3	538	493	286	12,719	228	209	117	9,085
South Dakota	48	45	3	0	23	16	1	6	496	384	261	12,269	211	164	95	10,853
South Atlantic	2,680	2,394	257	29	1,473	1,052	113	308	567	454	455	10,874	247	195	206	10,445
Delaware	45	40	4	0	23	19	1	3	537	487	362	8,586	271	242	202	8,586
District of Columbia	37	33	4	1	36	23	4	10	1,012	712	1,207	12,355	491	338	641	12,355
Florida	880	812	59	8	521	404	29	88	617	518	509	11,000	228	190	193	9,977
Georgia	353	304	45	5	188	123	18	47	544	413	421	10,345	264	199	205	9,582
Maryland	254	231	20	3	170	124	13	32	695	560	659	11,775	326	260	328	11,443
North Carolina	392	342	45	5	201	131	19	52	523	390	418	11,613	232	171	195	11,258
South Carolina	209	180	26	3	102	68	8	26	511	393	353	9,746	236	180	159	9,974
Virginia	346	307	35	4	172	116	15	42	509	384	427	10,853	247	185	210	11,259
West Virginia	164	144	19	1	60	46	6	9	374	322	313	9,060	202	177	146	9,445

See footnotes at end of table.

Table 8.9—Continued

Number of persons served and program payments for hospital outpatient services received by Medicare beneficiaries, by area of residence: Calendar year 1990

Area of residence	Persons served in thousands				Program payments in millions				Average program payment per person served[5]				Average program payment per enrollee			
	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]	Total	Aged[2]	Disabled[3]	ESRD[4]
East South Central	1,011	876	125	10	$453	$314	$42	$97	$462	$368	$349	$10,568	$214	$170	$161	$9,495
Alabama	279	244	32	3	124	85	10	28	454	356	327	11,042	221	173	157	10,031
Kentucky	262	227	33	2	107	81	11	15	415	362	346	9,990	204	179	162	8,596
Mississippi	161	137	22	2	64	39	6	19	409	291	276	10,271	179	127	118	9,195
Tennessee	309	268	38	3	158	109	15	35	536	425	414	10,627	236	184	190	9,678
West South Central	1,341	1,201	124	16	763	528	50	185	591	457	422	12,359	248	190	180	11,204
Arkansas	169	149	19	1	77	54	6	17	467	371	339	13,365	202	161	142	11,859
Louisiana	248	215	29	4	180	121	13	46	738	572	436	13,484	357	276	203	12,272
Oklahoma	192	176	15	1	88	68	5	15	475	400	364	10,662	202	171	147	10,086
Texas	732	661	61	9	418	285	27	106	600	453	455	12,046	238	177	190	10,866
Mountain	712	645	61	6	397	304	32	62	592	499	567	11,196	252	211	249	9,682
Arizona	188	171	16	2	155	119	12	24	856	723	802	12,378	322	269	325	10,194
Colorado	166	149	16	1	80	61	8	12	518	436	529	10,554	233	195	245	9,235
Idaho	66	61	5	0	30	24	1	5	477	413	338	10,258	236	205	156	10,258
Montana	55	50	5	0	27	22	3	2	524	476	550	7,459	237	215	240	6,582
Nevada	47	42	5	0	24	16	3	5	524	388	656	12,353	177	129	251	9,608
New Mexico	80	72	8	1	42	29	3	10	564	438	429	11,853	249	192	192	11,315
Utah	84	77	6	0	29	24	2	3	373	332	370	9,457	186	165	185	7,964
Wyoming	25	23	2	0	11	9	1	1	454	431	438	5,725	214	202	215	4,770
Pacific	1,615	1,441	155	20	1,032	707	89	236	662	508	599	12,159	239	179	255	10,861
Alaska	13	11	1	0	8	6	1	1	699	587	793	8,382	360	278	360	8,382
California	1,170	1,037	117	16	773	518	71	184	685	518	634	11,909	245	180	274	10,790
Hawaii	34	31	2	1	27	13	1	13	828	454	303	14,684	226	120	93	14,045
Oregon	170	155	14	1	85	66	6	13	519	443	442	13,754	205	172	193	9,794
Washington	228	206	20	2	139	103	10	25	625	514	529	12,488	232	188	215	10,874
Outlying areas[5]	147	125	19	2	48	22	3	23	337	182	181	10,633	142	79	64	9,238

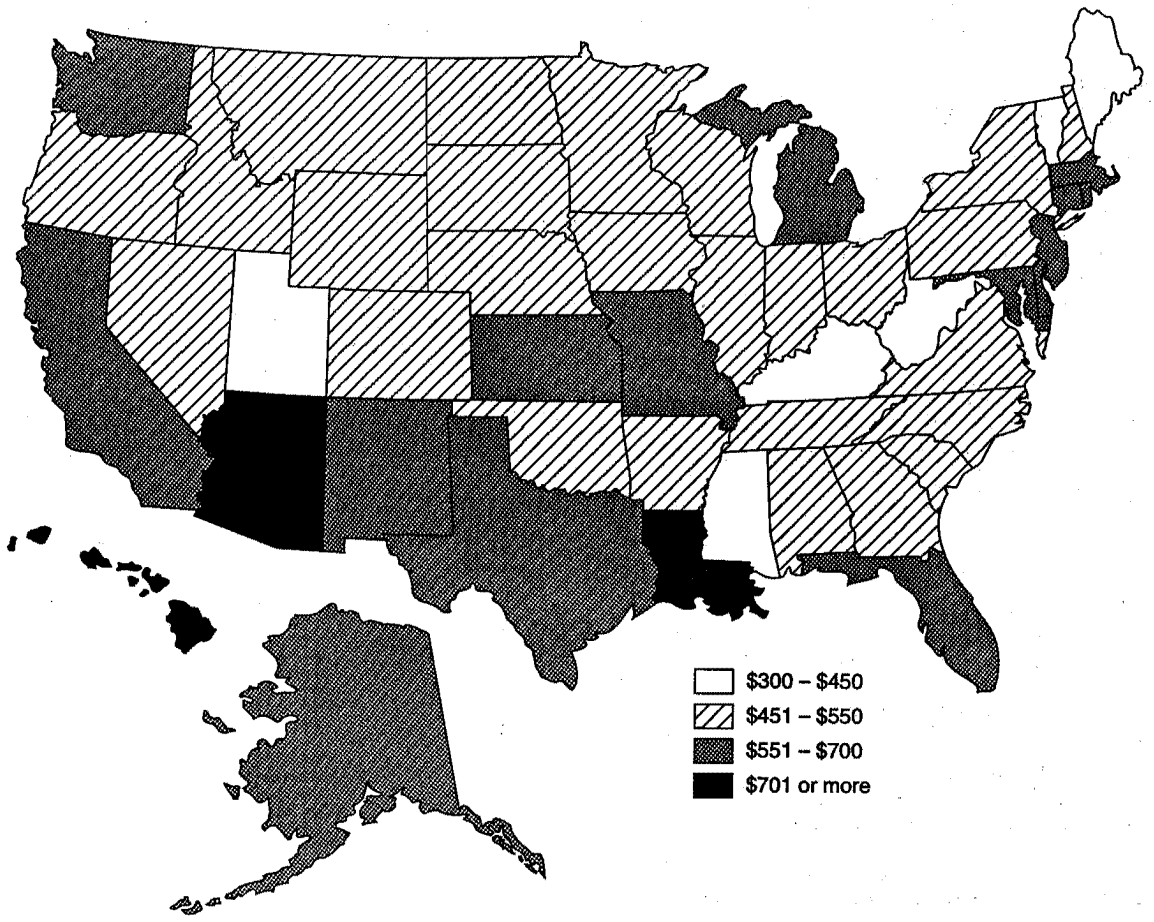
[1]Consists of 50 States and the District of Columbia.
[2]Aged beneficiaries with end stage renal disease excluded from the data; includes Medicare status code 10 only.
[3]Disabled beneficiaries with end stage renal disease excluded from the data; includes Medicare status code 20 only.
[4]ESRD enrollees have end stage renal disease; these data include ESRD beneficiaries entitled to Medicare because of age, disability, or ESRD (Medicare status codes 11, 21, and 31).
[5]The average program payment per person served does not reflect hospital outpatient visits for beneficiaries with no program payments in the reporting year.
[6]Consists of Puerto Rico, Virgin Islands, Guam, other areas, and residence unknown.

NOTES: ESRD is end stage renal disease. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Figure 8.10

Average program payments per person served for hospital outpatient services under Medicare: Calendar year 1990



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8.11

Number of hospital outpatient bills, covered charges, and program payments under Medicare, by 20 selected reasons for the visit: Calendar year 1990

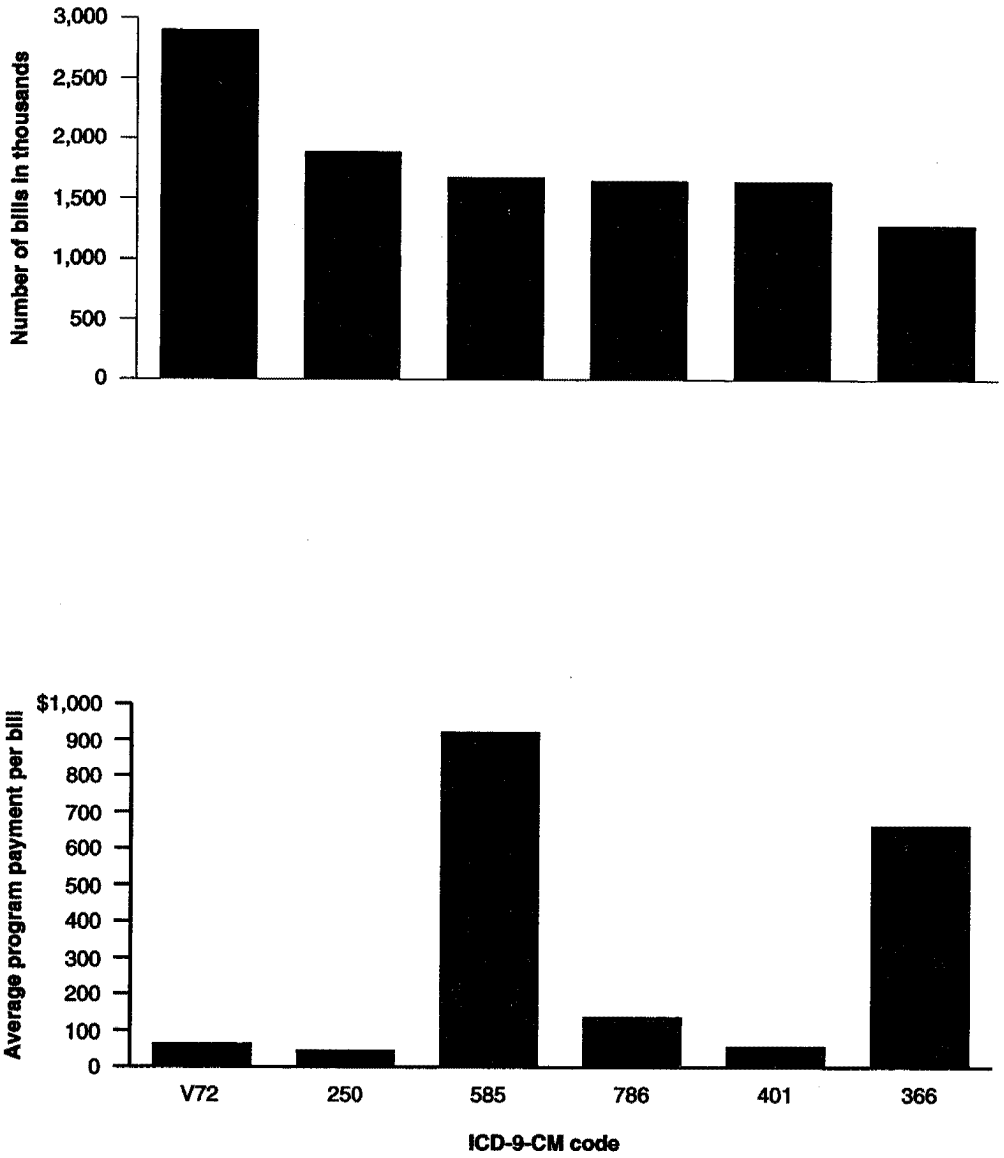
Reason for the visit	ICD-9-CM Code[1]	Number of bills	Covered charges in thousands	Program payments in thousands	Average charge per bill	Average program payment per bill[2]
Total, all reasons for the visit	—	51,451,340	$18,346,471	$8,171,088	$357	$168
20 selected reasons for the visit[3]	—	21,562,780	8,111,622	3,922,926	376	191
Special investigations and examinations	V72	2,889,920	424,302	171,432	147	61
Diabetes mellitus	250	1,885,340	173,628	76,592	92	42
Chronic renal failure	585	1,673,920	2,115,073	1,524,762	1,264	920
Symptoms involving respiratory system and other chest symptoms	786	1,647,220	532,647	205,325	323	135
Essential hypertension	401	1,642,760	190,967	81,547	116	54
Cataract	366	1,281,820	2,066,405	825,871	1,612	661
General symptoms	780	1,237,980	360,268	143,573	291	120
Other symptoms involving abdomen and pelvis	789	1,120,600	372,949	141,664	333	131
Other disorders of urethra and urinary tract	599	981,560	174,208	67,665	177	70
Other and unspecified disorders of back	724	781,380	249,845	98,222	320	133
Other forms of chronic ischemic heart disease	414	773,480	311,951	127,066	403	173
Other disorders of breast	611	718,600	113,485	41,993	158	71
Other and unspecified anemias	285	705,840	144,365	59,932	205	86
Heart failure	428	689,960	135,151	54,813	196	83
Cardiac dysrhythmias	427	630,680	202,610	79,748	321	132
Other ill-defined and unknown causes of morbidity and mortality	799	613,460	76,844	32,642	125	58
Other and unspecified disorders of joint	719	601,580	134,365	54,313	223	99
Follow-up examination	V67	593,060	109,650	45,377	185	81
Chronic airway obstruction, not elsewhere classified	496	552,800	122,833	49,921	222	96
Ill-defined descriptions and complications of heart disease	429	540,820	100,074	40,467	185	79
All other reasons for the visit	—	29,888,560	10,234,849	4,248,162	342	151

[1]Reasons for the visit from the *International Classification of Diseases, 9th Revision, Clinical Modification.*
[2]The average program payment per bill reflects only those bills for which there were program payments during the reporting year.
[3]Based on frequency of occurrence.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Figure 8.12

Six leading Medicare hospital outpatient reasons for visit: Calendar year 1990



NOTES: Principal code and reason for visit are from the *International Classification of Diseases, 9th Revision, Clinical Modification:* special investigations and examinations, V72; diabetes mellitus, 250; chronic renal failure, 585; symptoms involving respiratory system and other chest symptoms, 786; essential hypertension, 401; cataract, 366.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Table 8.13

Number of hospital outpatient procedures, covered charges, and program payments for Medicare beneficiaries, by the 20 leading principal HCPCS surgical procedures: Calendar year 1990

Principal HCPCS procedure	HCPCS code	Number of procedures	Covered charges in thousands	Operating charges in thousands	Program payments in thousands	Average covered charge per procedure	Average operating charge per procedure	Average program payment per procedure[1]
Total, all procedures	—	5,248,900	$6,021,969	$2,089,158	$2,385,855	$1,147	$398	$464
Total 20 leading principal HCPCS[2] surgical procedures	—	833,360	798,677	309,514	315,720	958	371	386
Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or phacoemulsification technique	66984	227,300	521,009	182,895	208,096	2,292	805	922
Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure	45378	120,100	64,141	24,830	24,907	534	207	210
Laser surgery (YAG laser) (one or more stages)	66821	118,460	45,410	27,588	16,496	383	233	141
Cystourethroscopy (separate procedure)	52000	47,680	24,670	13,646	10,282	517	286	221
Sigmoidoscopy, flexible fiberoptic; diagnostic	45330	41,080	10,854	4,383	4,164	264	107	106
Lumbar or caudal epidural	62289	28,280	9,089	3,869	3,193	321	137	115
Lumbar or caudal epidural, single	62278	25,420	9,154	4,118	3,169	360	162	128
Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)	65855	25,320	8,660	4,976	3,401	342	197	136
For removal of polypoid lesion(s)	45385	24,400	16,395	6,306	6,677	672	258	275
For biopsy and/or collection of specimen by brushing or washing	43239	23,900	13,801	4,994	5,303	577	209	222
Photocoagulation (laser or xenon arc)	67228	23,640	7,458	3,953	2,937	315	167	126
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk or extremities (including hands and feet); 2.5 cm or less	12001	22,420	3,306	102	1,084	147	5	54
Median nerve at carpal tunnel	64721	16,600	16,192	8,791	6,661	975	530	404
For biopsy and/or collection of specimen by brushing or washing	45380	16,460	10,601	3,846	4,171	644	234	255
Transfusion, blood or blood components, indirect	36430	14,940	7,998	449	3,279	535	30	221
Photocoagulation (laser or xenon arc)	67210	13,220	4,203	2,518	1,670	318	191	130
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk or extremities (including hands and feet); 2.6 cm to 7.5 cm.	12002	12,580	2,007	44	647	160	4	56
Iridotomy by photogoagulation (1 or more sessions) (e.g. for glaucoma)	66761	10,960	4,136	2,504	1,629	377	228	152
Repair inguinal hernia, age 5 or over	49505	10,880	18,252	9,626	7,495	1,678	885	693
Catheterization uretha; simple	53670	9,720	1,341	75	459	138	8	52
Total, all other diagnoses	—	4,415,540	5,223,292	1,779,644	2,070,135	1,183	403	479

[1]The average program payment per procedure reflects only those bills for which there were program payments during the reporting year.
[2]Leading surgical HCPCS codes were selected from among the code range 10000-69979 (surgery procedures). Certain procedures within this range were excluded based on the following: (a) the procedure performed was truly a diagnostic procedure (e.g., proctosigmoidoscopy, code 54300); (b) the procedure performed was a combined diagnostic and incisional, excisional, or discissional procedure, although truly diagnostic—and not therapeutic—in nature (e.g. esophagoscopy with excisional biopsy of polyp, code 43020); (c) the procedure performed was minimally incisional, invasive, and primarily to faciliate a medical (e.g. chemotherapy, code 36640; transfusion, code 36620), diagnostic (e.g., routine venipuncture, code 36145), or anesthetic (e.g., local infiltration or injection, code 62274) service. Leading procedures were based on the frequency of occurrence.

NOTES: HCPCS is Health Care Financing Administration Common Procedure Coding System. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.