A Comparison of Medicare Pay in the Office and Hospital Outpatient Settings

Introduction

In 2021, 56% of Medicare Physician Fee Schedule (MPFS) spending occurred in the office setting, and another 12% occurred in the hospital outpatient setting. Many physician services can be provided in either place, but the amount that Medicare pays can differ widely between the two settings. In the office, Medicare makes a single payment based on the non-facility MPFS amount, whereas in the hospital outpatient department (HOPD), payment is the MPFS facility amount plus a separate Hospital Outpatient Prospective Payment System (OPPS) facility fee. A key factor contributing to the pay differences between the settings is the difference in how annual updates to the MPFS and OPPS fee schedule amounts are determined. Under current law, MPFS updates are not adjusted for inflation and have averaged just 0.4% per year over the last two decades, whereas OPPS facility fee updates are based on a market basket inflation adjustment and have averaged 2.4% per year over that period.

This report compares 2021 Medicare payment amounts in the office and HOPD settings for select MPFS services. Payment amounts for these services are also compared for 2011 to see how the differential has changed over time. The analysis is limited to commonly performed MPFS services that meet a threshold amount for spending to ensure that any pay differences found will be relevant to overall Medicare spending. There were 87 services that met the spending threshold and other criteria for comparison. For 2021 the median service in this group was paid 40% more when provided in the HOPD compared to the office, up from a 12% pay difference in 2011.

Methods

Medicare payments were compared at the procedure or Healthcare Common Procedure Coding System (HCPCS) level. Thousands of HCPCS are paid under the MPFS, but spending per service is highly skewed, with the most commonly performed services accounting for a large share of spending. The analysis was limited to high dollar value services to exclude those where any difference in pay by site of service would have little or no impact on overall Medicare spending. The comparison was also limited to services that were commonly performed in both the office and HOPD.

More than one MPFS procedure may be provided in a patient encounter, and payments may be discounted when this occurs. Since the payment amounts compared in the analysis were the full fee schedule amounts, services that were usually provided in the same encounter as another MPFS service were excluded. The specific criteria used to select HCPCS for comparison were the following:

- The service accounted for at least 0.02% of MPFS spending for 2021. There were 492 HCPCS that met this threshold (which amounted to approximately $18.5 million in allowed charges), and these services accounted for 90% of MPFS spending for that year.
- Had at least 10% of utilization in both the office and hospital outpatient settings.
- Was not provided with another MPFS service in at least 25% of beneficiary/date of service/provider encounters for the service in 2021 (based on the Medicare Carrier 5% claims file for that year).
- Was paid separately under both the MPFS and Medicare OPPS for 2021 (had payment amounts under both fee schedules).

Prepared by Kurt Gillis, Economic and Health Policy Research, American Medical Association. April 2023.

These exclusions resulted in 91 potential HCPCS for comparison. Additional checks were performed to exclude services where the comparison was potentially inappropriate including:

- Excluding services where the actual amount paid for the OPPS facility fee (the average from Medicare hospital outpatient claims for 2021) was less than half the OPPS facility fee schedule amount for 2021. In other words, services were excluded if the OPPS facility fee schedule amount appeared to overstate the amount that Medicare typically paid for the OPPS facility fee (Two HCPCS excluded).
- Despite having a facility fee schedule amount under the Medicare OPPS, services may not be paid a separate facility fee if billed with another procedure. Services were excluded if the OPPS facility fee was paid less than 10% of the time it was billed (based on Medicare hospital outpatient claims for 2021). (One additional HCPCS excluded).
- Excluding services where non-MPFS HCPCS appeared to be bundled with the OPPS payment but were paid separately in the office (and those separate payments were substantial). Non-MPFS HCPCS including drugs, supplies and clinical lab services were billed in the same patient encounter for many of the services considered for comparison. In general, these HCPCS were not paid in the hospital outpatient setting but were paid separately in the office, although the amount paid per encounter in the office was generally low (less than $20). One service was excluded from the analysis because the amount paid separately in the office was substantial ($1,000 or more) for some of the non-MPFS HCPCS that it was typically billed with.

With these additional exclusions, 87 HCPCS were included in the analysis for 2021. These HCPCS ranged from $18.5 million to $12.1 billion in allowed charges for 2021 and accounted for 34% of all MPFS spending in that year. The payments used in the comparison were the national average MPFS amounts (both facility and non-facility), and on-campus OPPS facility fee amounts for 2021 (all available from the CMS website). Procedures were mapped to the Revised BETOS Classification System (RBCS) to group them into clinically meaningful categories. Among the procedures used in the comparison for 2021, 7 were E&M services, 54 were imaging services, 18 were procedures and 8 were tests. Payments for these services were also compared using fee schedule amounts from 2011, although 14 of the procedures were new since 2011 and did not have payment amounts for that year. Among the 73 procedures compared for 2011, 6 were E&M services, 50 were imaging services, 9 were procedures and 8 were tests.

Payment differences were measured as the ratio of hospital outpatient to office pay. Payment amounts were not adjusted for inflation because this ratio was calculated separately for 2011 and 2021.

Results

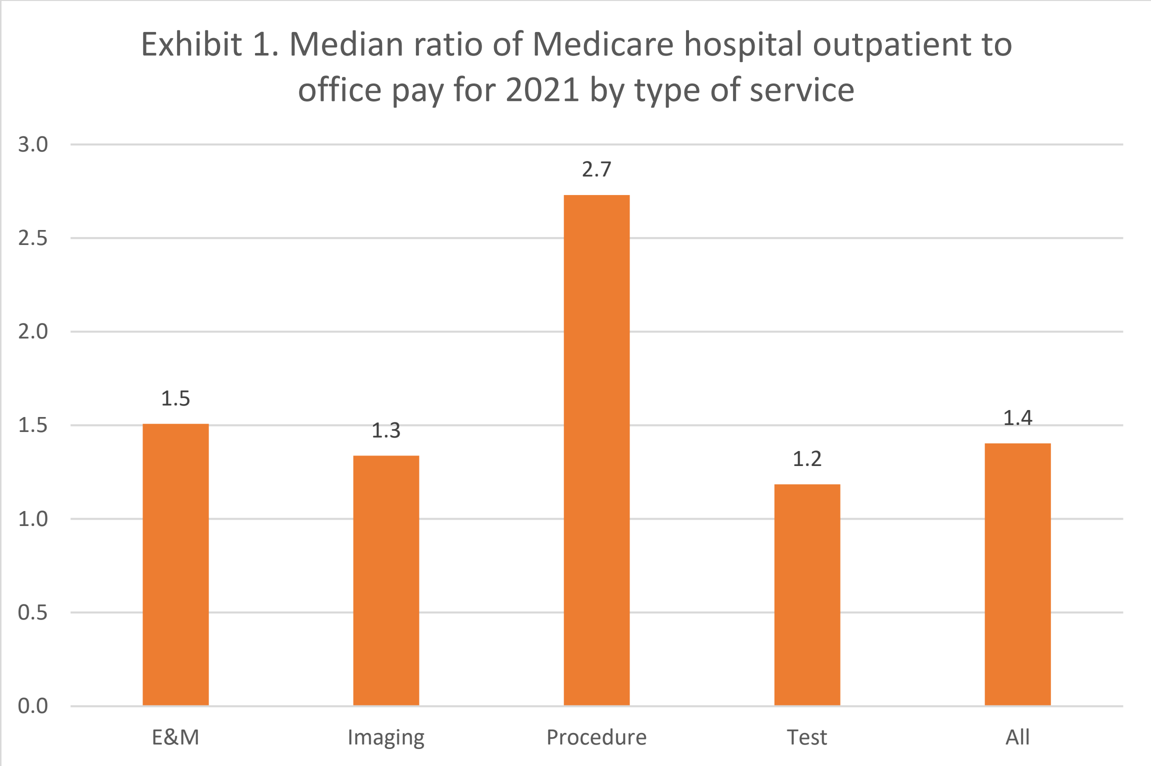
For the 87 services compared for 2021, Medicare pay in the hospital outpatient setting ranged anywhere from 30% less, to over 6 times more, than pay in the office setting. The office fee schedule amount exceeded the hospital outpatient amount for 6 services, but for two of these the difference was less than 1%. The median ratio of hospital outpatient to office pay was 1.4. That is, the median service (among the 87 compared for 2021) was paid 40% more when provided in the HOPD compared to the office. Pay differences varied by type of service, with the median ratio of hospital outpatient to office pay ranging from 1.2 for tests, and 1.3 for imaging, to 2.7 for procedures (Exhibit 1).

This pay difference has widened over the last decade. From 2011 to 2021, the change in hospital outpatient pay exceeded the change in office pay for 66 of the 73 services examined. In 2011, pay for the median service (among the 73 compared) was 12% greater in the hospital outpatient setting than in the office, but by 2021 this difference had increased to 40%. The median pay ratio increased from 2011 to 2021 for imaging, procedures and tests, but decreased slightly for E&M (Exhibit 2). Payment amounts and ratios for both 2011 and 2021 are shown for all procedures included in the analysis in Exhibit 3.

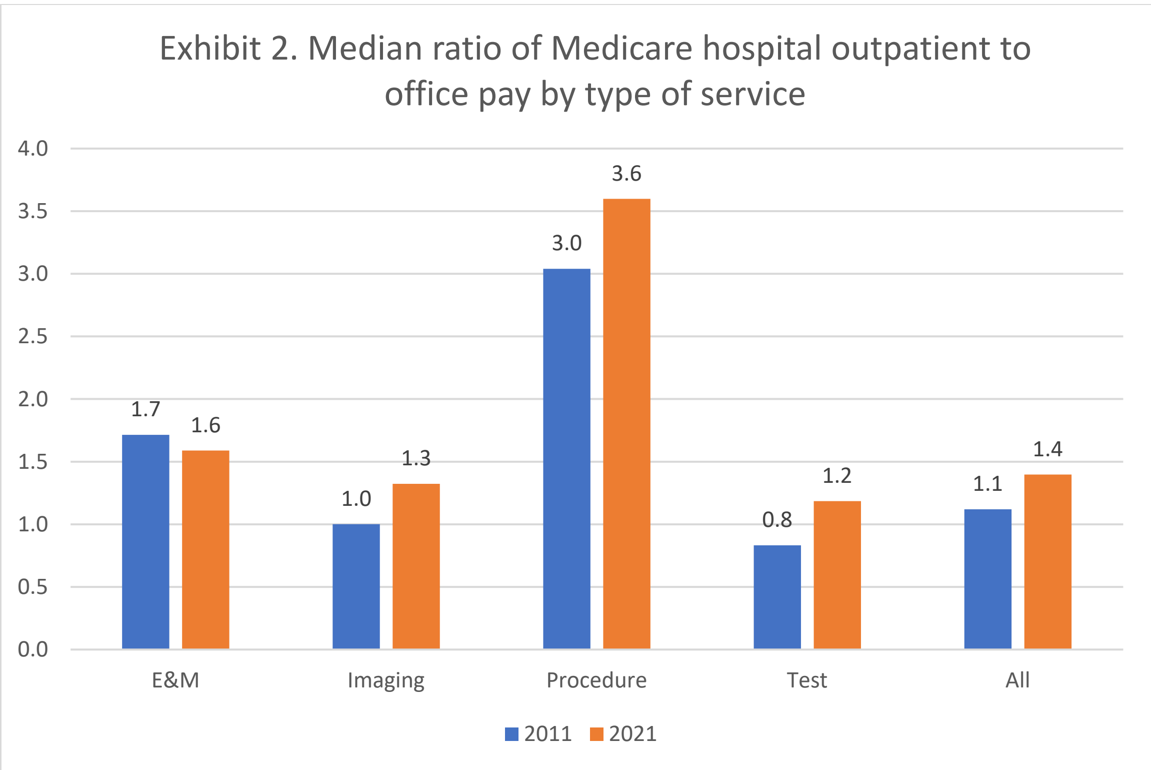
Limitations

This comparison of Medicare payment amounts in the office and HOPD settings is complicated by the fact that bundling of Medicare pay is more extensive when services are provided in the HOPD setting compared to the office. Non-MPFS HCPCS for clinical lab services, drugs and supplies were often billed with the procedures that were compared, and these were rarely paid separately on hospital outpatient claims but were usually paid separately in the office. For example, CPT 62323 was billed with a drug (most commonly HCPCS J1040 - Methylprednisolone) that was nearly always paid separately when provided in the office but never in the HOPD. The separate payments for these ancillary services and supplies could account for some of the difference between HOPD and office pay.

Aggregating across procedures to estimate the total impact of the Medicare pay differences found here was beyond the scope of this analysis due to the bundling issue and the fact that multiple MPFS procedures are often provided in the same patient encounter. When this occurs payments may be discounted for some of the procedures. For example, CPT 26055 (Incise finger tendon sheath) was often provided with another surgical procedure and/or performed multiple times in a single encounter. When this occurs the MPFS payment for CPT 26055 may be subject to Medicare's multiple procedure discount and paid at 50% of the full fee schedule amount. And the OPPS facility fee may be paid for only one of the procedures. Each combination of surgical procedures observed in the claims would have to be priced separately to determine the office to HOPD pay difference for that combination. The comparison of full (undiscounted) fee schedule amounts described in this report is only relevant in the cases where the procedure is performed alone, or the procedure combination is not subject to multiple procedure discounts or other payment adjustments.



Note: comparison based on 87 procedures where the hospital outpatient payment amount is for on-campus services.



Note: comparison based on 73 procedures where the 2021 hospital outpatient payment amount is for on-campus services.

Exhibit 3. National average Medicare payment amounts in office and HOPD for 2011 and 2021

			2011 Medicare payment amounts			*2021 Medicare payment amounts*		
procedure	*descriptor*	*RBCS category*	*office*	*HOPD*	*ratio HOPD to office*	*office*	*HOPD*	*ratio HOPD to office*
99204	Office o/p new mod 45-59 min	E&M	$158.33	$254.87	1.6	$169.93	$256.22	1.5
99205	Office o/p new hi 60-74 min	E&M	$197.06	$331.33	1.7	$224.36	$305.42	1.4
99212	Office o/p est sf 10-19 min	E&M	$41.45	$100.27	2.4	$56.88	$155.03	2.7
99213	Office o/p est low 20-29 min	E&M	$68.97	$124.40	1.8	$92.47	$186.78	2.0
99214	Office o/p est mod 30-39 min	E&M	$102.27	$175.48	1.7	$131.20	$219.23	1.7
99215	Office o/p est hi 40-54 min	E&M	$137.60	$235.51	1.7	$183.19	$266.69	1.5
99495	Trans care mgmt 14 day disch	E&M	#N/A	#N/A	#N/A	$207.96	$263.90	1.3
70486	Ct maxillofacial w/o dye	Imaging	$250.75	$250.59	1.0	$140.62	$150.84	1.1
70491	Ct soft tissue neck w/dye	Imaging	$310.88	$368.44	1.2	$204.12	$245.89	1.2
70551	Mri brain stem w/o dye	Imaging	$416.89	$416.66	1.0	$220.52	$302.36	1.4
70553	Mri brain stem w/o & w/dye	Imaging	$651.67	$651.50	1.0	$362.54	$480.83	1.3
71046	X-ray exam chest 2 views	Imaging	#N/A	#N/A	#N/A	$34.20	$91.72	2.7
71250	Ct thorax dx c-	Imaging	$244.97	$244.82	1.0	$145.85	$162.01	1.1
71260	Ct thorax dx c+	Imaging	$312.24	$361.99	1.2	$184.58	$235.78	1.3
71271	Ct thorax lung cancer scr c-	Imaging	#N/A	#N/A	#N/A	$150.74	$133.94	0.9
72100	X-ray exam l-s spine 2/3 vws	Imaging	$41.11	$56.93	1.4	$40.48	$120.14	3.0
72110	X-ray exam l-2 spine 4/>vws	Imaging	$56.06	$91.83	1.6	$51.64	$121.88	2.4
72131	Ct lumbar spine w/o dye	Imaging	$244.97	$244.82	1.0	$142.36	$158.17	1.1
72141	Mri neck spine w/o dye	Imaging	$423.01	$423.11	1.0	$215.64	$302.71	1.4
72146	Mri chest spine w/o dye	Imaging	$423.01	$423.11	1.0	$215.64	$302.71	1.4
72148	Mri lumbar spine w/o dye	Imaging	$417.23	$417.34	1.0	$215.99	$302.71	1.4
72156	Mri neck spine w/o & w/dye	Imaging	$662.54	$662.37	1.0	$366.03	$480.83	1.3
72158	Mri lumbar spine w/o & w/dye	Imaging	$652.35	$652.18	1.0	$365.33	$480.83	1.3
72197	Mri pelvis w/o & w/dye	Imaging	$646.23	$646.06	1.0	$389.06	$475.94	1.2
73030	X-ray exam of shoulder	Imaging	$31.26	$55.23	1.8	$34.89	$90.32	2.6
73110	X-ray exam of wrist	Imaging	$36.70	$53.87	1.5	$41.17	$89.62	2.2
73130	X-ray exam of hand	Imaging	$32.28	$53.53	1.7	$36.99	$89.62	2.4

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73221	Mri joint upr extrem w/o dye	Imaging	$411.79	$411.56	1.0	$228.90	$297.13	1.3
73502	X-ray exam hip uni 2-3 views	Imaging	#N/A	#N/A	#N/A	$47.45	$92.07	1.9
73560	X-ray exam of knee 1 or 2	Imaging	$30.92	$54.55	1.8	$34.89	$89.27	2.6
73562	X-ray exam of knee 3	Imaging	$37.03	$55.23	1.5	$41.17	$90.32	2.2
73564	X-ray exam knee 4 or more	Imaging	$42.47	$56.93	1.3	$46.76	$120.14	2.6
73610	X-ray exam of ankle	Imaging	$32.62	$53.53	1.6	$37.34	$89.62	2.4
73630	X-ray exam of foot	Imaging	$31.94	$53.53	1.7	$34.89	$89.27	2.6
73700	Ct lower extremity w/o dye	Imaging	$244.97	$244.82	1.0	$142.36	$158.17	1.1
73718	Mri lower extremity w/o dye	Imaging	$410.44	$410.20	1.0	$256.46	$296.08	1.2
73721	Mri jnt of lwr extre w/o dye	Imaging	$411.45	$411.22	1.0	$228.20	$296.78	1.3
74018	X-ray exam abdomen 1 view	Imaging	#N/A	#N/A	#N/A	$30.36	$89.97	3.0
74176	Ct abd & pelvis w/o contrast	Imaging	$216.43	$278.45	1.3	$200.64	$315.97	1.6
74177	Ct abd & pelv w/contrast	Imaging	$340.10	$388.49	1.1	$339.16	$457.80	1.3
74178	Ct abd & pelv 1/> regns	Imaging	$430.48	$432.43	1.0	$380.33	$466.52	1.2
74183	Mri abdomen w/o & w/dye	Imaging	$645.89	$645.72	1.0	$389.76	$475.94	1.2
75574	Ct angio hrt w/3d image	Imaging	$372.38	$372.38	1.0	$295.20	$295.44	1.0
76536	Us exam of head and neck	Imaging	$118.92	$124.14	1.0	$119.33	$137.23	1.2
76700	Us exam abdom complete	Imaging	$136.25	$136.37	1.0	$124.57	$148.75	1.2
76705	Echo exam of abdomen	Imaging	$107.37	$125.50	1.2	$93.16	$138.28	1.5
76770	Us exam abdo back wall comp	Imaging	$132.85	$132.98	1.0	$115.15	$145.26	1.3
76775	Us exam abdo back wall lim	Imaging	$112.12	$125.50	1.1	$60.02	$137.93	2.3
77080	Dxa bone density axial	Imaging	$97.51	$81.39	0.8	$38.73	$118.74	3.1
78306	Bone imaging whole body	Imaging	$253.46	$287.17	1.1	$307.06	$418.64	1.4
91110	Gi tract capsule endoscopy	Imaging	$920.08	$898.61	1.0	$885.59	$938.01	1.1
93306	Tte w/doppler complete	Imaging	$232.74	$470.00	2.0	$207.96	$553.72	2.7
93351	Stress tte complete	Imaging	$247.69	$653.89	2.6	$243.20	$567.33	2.3
93880	Extracranial bilat study	Imaging	$183.47	$183.23	1.0	$204.12	$269.21	1.3

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procedure	*descriptor*	*RBCS category*	*office*	*HOPD*	*ratio HOPD to office*	*office*	*HOPD*	*ratio HOPD to office*
93922	Upr/l xtremity art 2 levels	Imaging	$110.42	$78.48	0.7	$87.23	$124.86	1.4
93923	Upr/lxtr art stdy 3+ lvls	Imaging	$170.90	$129.24	0.8	$135.04	$161.53	1.2
93925	Lower extremity study	Imaging	$182.11	$181.87	1.0	$259.95	$268.51	1.0
93970	Extremity study	Imaging	$187.89	$187.65	1.0	$200.29	$263.98	1.3
93971	Extremity study	Imaging	$119.26	$119.04	1.0	$125.96	$130.95	1.0
93975	Vascular study	Imaging	$243.95	$243.71	1.0	$284.03	$287.01	1.0
93978	Vascular study	Imaging	$186.53	$186.29	1.0	$192.96	$269.56	1.4
11042	Deb subq tissue 20 sq cm/<	Procedure	$86.64	$235.39	2.7	$133.29	$407.25	3.1
15823	Revision of upper eyelid	Procedure	$605.80	$2,085.46	3.4	$631.91	$2,273.65	3.6
20610	Drain/inj joint/bursa w/o us	Procedure	$76.79	$233.39	3.0	$65.60	$307.93	4.7
22513	Perq vertebral augmentation	Procedure	#N/A	#N/A	#N/A	$6,815.32	$6,788.00	1.0
22514	Perq vertebral augmentation	Procedure	#N/A	#N/A	#N/A	$6,789.85	$6,753.45	1.0
26055	Incise finger tendon sheath	Procedure	$546.68	$1,479.15	2.7	$610.28	$1,693.13	2.8
31237	Nasal/sinus endoscopy surg	Procedure	$325.49	$1,695.96	5.2	$262.40	$1,657.25	6.3
33285	Insj subq car rhythm mntr	Procedure	#N/A	#N/A	#N/A	$5,200.12	$8,242.60	1.6
36901	Intro cath dialysis circuit	Procedure	#N/A	#N/A	#N/A	$756.48	$1,576.77	2.1
36902	Intro cath dialysis circuit	Procedure	#N/A	#N/A	#N/A	$1,359.44	$5,199.70	3.8
36903	Intro cath dialysis circuit	Procedure	#N/A	#N/A	#N/A	$5,151.97	$10,362.91	2.0
52310	Cystoscopy and treatment	Procedure	$253.80	$1,368.06	5.4	$320.67	$1,945.82	6.1
62321	Njx interlaminar crv/thrc	Procedure	#N/A	#N/A	#N/A	$277.75	$744.15	2.7
62323	Njx interlaminar lmbr/sac	Procedure	#N/A	#N/A	#N/A	$273.91	$735.43	2.7
63650	Implant neuroelectrodes	Procedure	$414.85	$4,967.87	12.0	$2,319.34	$6,584.63	2.8
64483	Njx aa&/strd tfrm epi l/s 1	Procedure	$240.21	$625.28	2.6	$255.77	$935.86	3.7
64615	Chemodenerv musc migraine	Procedure	#N/A	#N/A	#N/A	$157.72	$387.48	2.5
97597	Rmvl devital tis 20 cm/<	Procedure	$72.03	$127.26	1.8	$102.59	$215.84	2.1
88112	Cytopath cell enhance tech	Test	$102.61	$92.88	0.9	$67.69	$77.67	1.1
88305	Tissue exam by pathologist	Test	$106.01	$72.84	0.7	$71.53	$87.45	1.2

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procedure	*descriptor*	*RBCS category*	*office*	*HOPD*	*ratio HOPD to office*	*office*	*HOPD*	*ratio HOPD to office*
93280	Pm device progr eval dual	Test	$62.18	$75.85	1.2	$79.91	$75.88	0.9
95810	Polysom 6/> yrs 4/> param	Test	$694.14	$906.14	1.3	$628.77	$1,041.25	1.7
95811	Polysom 6/>yrs cpap 4/> parm	Test	$749.18	$911.92	1.2	$656.34	$1,045.78	1.6
95816	Eeg awake and drowsy	Test	$291.86	$221.34	0.8	$386.62	$322.37	0.8
95819	Eeg awake and asleep	Test	$325.49	$221.00	0.7	$463.73	$322.72	0.7
G0416	Prostate biopsy, any mthd	Test	$583.38	$321.34	0.6	$354.16	$469.91	1.3

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