COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

May 1, 2019

The Honorable Dominick Moreno, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Moreno:

Enclosed please find the Department of Health Care Policy and Financing's statutory report to the Joint Budget Committee on the Medicaid Provider Rate Review Recommendation Report.

Section 25.5-4-401.5 (2)(a), C.R.S., requires the Department to "conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review … compare the rates paid with available benchmarks … and use qualitative tools to assess whether payments are sufficient … on or before May 1st."

The Department's report contains appropriate analyses, rate comparisons, and sufficiency assessments for seven sets of services: Ambulatory Surgical Centers, fee-for-service behavioral health services, Residential Child Care Facilities, Psychiatric Residential Treatment Facilities, Special Connections Program services, dialysis and end-stage renal disease services, and durable medical equipment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, David DeNovellis, at david.denovellis@state.co.us or 303-866-6912.

Sincerely,

Kim Bimestefer
Executive Director

KB/EH

Enclosure(s): 2019 Medicaid Provider Rate Review Recommendation Report

Cc: Representative Daneya Esgar, Vice-chair, Joint Budget Committee
Representative Chris Hansen, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
John Ziegler, Staff Director, JBC
Eric Kurtz, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
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John Bartholomew, Finance Office Director, HCPF
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Interim Community Living Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Stephanie Ziegler, Cost Control and Quality Improvement Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
David DeNovellis, Legislative Liaison, HCPF

2019 Medicaid Provider Rate Review Analysis Report

May 1, 2019

Submitted to: The Joint Budget Committee and the Medicaid Provider Rate Review Advisory Committee

COLORADO
Department of Health Care Policy & Financing

Table of Contents

Executive Summary

This report contains the work of the Colorado Department of Health Care Policy & Financing (the Department) to review rates paid to providers under the Colorado Medical Assistance Act. Services under review this year, Year Four of the five-year rate review cycle, are listed in the table below.

Rate Review – Year Four Services	
Ambulatory Surgical Centers	Special Connections Program Services
Fee-for-Service Behavioral Health Services	Dialysis and End-Stage Renal Disease Services
Residential Child Care Facilities	Durable Medical Equipment
Psychiatric Residential Treatment Facilities	

This report is intended to be used by the Department, in collaboration with the Medicaid Provider Rate Review Advisory Committee (MPRRAC) and stakeholders, to evaluate findings and generate recommendations, which will be presented in the 2019 Rate Review Recommendation Report November 1, 2019.

This report contains a service grouping description, rate comparison analysis, access to care analysis, stakeholder feedback, additional research, and conclusion for each service.

For each service grouping, rate benchmark comparisons, which describe (as a percentage) how Colorado Medicaid[1] payments compare to other payers, are listed below.

- Ambulatory Surgical Centers (ASCs): **63.95%**
- Fee-for-Service (FFS) Behavioral Health services: **94.67%**
- Residential Child Care Facilities (RCCFs): **68.56%**
- Psychiatric Residential Treatment Facilities (PRTFs): **114.36%**
- Special Connections Program services ranged from: **9.78% - 630.72%**[2]
- Dialysis and End-stage Renal Disease (ESRD) services: **83.22%**[3]
- Durable Medical Equipment (DME): **100.75%**

The Department's conclusions for each service grouping are summarized below.

- Analyses suggest that ASC payments were sufficient to allow for member access and provider retention. However, planned additional research may reveal more information that could lead to a different conclusion.
- Analyses suggest that FFS behavioral health service payments were sufficient to allow for member access and provider retention.
- Analyses are inconclusive to determine if RCCF payments were sufficient to allow for member access and provider retention.
- Analyses were inconclusive to determine if PRTF payments were sufficient to allow for member access and provider retention.
- Analyses are inconclusive to determine if Special Connections payments were sufficient to allow for member access to provider retention.

[1] The consumer-facing name for Colorado Medicaid is Health First Colorado. In this report, the Department refers to the program as Colorado Medicaid.

[2] This is shown as a range because the services vary within the program. The Department is not able to estimate a weighted average rate benchmark comparison for the Special Connections service grouping at this time due to the lack of available claims data for analysis.

[3] The dialysis and ESRD facility and professional payments together come to 83.22% of the benchmark.

- Analyses suggest that dialysis and ESRD service payments were sufficient to allow for member access and provider retention.
- Analyses suggest that DME payments for rates not subject to UPL were sufficient to allow for member access and provider retention. Current data suggest that DME rates subject to UPL are sufficient for member access and provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

For certain services, in certain regions, the Department plans to conduct additional research to identify if access issues exist, if they are unique to Colorado Medicaid or Medicaid, and if they are attributable to rates.

While it is important to thoughtfully and critically examine the contents of this report, readers must remember that services reviewed in this year's report are part of a larger set of services. Services reviewed this year encompass only a subset of all services reviewed over the five-year cycle.

Members of the public are invited to: engage in the rate review process; provide input on access, quality, and provider rates; and attend MPRRAC meetings. The five-year rate review schedule, MPRRAC meeting schedule, past MPRRAC meeting materials, and more can be found on the Department website.

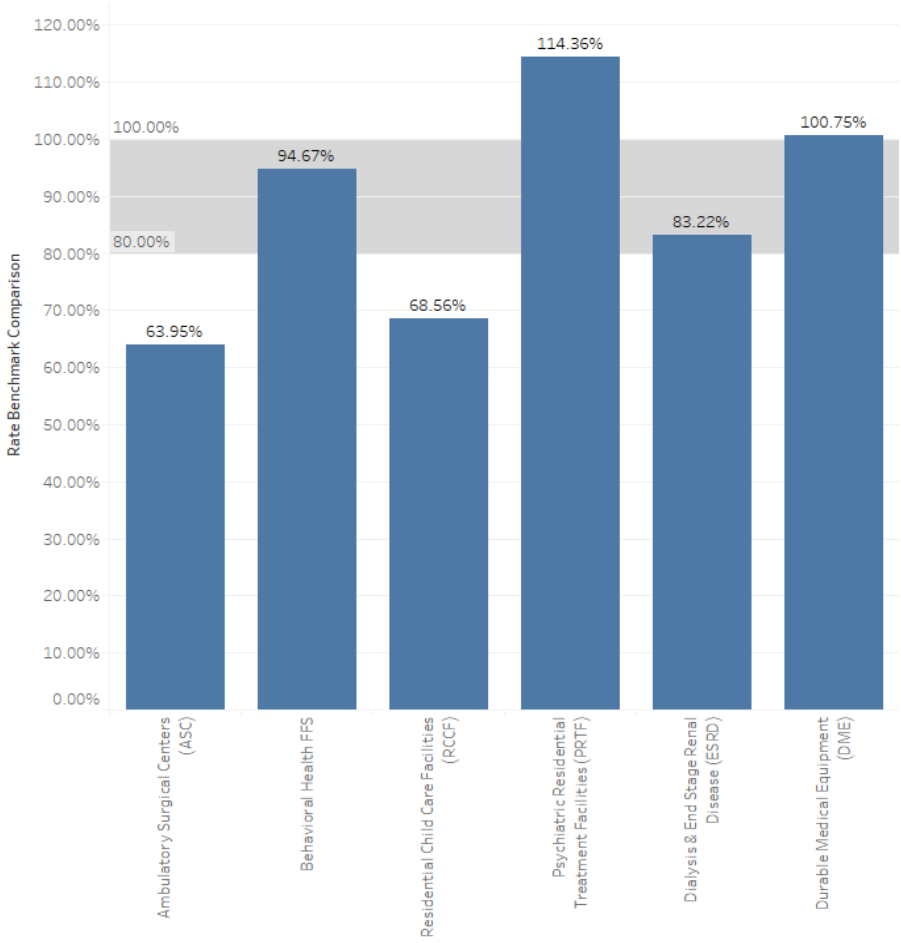

Figure 1. Colorado Medicaid rate benchmark comparison for all Year Four service groupings except Special Connections[4] (FY 2017-18).

[4] The Department is not able to estimate a weighted average rate benchmark comparison for the Special Connections service grouping at this time due to the lack of available claims data for analysis.

Introduction

The Department administers the State's public health insurance programs, including Colorado Medicaid, Child Health Plan *Plus* (CHP+), and a variety of other programs for Coloradans who qualify. Colorado Medicaid is jointly funded by a federal-state partnership. The Department's mission is to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources.

In 2015, the Colorado State Legislature adopted Senate Bill 15-228 "Medicaid Provider Rate Review," an act concerning a process for the periodic review of provider rates under the Colorado Medical Assistance Act. In accordance with Colorado Revised Statutes (CRS) 25.5-4-401.5, the Department established a rate review process that involves four components:

- assess and, if needed, review a five-year schedule of rates;
- conduct analyses of service, utilization, access, quality, and rate comparisons for services under review and present the findings in a report published the first of every May;
- develop strategies for responding to the analysis results; and
- provide recommendations on all rates reviewed and present them in a report published the first of every November.

The rate review process is advised by the MPRRAC, whose members recommend changes to the five-year schedule, provide input on published reports, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

MPRRAC meetings for services under review this year, Year Four of the five-year rate review cycle, began in November 2018 and included a general discussion of preliminary analyses and stakeholder feedback. Summaries from meetings, including presentation materials, documents from stakeholders, and meeting minutes, are found on the Department website.

This report contains:

- comparisons of Colorado Medicaid provider rates to those of other payers;
- access to care analyses; and
- assessments of whether payments were sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services, including where additional research is necessary to identify potential access issues.

Payment Philosophy

The rate review process is a method to systematically review provider payments in comparison to other payers and evaluate access to care. This process, which includes feedback from the MPRRAC, has helped inform the Department's payment philosophy for fee-for-service (FFS) rates.

Where Medicare is an appropriate comparator, the Department believes that a reasonable threshold for payments is 80% - 100% of Medicare; however, there are four primary situations where Medicare may not be an appropriate model when comparing a rate, including, but not limited to:

1. Medicare does not cover services covered by Colorado Medicaid or Medicare does not have a publicly available rate (e.g., certain DME services).
2. Medicare's population is different enough that services rendered do not necessarily translate to similar services covered by Colorado Medicaid (e.g., RCCFs).

3. Instances where differences between Colorado Medicaid's and Medicare's payment methodologies prohibit valid rate comparison, even if covered services are similar.
4. There is a known issue with Medicare's rates.

When Medicare is not an appropriate comparator, the Department may use its rate setting methodology to develop rates. This methodology incorporates indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

While the Department views payments between 80% - 100% of Medicare and payments determined by the rate setting methodology as reasonable, factors such as those listed below, must be considered when setting or changing a rate. These include:

- budget constraints that may prevent payments at a certain amount;
- investigating whether a rate change could create distributional problems that may negatively impact individual providers and understanding feasible mitigation strategies;
- identifying certain services where the Department may want to adjust rates to incentivize utilization of high-value services; and
- developing systems to ensure that payments are associated with high-quality provision of services.

When the rate review process indicates a current rate does not align with the Department's payment philosophy, the Department may recommend or implement a rate change. It is also important to note that the Department may not recommend a change, due to the considerations listed above.

Format of Report

Information below explains the sections within each service grouping of the report, including each section's basic structure and content.

Service Description

Service definitions, procedure or revenue codes, and member and provider data are outlined in this section. This section is designed to provide the reader with an understanding of the service grouping under review, as well as the scale of members utilizing and providers delivering this service grouping. For each service grouping, statistics are provided. Those statistics and the fiscal year (FY) they represent are:

- Total Adjusted Expenditures – FY 2017-18[5]
- Total Members Utilizing Services – FY 2017-18
- Year-over-year Change in Members Utilizing Services – FY 2017 and FY 2018[6]
- Total Rendering Providers[7] – FY 2017-18

[5] Total adjusted expenditures may differ from total expenditures as reported in the annual budget due to additional adjustments conducted for this report (e.g., incurred but not reported claims, etc.) and varying service category definitions. For more information, see Appendix B.

[6] For all services except ASCs and RCCFs, year-over-year change in members was calculated using data from FY 2017 and FY 2018. For ASCs and RCCFs, active provider data from April-June 2017 and April-June 2018 was used.

[7] A rendering provider is any provider with at least one Colorado Medicaid paid claim in a given month between July 2015-June 2018.

- Year-over-year Change in Rendering Providers – FY 2017 and FY 2018[8]

Rate Comparison Analysis

The Department contracted with the actuarial firm Optumas to assist in the comparison of Colorado Medicaid provider rates to those of other payers.[9] The resulting rate comparison analysis outlined in this section provides a reference point for how Colorado Medicaid reimbursement rates compare to other payers.

Analysis in this section is based on FY 2017-18 administrative claims data and contains a rate benchmark comparison, which describes (as a percentage) how Colorado Medicaid payments compare to other payers. This section also lists the number of procedure codes compared to either Medicare or an average of other states' Medicaid rates, and the range of rate ratios.[10]

The Department first examined whether a service had a corresponding Medicare rate to identify comparator rates for analysis. Medicare rates were primarily relied upon for this analysis when available and appropriate. When Medicare rates were unavailable, the Department relied upon other state Medicaid agency rates.[11] The Department utilizes Medicare rates for comparison for reasons including:

- Medicare is the single largest health insurer in the country and is often recognized by the health insurance industry as a reference for payment policies and rates;
- Medicare's rates, methodologies, and service definitions are generally available to the public;
- Medicare rates are typically updated on a periodic basis; and
- most services covered by Colorado Medicaid are also covered by the Medicare program.

Technical information for all services, except PRTF and Special Connections Program services, is contained in Appendix B.[9]

Access to Care Analysis

The Department contracted with the actuarial firm, Optumas, to assist in evaluating access.[12] The resulting access to care analysis outlined in this section provides a reference point for how well Colorado Medicaid members can access health care services, and if rates are sufficient for provider retention. Access was measured for each of the three county classifications used by the Regional Accountable Entities (RAEs), which are urban, rural, and frontier.[13]

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[8] For all services except ASCs and RCCFs, year-over-year change in providers was calculated using data from FY 2017 and FY 2018. For ASCs and RCCFs, active provider data from April-June 2017 and April-June 2018 was used.

[9] PRTFs and Special Connections were not included in the Optumas rate comparison analysis due to protected health information (e.g., PRTFs) or the absence of available claims data (e.g., Special Connections).

[10] Definitions for certain terms in this report, such as rate ratio and rate benchmark comparison, are contained in Appendix A.

[11] Due to differences in eligible populations, RCCF services were compared to other state Medicaid rates, even though Medicare covers and has rates for these services.

[12] PRTFs and Special Connections were not included in the Optumas access to care analysis due to protected health information (e.g., PRTFs) or the absence of available claims data (e.g., Special Connections).

[13] County classifications are defined as the following: urban counties are any county in the contractor's service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor's service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor's service area with a population density less than or equal to 6 persons per square mile. Please see Figure 2. Colorado Counties and RAE County Classifications.

The access to care analysis includes a variety of metrics to capture a broad picture of access to these services by measuring realized access (e.g., penetration rate), potential access (e.g., member-to-provider ratio), and provider availability (e.g., panel size and active providers). It is important to note that these access to care metrics do not indicate how Colorado Medicaid members' access to services in those regions compared to access for individuals with other insurance, or to the uninsured population.[14]

The five metrics used to analyze access to care for Colorado Medicaid members include:

- Utilizers per provider (panel size) – the average number of members seen per active provider.
- Utilizer density – the total number of distinct utilizers in each county.
- Penetration rate – the estimated percentage of total Colorado Medicaid members in a geographic area (county) that received the service. Comparing the penetration rate across counties helps identify atypical utilization.[15]
- Member-to-provider ratio – the total number of Colorado Medicaid members residing in a geographic area compared to the total number of active providers in that geographic area; calculated as providers per 1,000 members. This metric allows for comparison across areas with large differences in population size.
- Drive times – the percentage of service utilizers that live within certain distances from provider locations, represented by drive time bands, using a Geographic Information System (GIS) software application referred to as ArcGIS. The percentage of Colorado Medicaid members is calculated as a percentage of members who utilized the service within each time band listed below:
    - 0 to 30 minutes;
    - 30 to 45 minutes;
    - 45 minutes to an hour;
    - an hour or more.

Access to care metrics are based on FY 2017-18 administrative claims data.[16,17] More technical information, including details regarding how to read and interpret access to care analysis results, is contained in Appendix B.

Stakeholder Feedback

This section contains summaries of stakeholder comments received during the rate review process.[18]

Additional Research

For certain service groupings and regions, particularly when the Department's analysis was inconclusive or indicated a potential access issue, the Department will work to identify other data sources that may be used to conduct additional research. These data sources may be created and maintained as part of the Department's

[14] Please see the Limitations section below for more information regarding this consideration.

[15] A higher penetration rate might indicate that there is a higher concentration of members in need of services relative to other counties; or other factors that impact service utilization in the county, such as drive times, member-to-provider ratios and provider supply, or wait times, amongst other factors.

[16] The utilizers per provider (panel size) metric is based on monthly administrative claims data from July 2015-June 2018.

[17] The Department is working to adopt formal network adequacy standards to reach more meaningful conclusions in future analyses, especially for member-to-provider ratios and drive time metrics.

[18] With permission from stakeholders, the Department posts stakeholder comments on the Department website, except when comments contain protected health information. This report references written comments the Department received September 2017-April 2018. The Department will post additional written comment on the Department website as it is received. Stakeholders did not provide comment for all service groupings; therefore, some service grouping sections do not summarize stakeholder comments.

ongoing benefit management and programmatic operations, while others may be created by other organizations or State agencies. The Department plans to use these data sources to conduct further research as the 2019 Medicaid Provider Rate Review Recommendation Report is developed. Options for additional research include:

- Examining claims and enrollment data to understand if members are accessing services in settings, or via delivery systems, that are excluded from the rate review analysis.
- Referring to research being conducted this year for inclusion in the Department's Access Monitoring Review Plan.
- Reviewing relevant, regional results on Key Performance Indicators (KPIs), which are tracked as a part of Colorado Medicaid's delivery system, the Accountable Care Collaborative.
- Reviewing relevant, practice-level results on quality metrics, including Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) measures.
- Working with the Department's provider relations and customer service teams to understand if there is a documented pattern of provider and member concerns.
- Examining regional and statewide reports and studies published by other agencies, such as the Colorado Department of Public Health and Environment (CDPHE), local public health agencies, the Center for Improving Value in Health Care (CIVHC), and the Colorado Health Institute (CHI), including the Colorado Health Access Survey (CHAS).

Conclusion

In accordance with 25.5.-4-401.5, C.R.S., the Department evaluated rate comparison and access to care analyses to determine whether payments are sufficient to allow for member access and provider retention and to support appropriate reimbursement of high-value services. In this report, conclusions state whether analyses suggest payments were sufficient and where additional research is necessary to identify potential access issues.

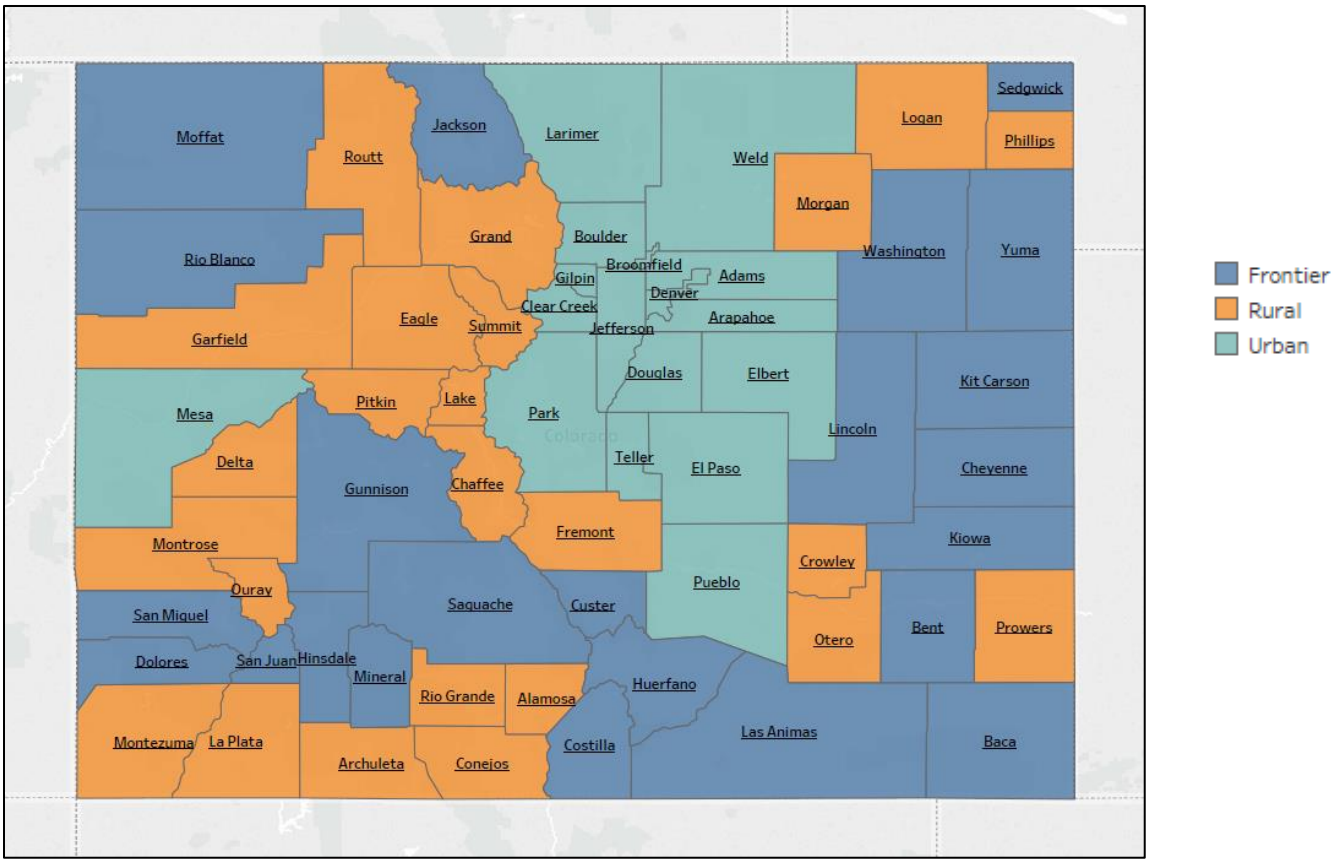


Figure 2. Colorado counties and RAE county classifications.

RAE County Classifications[19]					
Urban		**Rural**		**Frontier**	
Adams	Mesa	Alamosa	Logan	Baca	Las Animas
Arapahoe	Park	Archuleta	Montezuma	Bent	Lincoln
Broomfield	Pueblo	Chaffee	Montrose	Cheyenne	Mineral
Boulder	Teller	Conejos	Morgan	Costilla	Moffat
Clear Creek	Weld	Crowley	Otero	Custer	Rio Blanco
Denver		Eagle	Ouray	Dolores	Saguache
Douglas		Delta	Phillips	Gunnison	San Juan
Elbert		Fremont	Pitkin	Hinsdale	San Miguel
El Paso		Garfield	Prowers	Huerfano	Sedgwick
Gilpin		Grand	Rio Grande	Jackson	Washington
Jefferson		Lake	Routt	Kiowa	Yuma
Larimer		La Plata	Summit	Kit Carson	

[19] County classifications are defined as the following: urban counties are any county in the contractor's service area with a total population equal to or greater than 100,000 people; rural counties are any county in the contractor's service area with a total population of less than 100,000 people; and frontier counties are any county in the contractor's service area with a population density less than or equal to 6 persons per square mile.

Table 1. Colorado counties by RAE county classification.

Limitations

Results from this report and additional research will inform the development of Department recommendations. Still, it is important to note limitations inherent to analyses in this report and limitations that exist generally when evaluating payment sufficiency and access to care.

The access to care analyses and resulting conclusions are based on administrative claims data. Claims-based analyses do not provide information regarding appointment wait times, quality of care, or differences in provider availability and service utilization based on insurance type, nor do claims-based analyses allow for the Department to quantify care that an individual may have needed but did not receive. The Department plans to evaluate other data sources to address this. When the Department evaluates other data sources (mentioned above, in the Format of Report – Additional Research section), there may be assumptions and extrapolations made due to differences in geographic area designations, differences in population definitions, and differences in service definitions. Additionally, many of the access to care indicators are relative, and without defined standards, cannot indicate if all regions are performing well or if all regions are performing poorly. However, these indicators, when analyzed altogether, can help identify regions for focus. For more information, see Appendix B.

There are complicating factors regarding determining rate sufficiency. Member access and provider retention are influenced by factors beyond rates, such as: provider outreach and recruitment strategies; the administrative burden of program participation; health literacy and healthcare system navigation ability; provider scheduling and operational practices; and member characteristics and behaviors.[20] Additionally, rates may not be at their optimal level, even when there is no indication of member access or provider retention issues. For example, rates that are above optimal may lead to increases in unwarranted utilization or utilization of low-value services and rates that are less than optimal may lead to decreases in the provision of high-quality care or increases in the provision of services in a less cost-effective setting.

In addition to 25.5.-4-401.5, C.R.S., which guides the Department's rate review process, there are other federal statutes, rules and regulations, as well as Centers for Medicare and Medicaid Services (CMS) regulatory guidance, that guide the Department's analyses related to member access, provider retention, and payment sufficiency. Given data limitations, which impact how the data can be interpreted, and the increasing need to align the rate review process with other Departmental initiatives and federal regulations, the Department has incorporated changes to the access analysis methodology utilized in the 2019 Rate Review Analysis Report. The changes described in the Format of Report – Access to Care Analysis section, are intended to improve the Department's ability to apply and interpret data for policy and rate recommendations.

[20] The Department adapted some factors from: Long, Sharon 2013. Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State. Accessed via http://content.healthaffairs.org/content/32/9/1560.full.pdf+html

Ambulatory Surgical Centers

Service Description

The Ambulatory Surgical Center (ASC) service grouping is comprised of 2,743 procedure codes.[21]

ASC Statistics	
Total Adjusted Expenditures FY 2017-18	$13,415,406
Total Members Utilizing Services FY 2017-18	20,575
April-June 2018 Over April-June 2017 Change in Members Utilizing Services	2.34%
Total Rendering Providers FY 2017-18	235
April-June 2018 Over April-June 2017 Change in Rendering Providers	9.32%

Table 2. ASC expenditure and utilization data.

Services performed at an ASC are assigned to one of ten rate group brackets for reimbursement. If multiple procedures are provided in a single visit, they are grouped together, and reimbursement is based on the most complex procedure.[22] Table 3 (below) shows the ASC code grouping breakdown used in the rate comparison analysis.[23]

ASC Code Groupings		
Group Number	**Number of Codes**	**Rate Effective July 1, 2018-June 30, 2019**
Group 1	507	$267.86
Group 2	688	$358.73
Group 3	696	$410.26
Group 4	367	$506.77
Group 5	196	$576.77
Group 6	8	$664.45
Group 7	114	$800.39
Group 8	6	$782.70
Group 9	68	$1,077.13
Group 10	8	$1,786.57

Table 3. ASC code grouping breakdown.

[21] Utilization data for some of these codes was not available and thus certain codes were not included in the comparison analysis. For more information regarding codes included and excluded in the rate comparison analysis, please see Appendix B.

[22] ASC reimbursement includes related services and items, such as use of facilities, nursing services, blood products, and items directly related to the provision of surgical procedures.

[23] For more information on how claims are assigned to each group and for payment methodology, please see Appendix B.

Rate Comparison Analysis

On average, Colorado Medicaid payments for ASCs are estimated at 63.95% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[24]

ASC Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$12,339,335	$19,293,926	**63.95%**

Table 4. Comparison of Colorado Medicaid ASC service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be $6,954,591 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 824 procedure codes analyzed in this service grouping, 796 were compared to Medicare rates and 28 procedure code rates were compared to an average of 12 other states' Medicaid rates.[25] The ten ASC code grouping rate ratios ranged from 29.71%-139.02%.

[24] For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.

[25] States used in the ASC rate comparison analysis were Arizona, Nebraska, Wyoming, Alabama, Alaska, Connecticut, Idaho, Indiana, Montana, Nevada, South Dakota, and Texas. For more details on ASC rate comparisons, please see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for ASC services averaged 16.50 in April-June 2017 and decreased to 15.78 in April-June 2018. Additionally:

- In urban counties, utilizers per provider averaged 15.57 in April-June 2017 and decreased to 14.89 in April-June 2018.
- In rural counties, utilizers per provider averaged 3.75 in April-June 2017 and decreased to 3.40 in April-June 2018.
- In frontier counties, utilizers per provider averaged 1.99 in April-June 2017 and increased to 2.03 in April-June 2018.

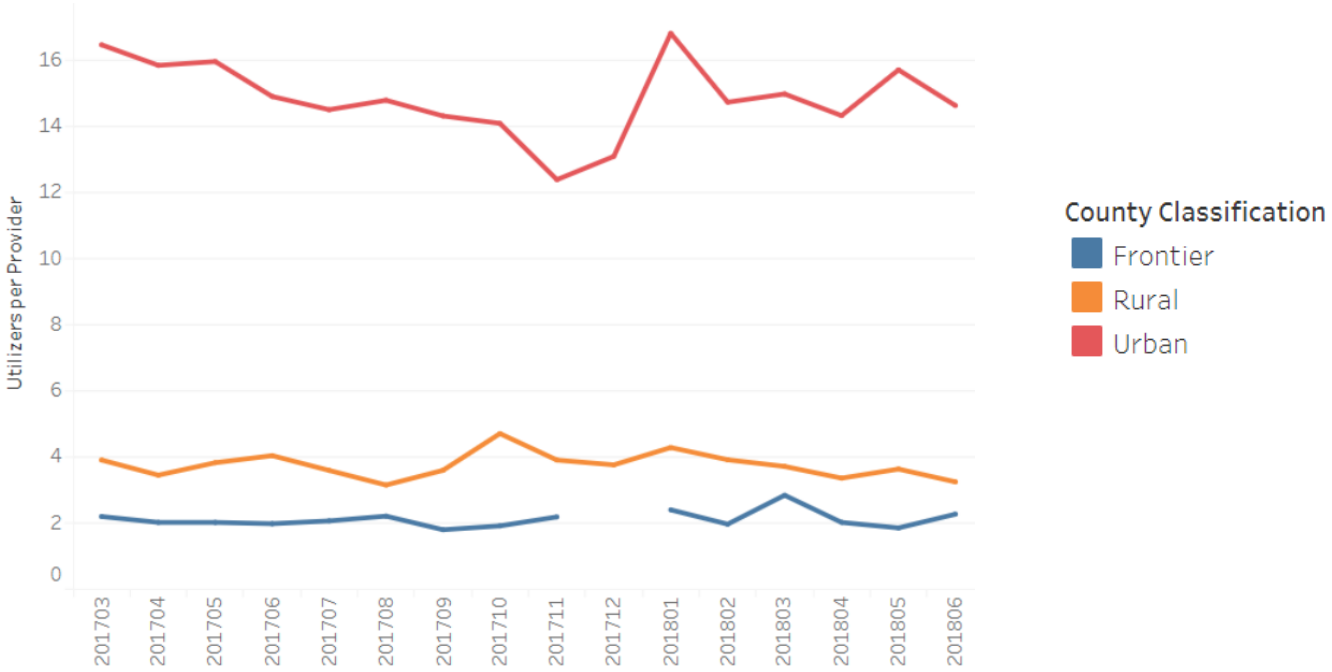


Figure 3. Utilizers per provider (panel size) for ASC services between March 2017 and June 2018.[26]

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time across all county classifications. The Department did not observe a significant difference between the rate of increased distinct utilizers and active providers, which led to the relatively stable number of utilizers per provider.[27]

The increases in active providers in the urban counties may indicate improvements in access to care for ASCs in these areas.

[26] Some data from the Frontier classification group was blinded for protected health information (PHI), accounting for the gap that appears in the line graph.

[27] For data specific to distinct utilizers and active providers, please see Appendix C.

There was a noticeable change November 2017-February 2018 that could be attributed to seasonal utilization patterns.[28]

Utilizer Density

The utilizer density metric provides information regarding where utilizers of ASC services reside throughout the state. Bent County had the lowest number of utilizers at 34 and El Paso County had highest number of utilizers at 4,286 in FY 2017-18.

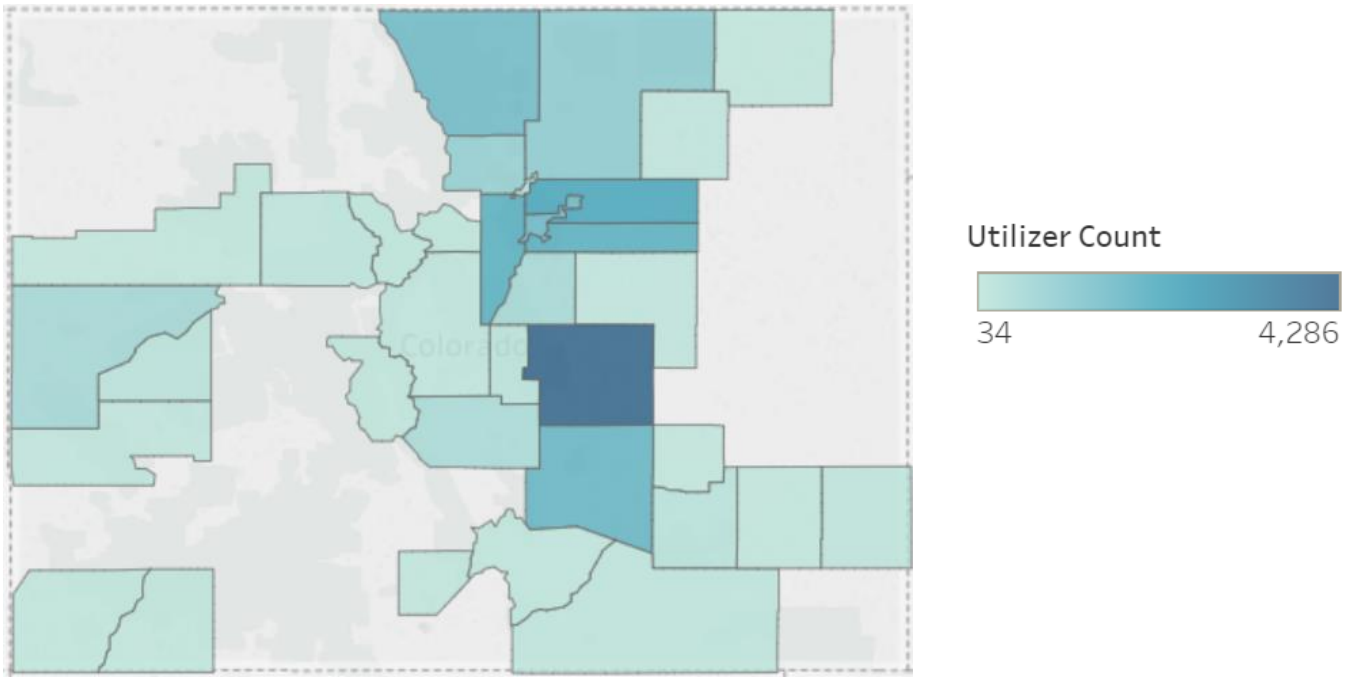


Figure 4. Utilizer density for ASC services by county for FY 2017-18.[29]

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for ASC services, or a low number of Colorado Medicaid members utilizing ASCs;
- accessing surgical services in other settings not included in this analysis.

Additionally, some counties have been omitted due to protected health information (PHI). For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

[28] For more information on which counties were attributed to urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.
[29] Please see Figure 2. Colorado Counties and RAE County Classifications on page 11 to reference Colorado counties by name.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for ASC services in FY 2017-18 ranged from 0.32% in La Plata County to 2.70% in Fremont County. The penetration rate in Denver County was 0.85%.

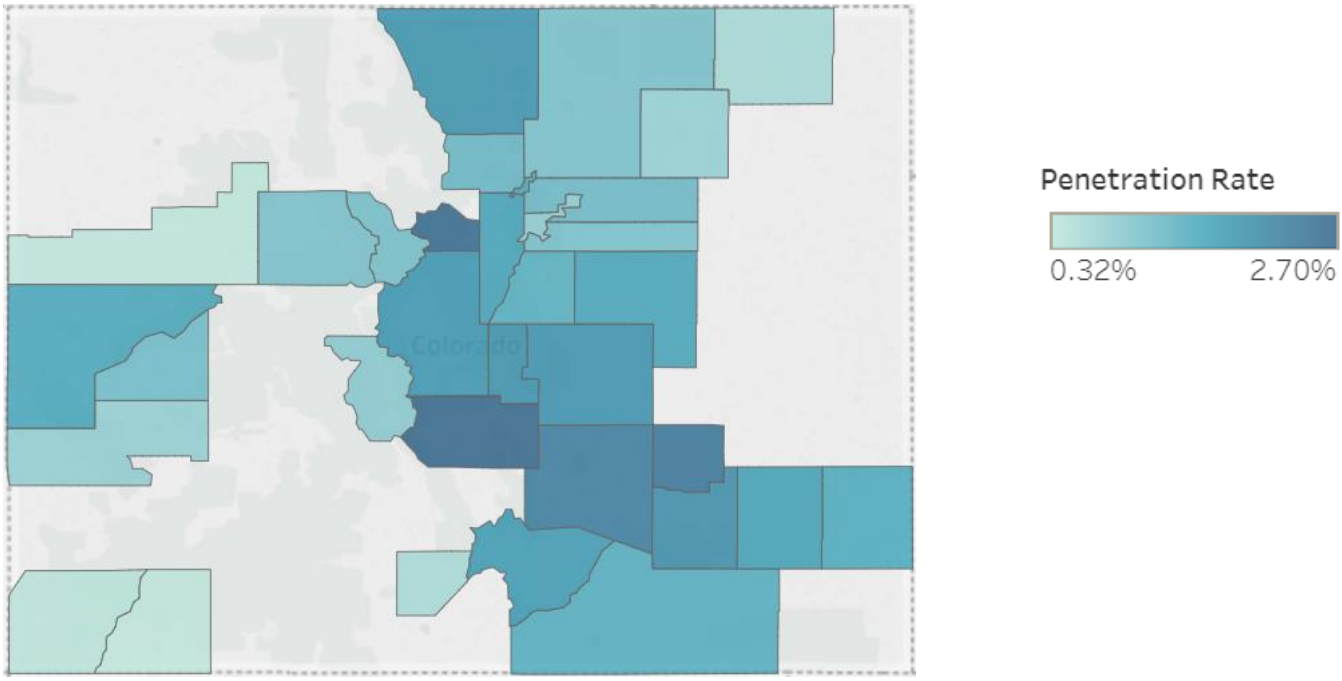


Figure 5. Penetration rates for ASC services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage received ASC services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of active ASC service providers relative to all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

ASC Member-to-Provider Ratios			
Region	**FY 2017-18 Providers**	**FY 2017-18 Members**	**Providers per 1,000 Members**
Frontier	69	41,742	1.65
Rural	112	162,003	0.69
Urban	227	1,217,439	0.19
Statewide	**235**	**1,408,747**	**0.17**

Table 5. Member-to-provider ratio for ASC services expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural and urban counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.[30]

[30] Currently, the Department does not use member-to-provider ratio standards specific to ASC services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department in determining whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of ASC utilizers that live within certain drive time bands from where ASC services have been provided.

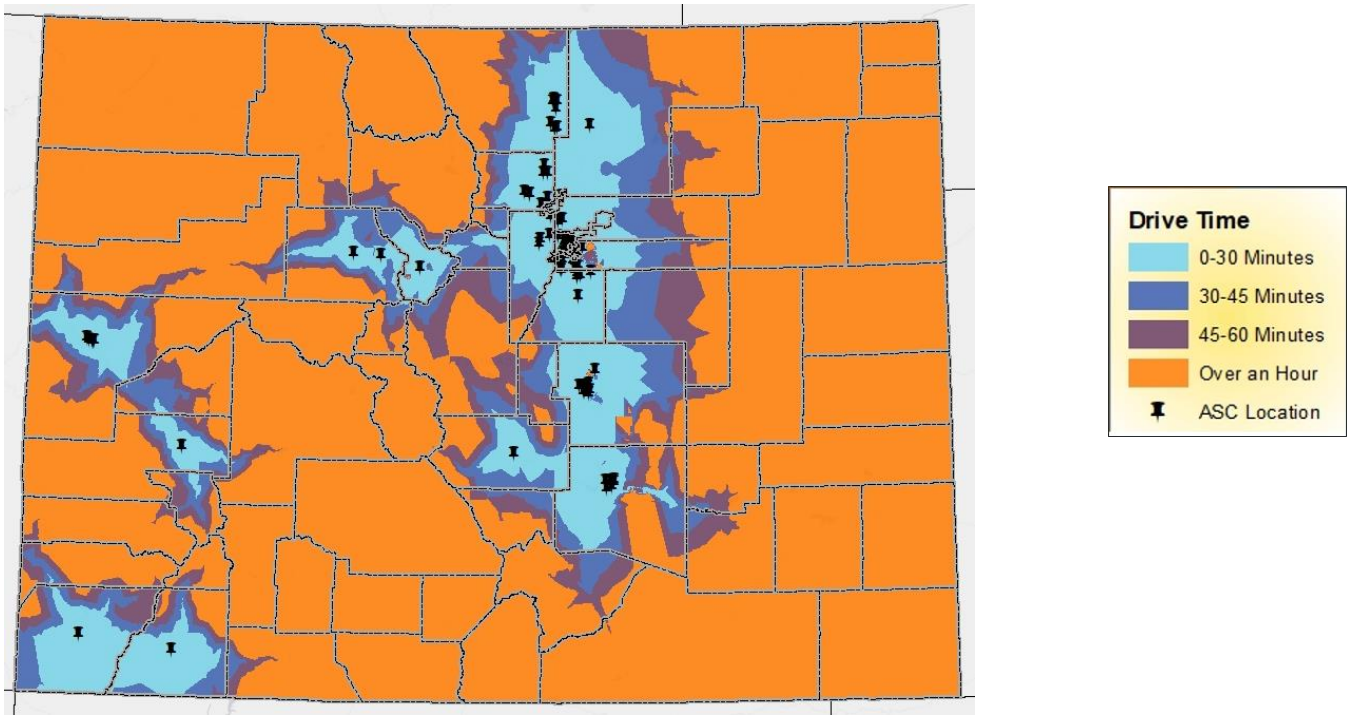


Figure 6. ArcGIS map of drive times for utilizers of ASC services in FY 2017-18.

Overall, 85% of the total utilizers of ASC services in FY 2017-18 needed to travel approximately 30 minutes or less to reach an ASC. Five percent of the total utilizers needed to travel approximately 30-45 minutes; 4% needed to travel approximately 45-60 minutes; and 6% needed to travel over an hour to reach an ASC.

Active ASCs enrolled in Colorado Medicaid tend to be located in more densely populated areas.[31]

Stakeholder Feedback

During the MPRRAC meeting on March 29, 2019, committee members commented that Colorado Medicaid may be able to save funds by reimbursing for more surgical procedures to closer align allowable procedures for ASC Medicaid services with that of ASC Medicare services. Committee members also commented that the Department should consider reimbursing ASCs for all procedures completed in a single visit, rather than only the most complex procedure.

Additional Research

The Department plans to conduct additional research related to noted regional differences, as well as ASC codes covered by Medicare, but not currently covered by Colorado Medicaid in an ASC setting. The Department will also consider the utilization of other services across the continuum of care. The Department also plans to conduct

[31] This could be due to availability of surgeons or proximity to a hospital site, amongst other factors.

additional research to determine, for example, whether care that could be performed in an ASC is currently being provided in the outpatient hospital setting.

Conclusion

Analyses suggest that ASC payments at 63.95% of the benchmark were sufficient to allow for member access and provider retention. However, additional research may reveal more information that could lead to a different conclusion.

Fee-for-Service Behavioral Health Services

Service Description

The Fee-for-Service (FFS) behavioral health service grouping is comprised of 33 procedure codes. Under a separate managed care arrangement, the Department pays a fixed, capitated rate to the RAEs to manage and reimburse for the vast majority of behavioral health services Colorado Medicaid members receive. Each RAE contracts with behavioral health providers and has flexibility to negotiate reimbursement rates with each of those providers. For services covered under the RAE contracts, behavioral health providers bill the RAEs directly for services rendered.[32] Capitated rates reimbursed through the RAEs are not included in the following analysis; only FFS behavioral health rates are included in the analysis.

FFS Behavioral Health Statistics	
Total Adjusted Expenditures FY 2017-18	$7,973,185
Total Members Utilizing Services FY 2017-18	87,589
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	25.78%
Total Rendering Providers FY 2017-18	2,245
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	17.54%

Table 6. FFS behavioral health services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for FFS behavioral health services are 94.67% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

FFS Behavioral Health Services Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$8,824,473	$9,321,763	**94.67%**

Table 7. Comparison of Colorado Medicaid FFS behavioral health service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be $497,290 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 33 procedure codes analyzed in this service grouping, 25 procedure code rates were compared to Medicare rates and eight procedure code rates were compared to an average of 11 other states' Medicaid rates.[33] Individual FFS behavioral health service rate ratios ranged from 22.71%-231.23%.

[32] RAE contracts include a list of covered diagnoses. Where a diagnosis is not part of the RAE contract, providers bill the Department directly for behavioral health services rendered. For example, in FY 2017, 97,000 claims for general psychotherapy services were reimbursed by RAEs, compared to 8,000 claims that were reimbursed FFS. When behavioral health providers bill the Department directly, the Department reimburses providers based on behavioral health service rates listed in the Colorado Medicaid Fee Schedule.

[33] States used in FFS behavioral health rate comparison analysis were Arizona, California, Nebraska, Oklahoma, Oregon, Wyoming, Idaho, Iowa, Louisiana, North Carolina, and Washington. For more details on FFS behavioral health rate comparisons, please see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for FFS behavioral health services averaged 11.06 in FY 2015-16 and decreased to 10.47 in FY 2016-17 and 10.02 in FY 2017-18. Additionally:

- In urban counties, utilizers per provider averaged 10.66 in FY 2015-16 and decreased to 10.26 in FY 2016-17 then decreased to 9.94 in FY 2017-18.
- In rural counties, utilizers per provider averaged 5.24 in FY 2015-16 and decreased to 4.94 in FY 2016-17 then decreased to 4.76 in FY 2017-18.
- In frontier counties, utilizers per provider averaged 1.78 in FY 2015-16 and increased to 1.90 in FY 2016-17 then decreased to 1.75 in FY 2017-18.

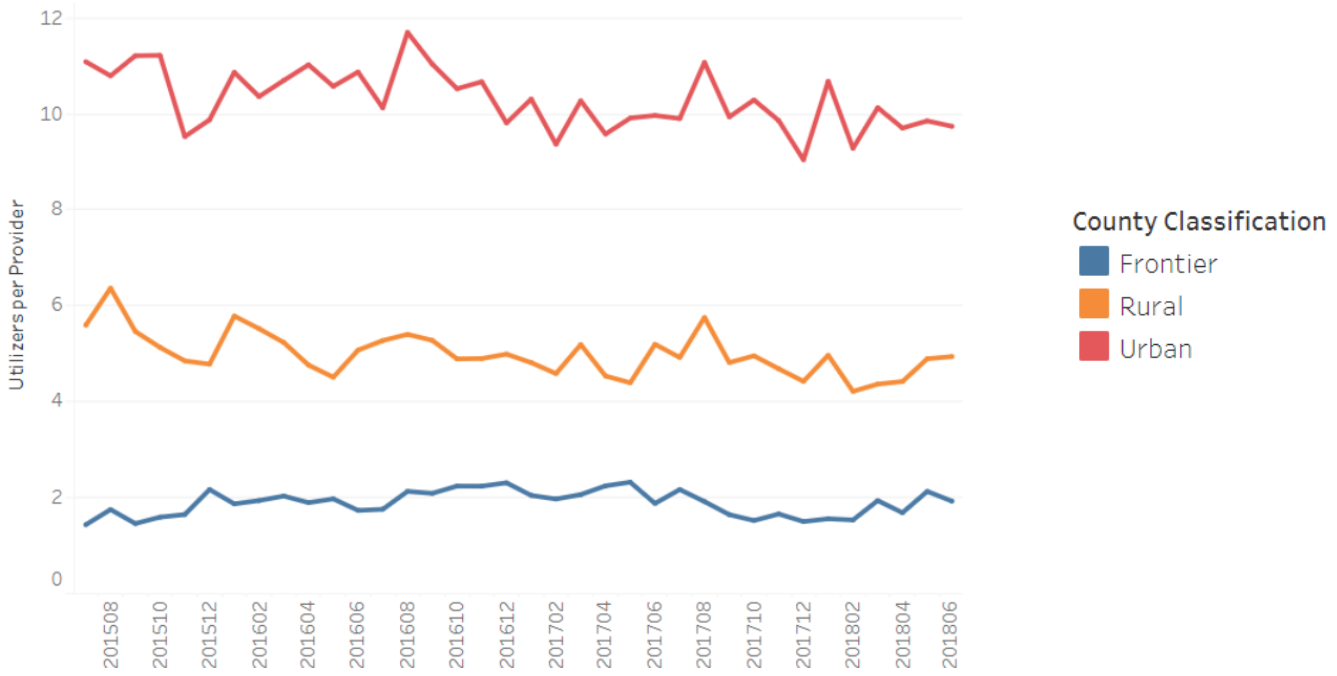


Figure 7. Utilizers per provider (panel size) for FFS behavioral health services between July 2015 and June 2018.

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time across all RAE county classifications. Distinct utilizers increased at a slower rate than active providers, which led to the decrease in the number of utilizers per provider.[34]

The increases in both the active providers and distinct utilizers in the urban counties may indicate improvements in access to care for FFS behavioral health services in these areas.

The increases in the active providers in the rural counties may indicate improvements in access to care for FFS behavioral health services in these areas.

[34] For data specific to distinct utilizers and active providers, please see Appendix C.

The relatively stable number of active providers and distinct utilizers in the frontier counties indicates no change in access to care for FFS behavioral health services in these areas.[35]

Utilizer Density

The utilizer density metric provides information regarding where utilizers of FFS behavioral health services reside throughout the state. Prowers County had the lowest number of utilizers at 31 and Arapahoe County had the highest number of utilizers at 14,313 in FY 2017-18.

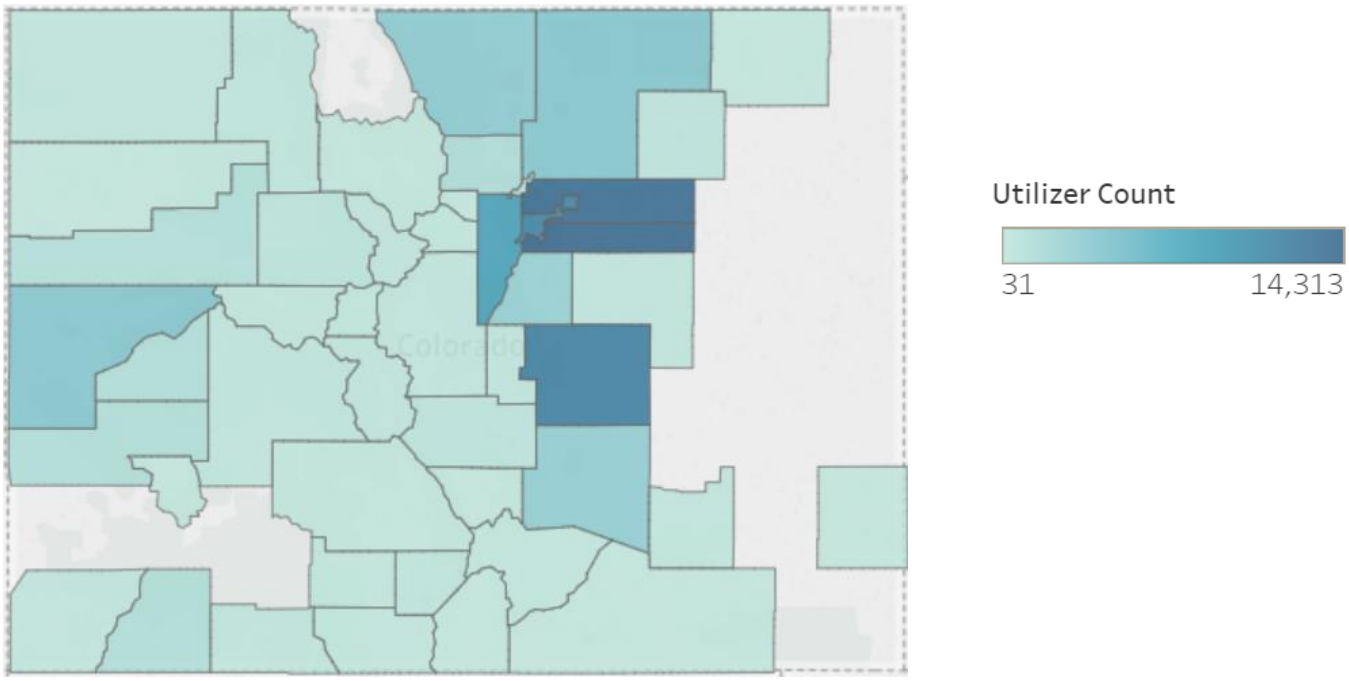


Figure 8. Utilizer density for FFS behavioral health services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for FFS behavioral health services, or a low number of Colorado Medicaid members utilizing FFS behavioral health services;
- utilizers primarily access behavioral health services, particularly adult populations, through the RAEs, which were not included in this analysis.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

[35] For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received FFS behavioral health services. Penetration rates for FFS behavioral health services in FY 2017-18 ranged from 0.54% in Prowers County to 11.61% in Mesa County. The penetration rate in Denver County was 6.02%.

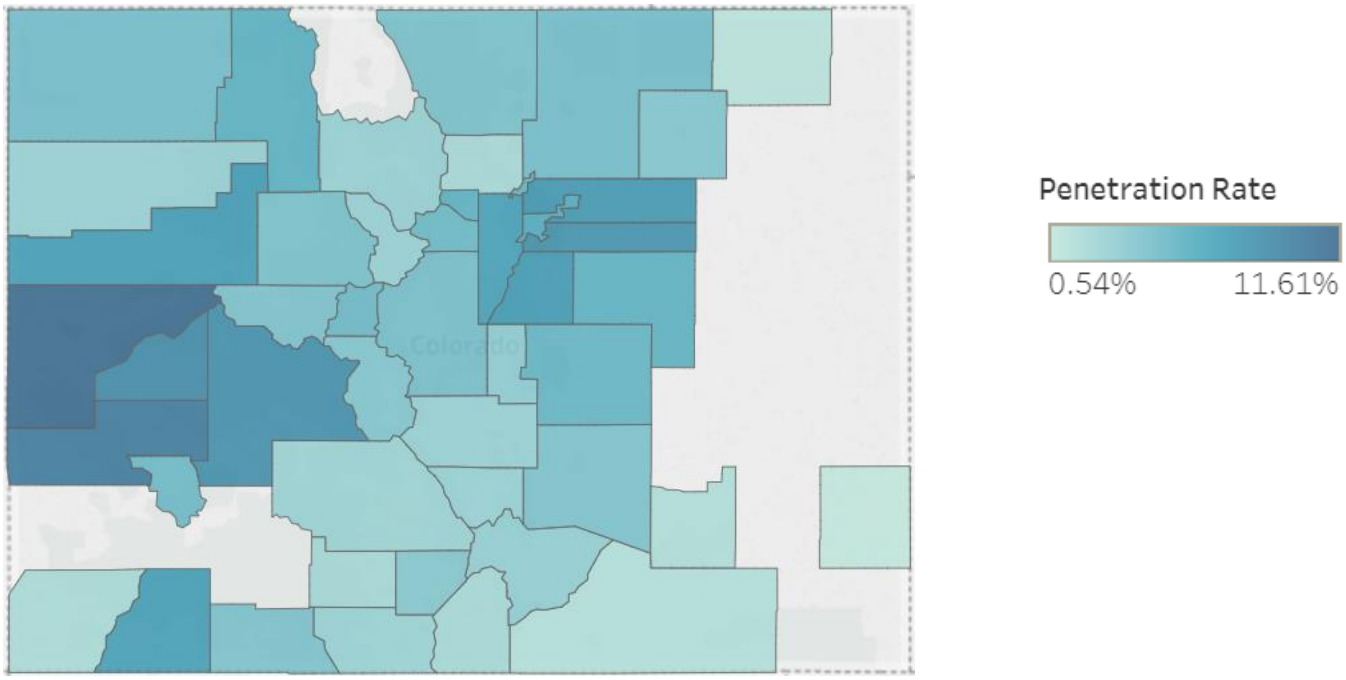


Figure 9. Penetration rates for FFS behavioral health services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving FFS behavioral health services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of FFS behavioral health service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

FFS Behavioral Health Member-to-Provider Ratios			
Region	**FY 2017-18 Providers**	**FY 2017-18 Members**	**Providers per 1,000 Members**
Frontier	307	41,742	7.35
Rural	599	162,003	3.70
Urban	2,097	1,217,439	1.72
Statewide	**2,245**	**1,408,747**	**1.59**

Table 9. Member-to-provider ratio for FFS behavioral health expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.[36]

[36] Currently, the Department does not use member-to-provider ratio standards specific to FFS behavioral health services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of FFS behavioral health services utilizers that live within certain drive time bands from where FFS behavioral health services have been provided.

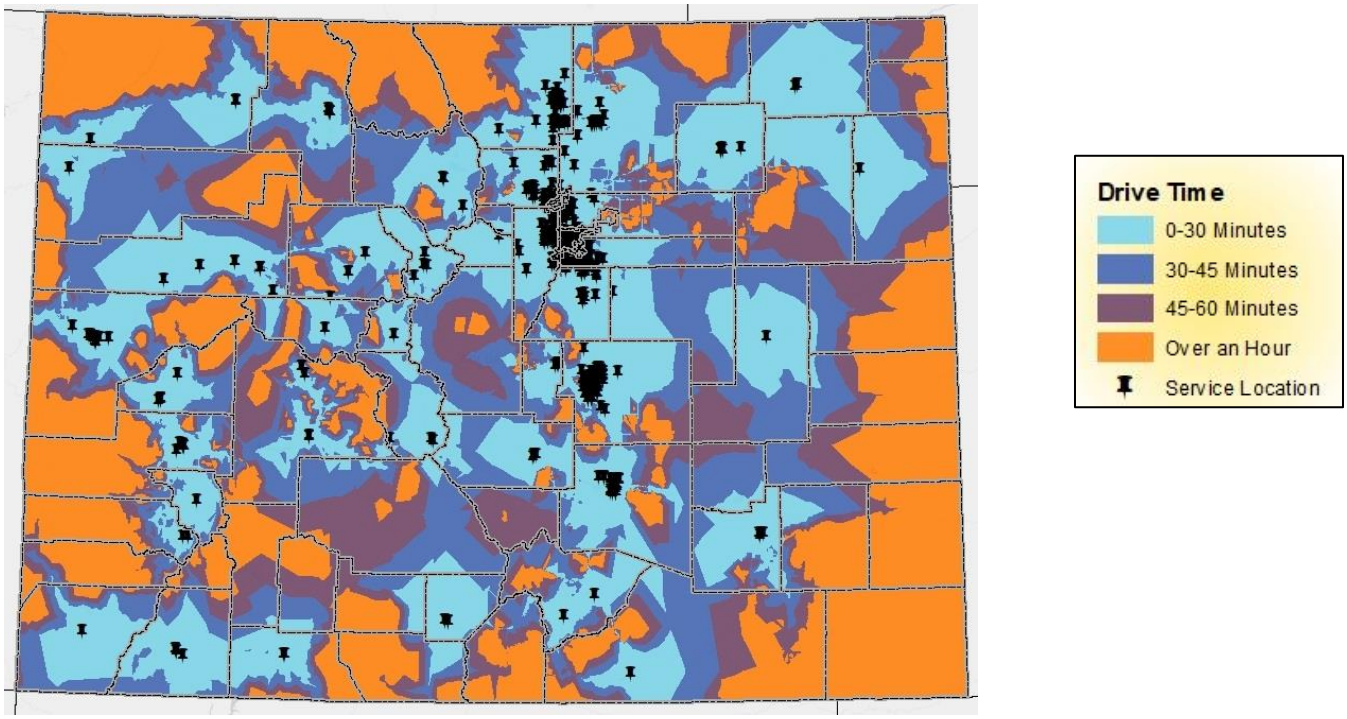


Figure 10. ArcGIS map of drive times for utilizers of FFS behavioral health services in FY 2017-18.

Overall, 96% of the total utilizers of FFS behavioral health services in FY 2017-18 needed to travel approximately 30 minutes or less to reach an FFS behavioral health provider. Additionally, 3% of the total utilizers needed to travel approximately 30-45 minutes; less than 1% of the total utilizers needed to travel approximately 45-60 minutes. Finally, less than 1% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered.

Stakeholder Feedback

The Department did not receive stakeholder feedback on FFS behavioral health services during the rate review process.

Additional Research

The Department plans to conduct additional research related to noted regional differences. The Department will also consider the utilization of other services across the continuum of care.

Conclusion

Analyses suggest that FFS behavioral health payments at 94.67% of the benchmark were sufficient to allow for member access and provider retention.

Residential Child Care Facilities

Service Description

Residential Child Care Facilities (RCCFs) provide residential treatment services for (primarily child welfare-involved) youth.[37, 38]

The RCCF service grouping is comprised of 16 procedure codes.

RCCF Statistics	
Total Adjusted Expenditures FY 2017-18	$6,868,228
Total Members Utilizing Services FY 2017-18	1,728
April-June 2018 Over April-June 2017 Change in Members Utilizing Services[39]	(11.57%)
Total Rendering Providers FY 2017-18	144
April-June 2018 Over April-June 2017 Change in Rendering Providers	6.67%

Table 10. RCCF services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for RCCFs are 68.56% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.[40]

RCCF Rate Benchmark Comparison		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$8,200,219	$11,960,022	**68.56%**

Table 11. Comparison of Colorado Medicaid RCCF service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be $7,759,803 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. All codes in this service grouping were compared to an average of 10 other states' Medicaid rates.[41, 42] RCCF individual rate ratios ranged from 47.00%-100.64%.

[37] These services are part of a child welfare services continuum; counties place members into an RCCF when other child welfare services (such as group home placement) are inadequate to meet the need. Room and board are funded by the counties. A defined list of services performed in the RCCFs, such as family psychotherapy, is reimbursed by Colorado Medicaid.
[38] RCCF services are not included in the RAE capitated behavioral health program.
[39] RCCF services were analyzed using claims data from April-June 2017 and April-June 2018.
[40] For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.
[41] States used in RCCF rate comparison analysis were Arizona, Wyoming, Idaho, Iowa, Oklahoma, Oregon, North Carolina, California, Louisiana, and Washington. For more details on RCCF rate comparisons, please see Appendix B.
[42] Medicare covers certain RCCF services for individuals under 65 years old who qualify for Medicare due to disability; however, because the population eligible for Medicare RCCF services is considerably different from the population eligible for Colorado Medicaid's RCCF services, the Department compared exclusively to other states' Medicaid rates.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

Statewide, utilizers per provider for RCCF services averaged 9.40 April-June 2017 and decreased to 8.13 April-June 2018. Additionally:

- For urban counties, utilizers per provider averaged 8.12 in April-June2017 and decreased to 6.88 in April-June 2018.
- For rural counties, utilizers per provider averaged 1.85 in April-June 2017 and decreased to 1.50 in April-June 2018.

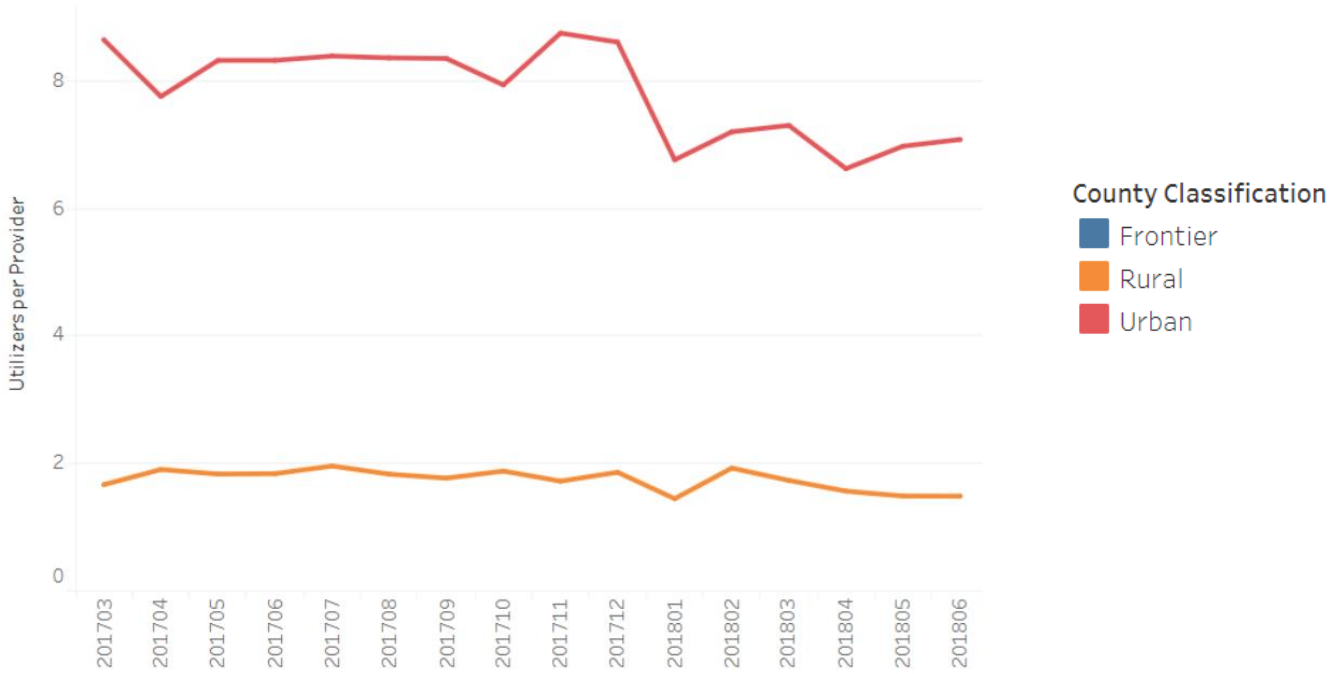


Figure 11. Utilizers per provider (panel size) for RCCF services between March 2017 and June 2018.[43]

Analysis indicates that there were increases in the number of active providers over this time. Distinct utilizers decreased at a faster rate than the increase in the number of active providers, which led to the decrease in the number of utilizers per provider.[44]

The decreases in distinct utilizers in the urban counties may indicate changes in access to care for RCCF services in these areas.

The increases in the active providers in the rural counties may indicate improvements in access to care for RCCF services in these areas.

[43] The Department is unable to show utilizers per provider information for frontier counties due to PHI.
[44] For data specific to distinct utilizers and active providers, please see Appendix C.

The Department is unable to show utilizers per provider information for frontier counties due to PHI. However, the Department intends to use the analysis internally to inform ongoing benefit and program management initiatives.[45]

Utilizer Density

The utilizer density metric provides information regarding where utilizers of RCCF services reside throughout the state. Boulder County had the lowest number of utilizers at 35 and Denver County had highest number of utilizers at 342 in FY 2017-18.

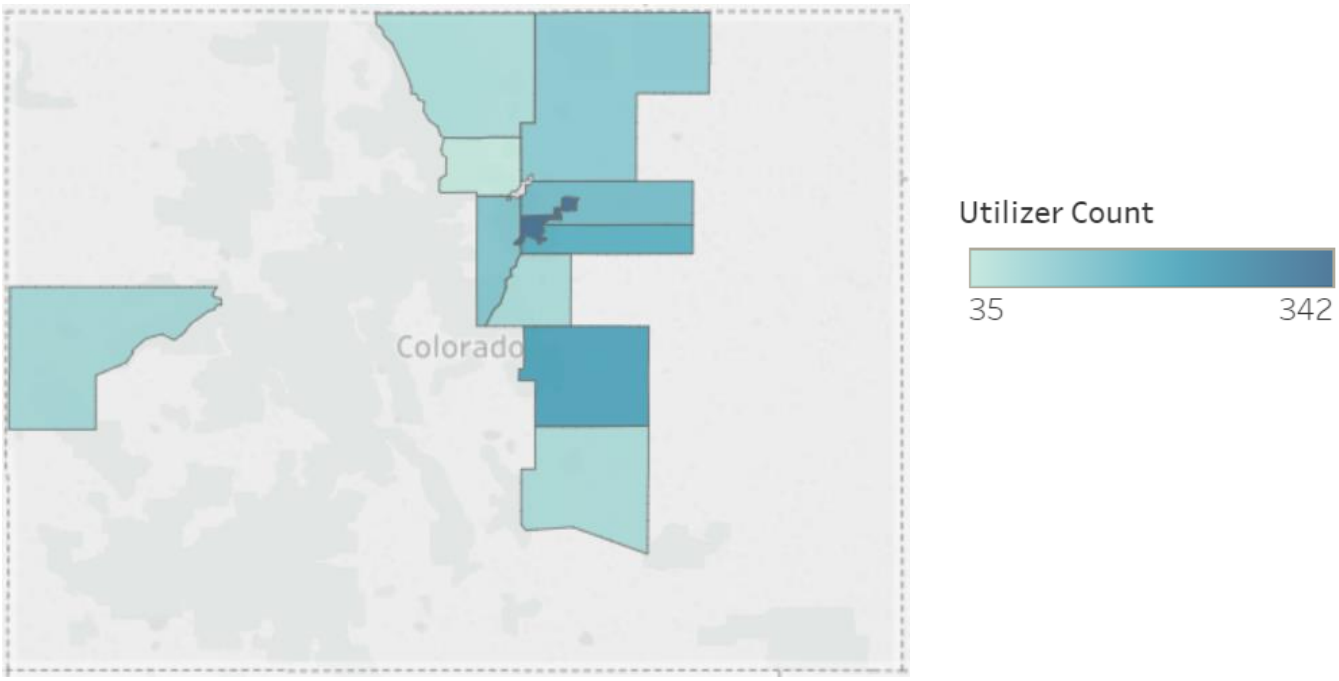


Figure 12. Utilizer Density for RCCF services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for RCCF services, or a low number of Colorado Medicaid members utilizing RCCF services;
- statewide initiatives that support keeping children in home-based settings when possible;
- Colorado Medicaid members receiving RCCF services tend to have a combination of high complexity and comorbid diagnoses that can make placement difficult.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

[45] For more information on which counties belong in each urban, rural, and frontier regions, please Figure 2. Colorado Counties and RAE County Classifications on page 11.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received the service. Penetration rates for RCCF services in FY 2017-18 ranged from 0.05% in Boulder County to 0.24% in Mesa County.

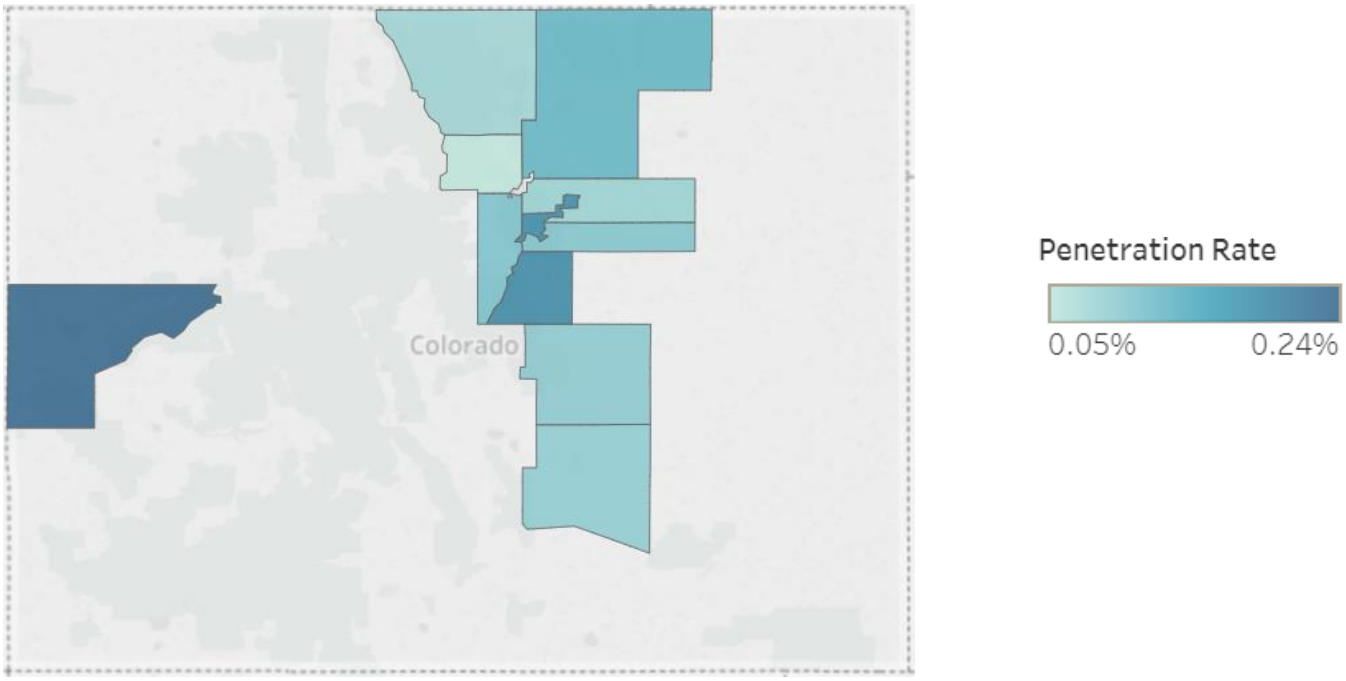


Figure 13. Penetration rates for RCCF services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving RCCF services.

Member-to-Provider Ratio

The member-to-provider ratio indicates the total number of RCCF service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

RCCF Member-to-Provider Ratios			
Region	**FY 2017-18 Providers**	**FY 2017-18 Members**	**Providers per 1,000 Members**
Frontier	67	41,742	1.61
Rural	102	162,003	0.63
Urban	144	1,217,439	0.12
Statewide	**144**	**1,408,747**	**0.10**

Table 12. Member-to-provider ratio for RCCF expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.[46]

Drive Times

There were no drive times calculated for the RCCF service grouping due to the residential nature of the services.

Stakeholder Feedback

During the March 29, 2019 MPRRAC meeting,[47] stakeholders provided comments regarding RCCF services and rates, which included:

- The number of youths placed in RCCFs has decreased significantly.
- In the last 10 years, over 23 residential programs closed. Out of 33 RCCF providers listed on the Colorado state vendor list published in July 2017, only 21 are still operating. Reduction of the number of residential treatment facilities is harmful and creates a barrier to receiving necessary treatment.
- Youth placed in out of home care require greater supervision, more treatment services, greater psychiatric oversight, and more medical services.
- Residential treatment providers reported that 2018 funding covered less than 78% of audited costs.
- Colorado is experiencing record low unemployment rates which makes it more difficult to be competitive in hiring, especially considering the 115% increase in Colorado's minimum wage from 2000 to 2019.[48]

Additional Research

The Department plans to conduct additional research of factors influencing access to RCCF services, regional differences, and stakeholder feedback. The Department will also consider the utilization of other services across the continuum of care, as well as state initiatives to decrease residential-based treatments and increase in-home and community-based services.

Conclusion

Analyses are inconclusive to determine if RCCF payments at 68.56% of the benchmark were sufficient to allow for member access and provider retention.

[46] Currently, the Department does not use member-to-provider ratio standards specific to RCCF services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist to determine whether the supply of providers is improving over time.
[47] March MPRRAC meeting materials can be accessed on the Department website.
[48] This information was provided by the Colorado Association of Family and Children's Agencies.

Psychiatric Residential Treatment Facilities

Service Description

A Psychiatric Residential Treatment Facility (PRTF) is an inpatient psychiatric facility for Colorado Medicaid members under the age of 21 who need intensive psychiatric care in a residential setting.

The PRTF service grouping is comprised of 1 revenue code. The PRTF revenue code is a per-diem facility payment that includes all physical and behavioral health care, as well as 24-hour maintenance care, including room and board.[49] PRTF services also include 24-hour nursing care and awake staff onsite.

The PRTF service grouping has a low number of utilizers, which restricts the Department's ability to show utilization data due to PHI.[50] The Department conducted a rate comparison analysis using the Colorado Medicaid per diem PRTF rate compared to other states' rates that reflect the same services.

PRTF Statistics	
Total Adjusted Expenditures FY 2017-18	$96,372
Total Rendering Providers FY 2017-18	1
FY 2018 Over FY 2017 Change in Rendering Providers	0.00%

Table 13. PRTF total expenditure and rendering provider data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for PRTFs are 114.36% of the benchmark.[51] A summary of the estimated total expenditures resulting from using comparable sources is presented below.

PRTF Rate Comparison Analysis					
State	**Rate**	**Revenue Code**	**Procedure Code**	**Unit Value**	**Service**
Colorado	$402.21	911	--	Per Diem	Psychiatric/Psychological Rehabilitation
Montana	$327.48	124	--	Per Diem	In-State PRTF
Nebraska	$337.20	--	T2033	Per Diem	PRTF – Specialty
Nebraska	$316.93	--	T2048	Per Diem	PRTF – Community Based Non-Specialty
Mississippi[52]	$425.26	--	--	Per Diem	PRTF Treatment Facility Rates

Table 14. Comparison of Colorado Medicaid PRTF service payments to those of other states' Medicaid rates (based on the most recent available public information).

[49] The county placing the member into the PRTF pays 20% of the per diem rate, which covers the cost of room and board. The county's payment is paid at the beginning of the year with forecasted data estimating the utilization of PRTF services.
[50] The Department blinds PHI data if services are utilized by less than 31 individuals to protect Colorado Medicaid members' identities.
[51] The benchmark for the PRTF service grouping was calculated using the average rate of all other states' rates.
[52] The Mississippi rate is an average of all statewide facility rates.

PRTF Rate Benchmark Comparison		
Colorado Per Diem Rate	Comparison Repriced	**Rate Benchmark Comparison**
$402.21	$351.72	**114.36%**

Table 15. Comparison of Colorado Medicaid PRTF service payments to those of other payers, expressed as a percentage (FY 2018).

Access to Care Analysis

The Department cannot perform an access to care analysis for PRTFs due to PHI.

Stakeholder Feedback

During the MPRRAC meeting on March 29, 2019, the sole rendering PRTF provider shared that the PRTF per diem rate barely covers operational costs for the facility.[53]

Additional Research

The Department identified several factors that could be contributing to low utilization of PRTF services. These factors include, but are not limited to:

- licensing rules that require RCCF facilities be on a different site than PRTFs;
- the prospective payment model requiring counties to pay 20% of the per diem rate to cover room and board at the beginning of each year;[54]
- RCCF services have evolved to meet the need for higher levels of care that were originally only provided at PRTFs; and
- PRTF per diem rate has only received across the board (ATB) increases since it was actuarially set.[55]

The Department plans to conduct additional research of factors influencing access to PRTF services, as well as payment models, county practices, and stakeholder feedback. The Department will also consider the utilization of other services across the continuum of care.

Conclusions

Analyses were inconclusive to determine if PRTF payments at 114.36% of the benchmark were sufficient to allow for member access and provider retention.

[53] For more information on comments provided during the March MPRRAC meeting, please see the Department website.
[54] Because payments are prospective, counties may pay more funds than are realized throughout the year, yet counties do not receive reimbursement if funding is unused.
[55] The PRTF per diem rate was actuarially set in FY 2014-15 at $390.77; across the board increases occurred on a yearly basis, resulting in the current rate at $402.21, set in FY 2018-19. For more information, please see the PRTF Fee Schedule.

Special Connections Program Services

Service Description

Special Connections is a program for pregnant women enrolled in Colorado Medicaid who have alcohol and/or drug abuse or dependence issues. Special Connections helps women have healthier pregnancies and healthier babies by providing case management, individual and group counseling, and health education during pregnancy and up to one year after delivery.[56] Special Connections services are in addition to the prenatal care a woman receives from her doctor or nurse-midwife.

Services can be outpatient or residential depending on a woman's level of risk. Services include:

- Case management
- Group health education with other pregnant women
- Group substance abuse counseling with other pregnant women
- In-depth risk screening
- Individual substance abuse counseling
- Referral to appropriate aftercare and ongoing support
- Urine screening and monitoring

The Department shares Special Connections program administration with the Office of Behavioral Health (OBH) within the Colorado Department of Human Services (CDHS). The Department is responsible for payment of medical services, maintaining federal authority to receive Federal Financial Participation, resolving claims and other system payment issues, and program implementation via RAEs, which have a robust behavioral health benefit.[57]

The Department does not currently have claims data from the Special Connections Program.[58] The lack of claims data impacted the utilizer and provider statistics, rate comparison analysis, and access to care analysis.

According to OBH data, 277 women were admitted to the program January 2017-November 2018.[59]

Special Connections Utilization History					
Fiscal Year	**Total Women Served**	**Cost per Member Overall**	**Cost per Member – Residential Services**	**Average Cost per Member – Outpatient Services**	**Percent of Average Cost per Member to Residential Cost**
FY 2014-15	212	$4,507.15	$8,745.77	$185.56	94.28%
FY 2015-16	159	$4,798.83	$8,097.26	$160.33	96.57%

Table 16. Special Connections utilization history and average costs per member.

There are currently ten providers servicing the Special Connections Program, two of which were recruited in FY 2017-18, which is a 20% year-over-year increase in providers from FY 2016-2017 to FY 2017-2018.[60] Each provider

[56] Women can only receive services up to one year postpartum if they were enrolled prenatally.
[57] OBH is responsible for payment of room and board. Please see the Slide 9 in the March MPRRAC Presentation for more information.
[58] The implementation of a new claims payment system and the associated rule change to include a new, isolated provider type interfered with claims data submission. The Department is working to retroactively input utilization data to use in future analyses.
[59] Data was provided by OBH; the Department does not have access to utilization data for FY 2016-17 at this time.
[60] For a list of current Special Connections providers, please see the list posted on the Department website.

is allowed 16 beds for members receiving residential services; there are currently 56 beds available across the state.[61]

Special Connections service utilization can be broken down into the following three groups:

- Intensive Residential Services – serves approximately 71% of Special Connections utilizers.
- Outpatient Services – serves 18% of Special Connections utilizers.
- Therapeutic Community – serves approximately 11% of Special Connections utilizers.

The Special Connections service grouping is comprised of five procedure codes, including H0004, H1000, H1002, H1003, and H2036, all of which have the HD modifier.[62]

Rate Comparison Analysis

Colorado Medicaid reimburses for five procedure codes.[63] A summary of the reimbursement rate and estimated benchmarks for each code resulting from using comparable sources is presented below.

Special Connections Rate Comparison							
Code	**Colorado Modifiers**	**Colorado Rate**	**Number of Comparison Rates Identified**	**Lowest Other State Rate**	**Highest Other State Rate**	**Other State Average**	**Colorado as a Percent of Other State Average**
H0004	HD	$14.04	30	$3.19	$128.96	$28.31	**49.59%**
H0004[64]	HD, HQ	$7.50	30	$3.19	$128.96	$28.31	**26.51%**
H1000	HD	$105.39	5	$8.41	$40.00	$16.71	**630.72%**
H1002	HD	$8.79	1	$48.79	$48.79	$48.79	**18.01%**
H1003	HD	$3.62	2	$35.00	$38.92	$36.96	**9.78%**
H2036	HD	$192.10	6	$117.11	$224.87	$167.72	**114.54%**

Table 17. Colorado Medicaid Special Connections rate comparison to other states' Medicaid rates.

Special Connections individual rate ratios ranged from 9.78%-630.72% of the other states' Medicaid rates averages.

Access to Care Analysis

The Department cannot perform an access to care analysis for Special Connections program services due to lack of available claims data for analysis.

[61] Beds are reserved for women based on level of risk; beds are also reserved for any dependent children that accompany the mother during treatment.
[62] H0004 has two rates, one for individual therapy (HD modifier), and one for group therapy (HD and HQ modifiers).
[63] These codes are also used for SUD services, so it is important to note that when used for Special Connections, they are modified with the HD modifier for Colorado Medicaid. Please see Appendix C for a description of each code.
[64] Other states did not tend to use the same modifiers as Colorado, so the Department applied the same comparison rate for H0004-HD and H0004-HQ.

Stakeholder Feedback

The Department received feedback from stakeholders regarding the Special Connections program, both through the rate review process and through other feedback channels.[65]

Stakeholder feedback the Department received prior to the MPRRAC meeting on March 29, 2019 included:

- There are access issues due to the restrictions on program eligibility[66] and difficulties providing residential services for pregnant women with dependent children.[67]
- The current Special Connections service rates are too low for program sustainability; the program requires providers with specialized qualifications and federal regulations limit institutes of mental disease to 16 beds.
- The reimbursement rate for outpatient SUD services negotiated through the RAEs is higher than the rate for similar outpatient services through the Special Connections program.

Stakeholder comment during the March 29, 2019 MPRRAC meeting included:

- The 56 beds available for Special Connections members are not solely allocated for women receiving Special Connections services, but also for pregnant women and parents who are not enrolled in the Medicaid program. As a result, the payer and a woman's situation (e.g., pregnant, with children) may be a consideration for providers accepting patients.
- There is currently an eight to twelve week waiting period for women who are placed on the wait list for Special Connections services. This equates to an entire trimester for pregnant women who are seeking substance abuse treatment. The long wait for treatment creates additional risks to both the woman and her child.
- The state is paying for the consequences of not treating these women and their families through the child welfare system and the criminal justice system, as well as other healthcare costs that arise from not receiving the care they need prenatally.
- The cost of treatment can range from $392 to $417 per day, but the current rate for Special Connections services is set at $192 per day. This low rate is prohibiting providers from entering the program, delivering the services, continuing to deliver the services, and ultimately pushes providers to serve other populations that reimburse at higher rates for the same or similar services.
- The operational challenges for these programs and the treatments provided by these programs tend to be complex in nature. Accommodating the family unit within a treatment setting is one example and can be associated with longer clinical hours, higher levels of staff specialty, and higher costs for treatment in general.
- Childcare costs are not included in Colorado Medicaid Special Connections rates.

Additional Research

OBH provided the Department with Special Connections Program utilization data they collected since FY 2014-15, as well as qualitative survey data regarding other states' Medicaid rates for similar services to the same population. This data helped the Department analyze the Special Connections rate comparison data and informed access to care considerations for the Special Connections program.

[65] Department subject matter experts (SMEs) shared additional feedback they received from various stakeholders prior to the March 29, 2019 MPRRAC meeting.
[66] Mothers must enroll prenatally to access post-partum services offered up to a year after giving birth.
[67] Mothers who have other dependent children require more resources in residential settings.

The Department, in partnership with OBH, plans to conduct additional research of factors influencing access to Special Connections services, including, but not limited to rates, program admission requirements, and waitlists. The Department will also evaluate stakeholder feedback and additional claims data as it becomes available. The Department will also consider the utilization of other services across the continuum of care.

Conclusion

Analyses are inconclusive to determine if Special Connections payments ranging from 9.78%-630.72% were sufficient to allow for member access and provider retention.

Dialysis and End-Stage Renal Disease Services

Service Description

The Dialysis and End-Stage Renal Disease (ESRD) service grouping is comprised of six facility revenue codes, including 821, 829, 841, 851, 881, 829; and five professional procedure codes, including 90937, 90989, 90993, 90963, 90966.

Dialysis and ESRD Statistics	
Total Adjusted Expenditures FY 2017-18 – Facility	$8,688,691
Total Adjusted Expenditures FY 2017-18 – Professional	$58,931
Total Members Utilizing Services FY 2017-18	572
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	13.72%
Total Rendering Providers FY 2017-18[68]	88
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	1.15%

Table 18. Dialysis and ESRD services expenditure and utilization data.

Rate Comparison Analysis

On average, Colorado Medicaid payments for dialysis and ESRD facility services are 83.26% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below for dialysis and ESRD facility rates.[69]

Dialysis and ESRD Rate Benchmark Comparison – Facility Rates			
Wage Index Region	**Colorado Repriced**	**Comparison Repriced**	**Rate Benchmark Comparison**
Boulder, CO	$397,734	$524,341,423	73.46%
Colorado Springs, CO	$733,096	$856,550	85.59%
Denver, Aurora, Lakewood	$5,919,790	$7,071,629	83.71%
Fort Collins, CO	$225,671	$294,733	76.57%
Grand Junction, CO	$68,938	$93,750	73.53%
Greeley, CO	$443,701	$565,291	78.49%
Pueblo, CO	$374,839	$416,414	90.02%
Rural Colorado	$609,871	$697,243	87.47%
All Colorado	**$8,773,641**	**$10,537,036**	**83.26%**

Table 19. Comparison of Colorado Medicaid dialysis and ESRD facility service payments, broken down by Wage Index Region, to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be $1,763,395 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. All the codes in the dialysis and ESRD facility service grouping

[68] Dialysis facilities provider counts were calculated using billing provider IDs.

[69] For this service grouping, detailed information regarding the rate comparison analysis methodology is contained in Appendix B.

were compared to adjusted Medicare rates. Dialysis and ESRD regional facility rate ratios ranged from 73.46%-90.02%.

On average, Colorado Medicaid payments for dialysis and ESRD professional services are 77.01% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below for dialysis and ESRD professional rates.

Dialysis and ESRD Rate Benchmark Comparison – Professional Rates		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$59,507	$77,269	**77.01%**

Table 20. Comparison of Colorado Medicaid dialysis and ESRD professional service payments to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be $17,762 in total funds if Colorado reimbursed at 100% of the combined benchmark in FY 2017-18. Of the five procedure codes analyzed in the dialysis and ESRD professional service grouping, three procedure code rates were compared to Medicare rates, one procedure code rate was compared to an average of seven other states' Medicaid rates,[70] while one procedure code had no comparable rate. Individual dialysis and ESRD professional service rate ratios ranged from 68.36%-109.35%.[71]

[70] States used in the dialysis and ESRD professional rate comparison analysis were Arizona, Nebraska, Oklahoma, Oregon, Wyoming, California, and Idaho. For more details regarding the dialysis and ESRD rate comparison analysis, please see Appendix B.

[71] The dialysis and ESRD facility and professional payments together come to 83.22% of the benchmark.

Access to Care Analysis

Utilizers per Provider (Panel Size) Summary

In urban counties, utilizers per provider for dialysis and ESRD services were 3.17 in FY 2015-16 and increased to 3.70 in FY 2016-17 and to 4.16 in FY 2017-18.

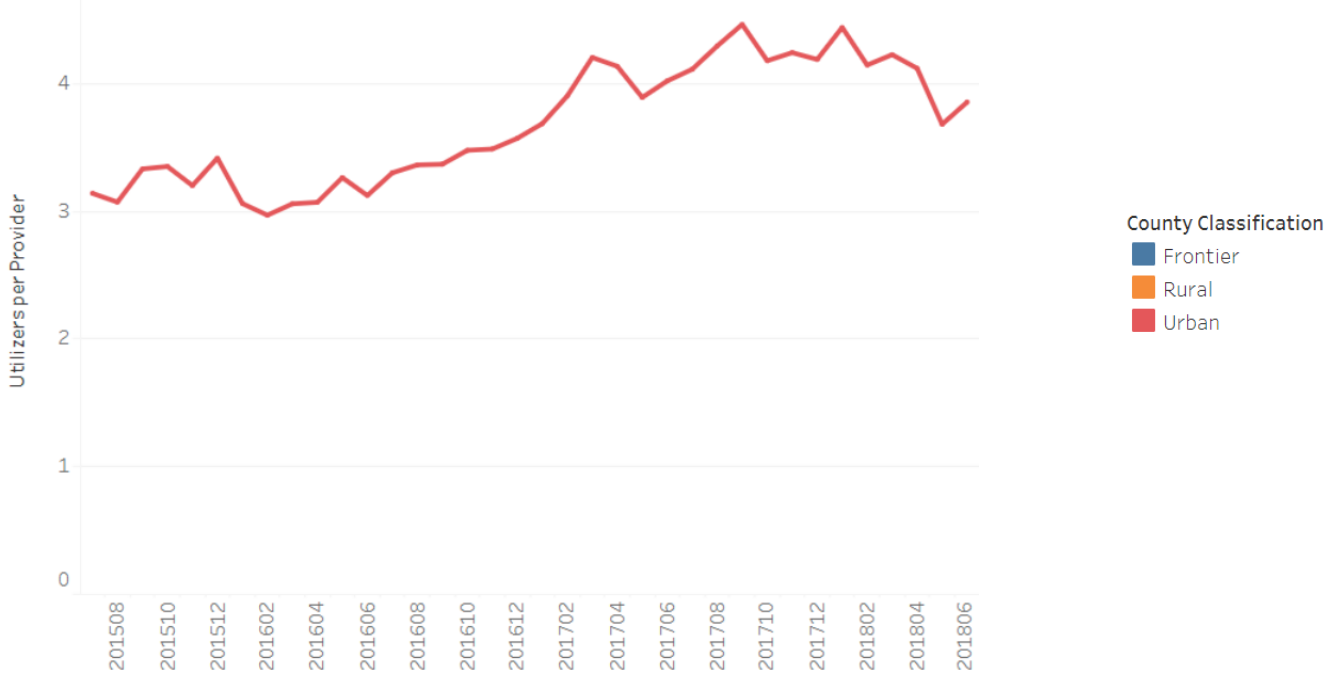


Figure 14. Utilizers per provider (panel size) for dialysis and ESRD services between July 2015 and June 2018.

Analysis indicates that there were increases in both the number of distinct utilizers and the number of active providers over this time. Distinct utilizers increased at a higher rate which led to the increase in the number of utilizers per provider.[72]

The increases in both active providers and distinct utilizers in the urban counties may indicate improvements in access to care for dialysis services in these areas.

The Department is unable to show utilizers per provider information for rural and frontier counties due to PHI. However, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.[73]

[72] For data specific to distinct utilizers and active providers, please see Appendix C.

[73] For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of dialysis services reside throughout the state. In FY 2017-18, Weld County had the lowest number of utilizers at 42 and Denver County had the highest number of utilizers at 123.

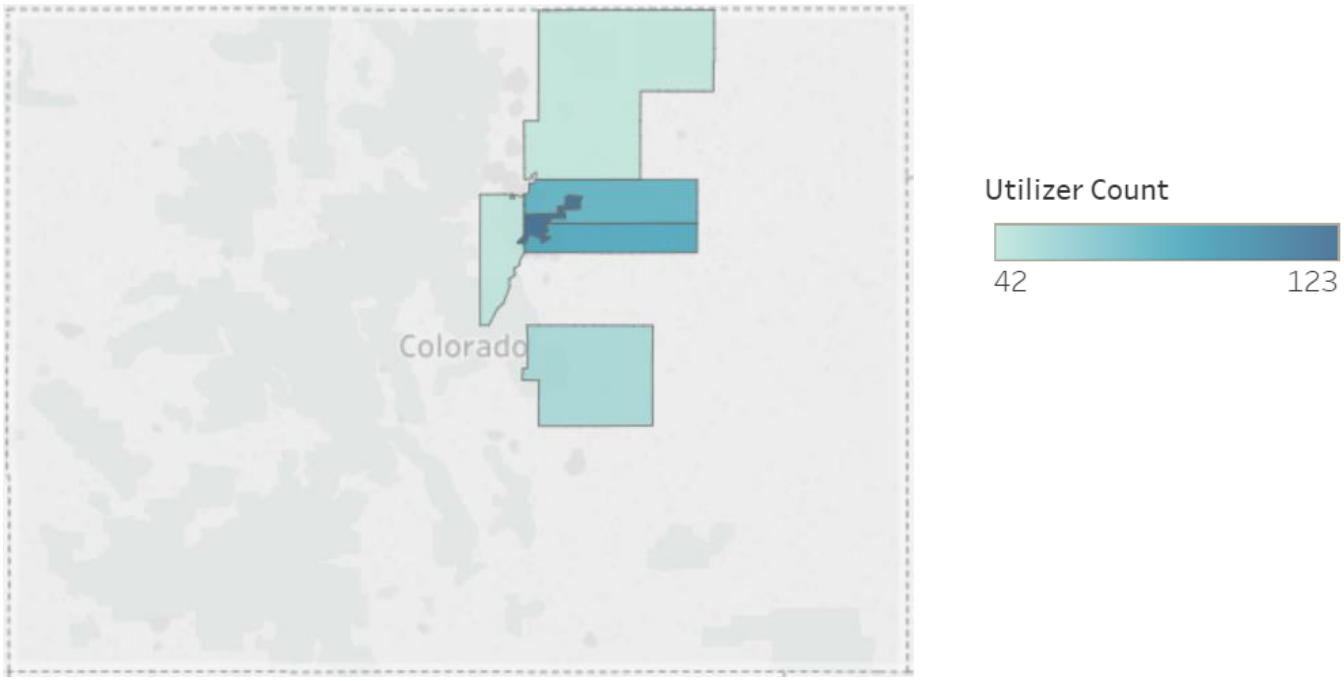


Figure 15. Utilizer density for dialysis and ESRD services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for dialysis services, or a low number of Colorado Medicaid members with ESRD and/or acute kidney failure;
- accessing services in other settings not included in this analysis.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received dialysis or ESRD services. Penetration rates in FY 2017-18 ranged from 0.02% in El Paso County to 0.07% in Denver County.

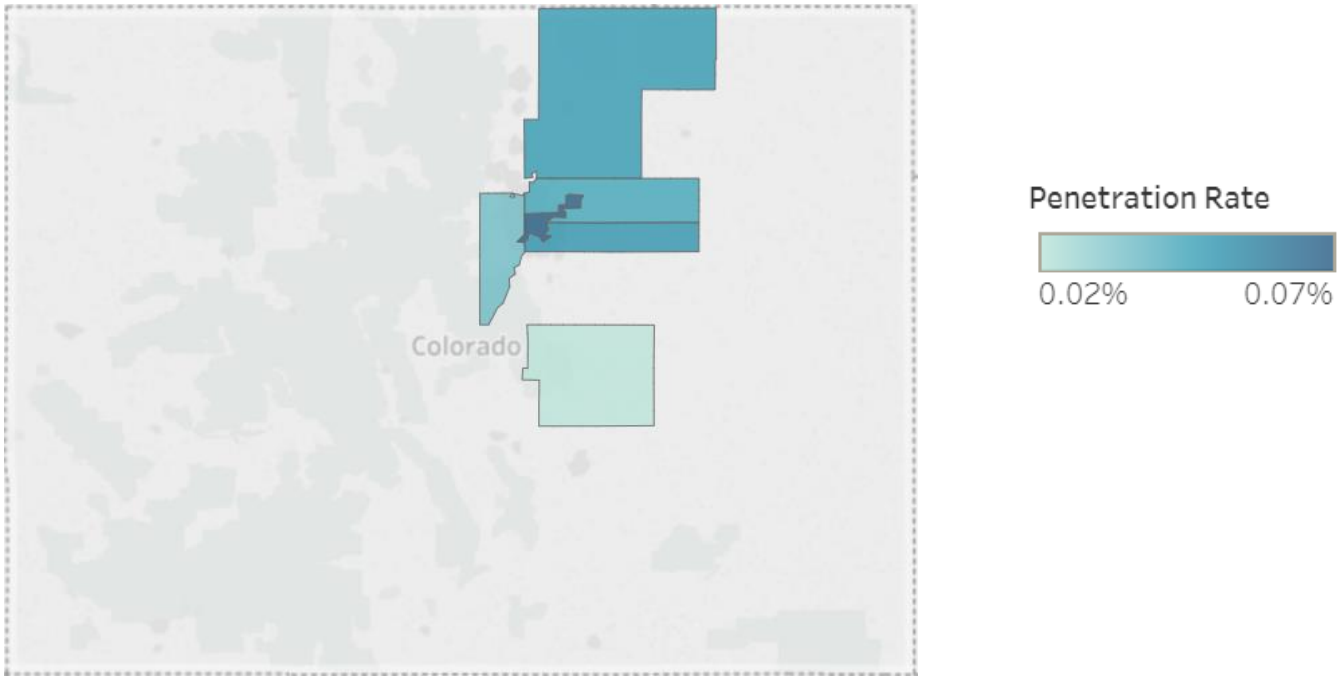


Figure 16. Penetration rates for dialysis and ESRD services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving dialysis services.

Member-to-Provider Ratios

The member-to-provider ratio indicates the total number of dialysis and ESRD service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

Dialysis and ESRD Member-to-Provider Ratios			
Region	**FY 2017-18 Providers**	**FY 2017-18 Members**	**Providers per 1,000 Members**
Frontier	10	41,742	0.24
Rural	23	162,003	0.14
Urban	80	1,217,439	0.07
Statewide	**88**	**1,408,747**	**0.06**

Table 21. Member-to-provider ratio for dialysis and ESRD expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.[74]

[74] Currently, the Department does not use member-to-provider ratio standards specific to dialysis and ESRD services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of dialysis and ESRD services utilizers that live within certain drive time bands from where dialysis and ESRD services have been provided.

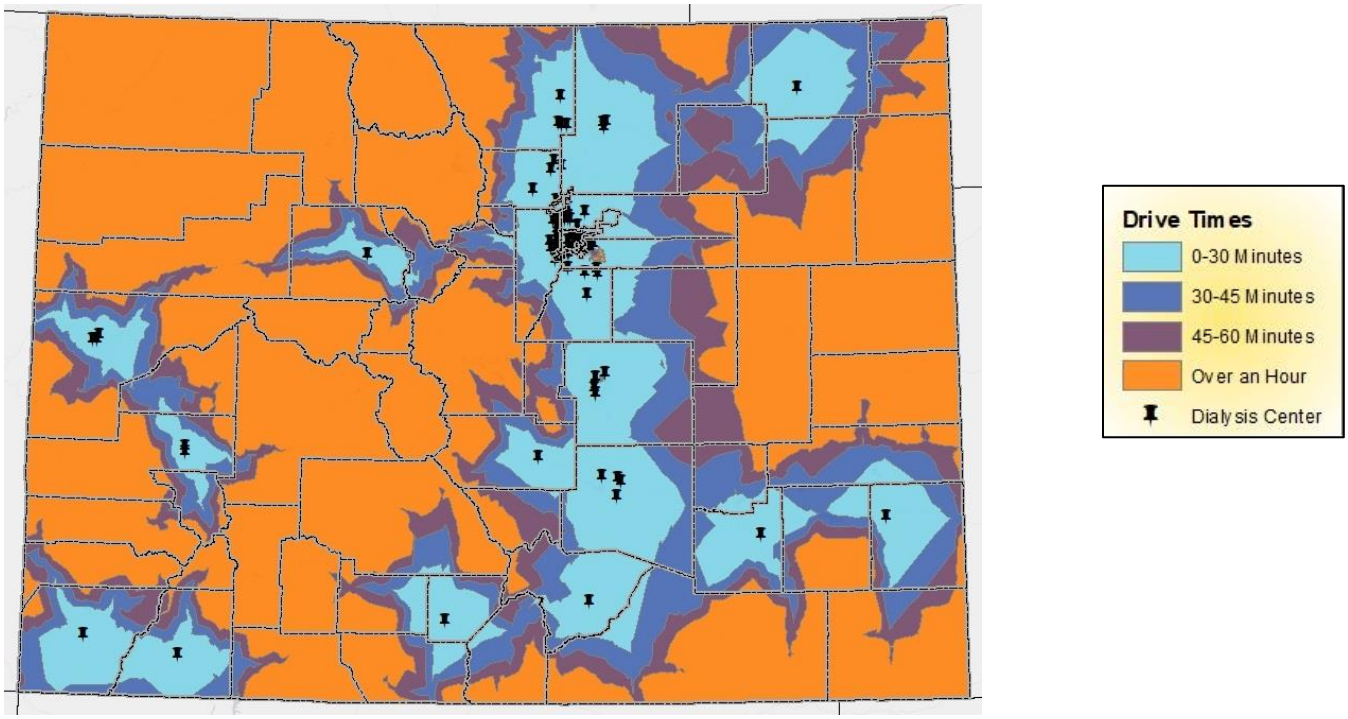


Figure 17. ArcGIS map of drive times for utilizers of dialysis and ESRD services in FY 2017-18.

Overall, 89% of the total utilizers of dialysis and ESRD services in FY 2017-18 needed to travel approximately 30 minutes or less to reach a location where one of these services had been provided. Additionally, 4% of the total utilizers needed to travel approximately 30-45 minutes; 4% of the total utilizers needed to travel approximately 45-60 minutes. Finally, 3% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered.

Stakeholder Feedback

The Department did not receive stakeholder feedback on dialysis and ESRD services.

Additional Research

The Department plans to conduct additional research related to noted regional differences.

Conclusion

Analyses suggest that dialysis and ESRD payments at 83.22% of the benchmark were sufficient to allow for member access and provider retention.[75]

[75] The dialysis and ESRD facility payments were at 83.26% of the benchmark and dialysis and ESRD professional payments were at 77.01% of the benchmark; facility and professional payments together come to 83.22% of the benchmark.

Durable Medical Equipment

Service Description

The durable medical equipment (DME) service grouping is comprised of 729 procedure codes.[76]

DME Statistics	
Total Adjusted Expenditures FY 2017-18	$56,415,187
Total Members Utilizing Services FY 2017-18	42,579
FY 2017-18 Over FY 2016-17 Change in Members Utilizing Services	0.75%
Total Rendering Providers FY 2017-18	217
FY 2017-18 Over FY 2016-17 Change in Rendering Providers	(8.82%)

Table 22. DME services expenditure and utilization data.

The Consolidated Appropriations Act of 2016 requires Colorado Medicaid to reimburse certain DME codes at no greater than 100% of the Medicare rate if those codes were covered by both Medicare and Medicaid in the previous fiscal year.[77,78] In calendar year (CY) 2018, 244 DME codes were subject to this Upper Payment Limit (UPL), 137 of which are included in the Year Four rate review.[79]

Because certain DME rates under review are subject to UPL limits, while others are not, the Department used three different comparison sources to analyze DME rates:[80]

- UPL codes were compared to Medicare rates.[81]
- Non-UPL codes with a Medicare comparator were compared to Medicare rates.
- Non-UPL codes without a Medicare comparator were compared to Medicaid rates in six other states.[82]

The following Rate Comparison and Access Analysis sections contain separate findings for UPL and non-UPL DME.

[76] Only DME codes that start with the letters A, E, and K are under review in Year Four of the rate review process; orthotics, prosthetics, and disposable supplies will be reviewed in Year Five of the rate review process. Not all codes had a comparator rate, and thus were not included in this analysis.
[77] DME codes that start with the letters A, E, and K are subject to this limit; orthotics, prosthetics, and disposable supply codes are not.
[78] For more information about the Upper Payment Limit (UPL) implementation for DME rates, please refer to this provider communication on the Department's website.
[79] The original effective date was January 2019; however, CMS passed the 21st Century Cures Act, changing the effective date to January 2018.
[80] For more information regarding the methodology used to conduct the DME rate comparison analysis, see Appendix B.
[81] For a list of DME UPL codes, please see the DME UPL fee schedule on the Department website.
[82] States used in the DME rate comparison analysis were Arizona, California, Nebraska, Oklahoma, Oregon, and Wyoming.

Rate Comparison Analysis

DME Subject to UPL

Colorado Medicaid payments for DME subject to the UPL are 100% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DME Rate Benchmark Comparison – UPL		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$39,450,727	$39,450,727	**100.00%**[83]

Table 23. Comparison of Colorado Medicaid DME payments (subject to UPL) to those of other payers, expressed as a percentage (FY 2017-18).

Of the 458 procedure codes analyzed in this service grouping, 137 procedure code rates were compared to Medicare rates.[84]

DME Not Subject to UPL

On average, Colorado Medicaid payments for DME not subject to the UPL are 104.83% of the benchmark. A summary of the estimated total expenditures resulting from using comparable sources is presented below.

DME Rate Benchmark Comparison – Non-UPL		
Colorado Repriced	Comparison Repriced	**Rate Benchmark Comparison**
$7,585,351	$7,235,407	**104.84%**[85]

Table 24. Comparison of Colorado Medicaid DME payments (not subject to UPL) to those of other payers, expressed as a percentage (FY 2017-18).

The estimated fiscal impact to Colorado Medicaid would be a savings of $349,944 in total funds if Colorado had reimbursed at 100% of the combined benchmark in FY 2017-18. Of the 458 procedure codes analyzed in this service grouping, 182 procedure code rates were compared to Medicare rates, while 139 procedure code rates were compared to an average of six other states' Medicaid rates. Individual DME service rate ratios ranged from 3.9%-1,478%.[86]

[83] These codes are subject to the UPL, and thus are set at 100% of Medicare rates.

[84] All procedure codes had a comparable rate because all DME codes subject to UPL were paid by both Medicaid and Medicare.

[85] Colorado Medicaid payments for DME not subject to the UPL are 115.50% of Medicare rates and 99.29% of other states' Medicaid rates. Please see Appendix C for more details regarding the rate benchmark comparison for DME not subject to the UPL.

[86] For details on individual service rate ratios, please see Appendix B.

Access to Care Analysis

Utilizers per Provider (Panel Size)

Statewide, utilizers per provider for DME services averaged 84.23 in FY 2015-16 and increased to 90.84 in FY 2016-17 and increased to 95.16 in FY 2017-18. Additionally:

- In urban counties, utilizers per provider averaged 71.53 in FY 2015-16 and increased to 77.71 in FY 2016-17 then increased to 81.71 in FY 2017-18.
- In rural counties, utilizers per provider averaged 19.11 in FY 2015-16 and increased to 19.57 in FY 2016-17 then increased to 20.16 in FY 2017-18.
- In frontier counties, utilizers per provider averaged 7.48 in FY 2015-16 and increased to 8.27 in FY 2016-17 then increased to 9.10 in FY 2017-18.

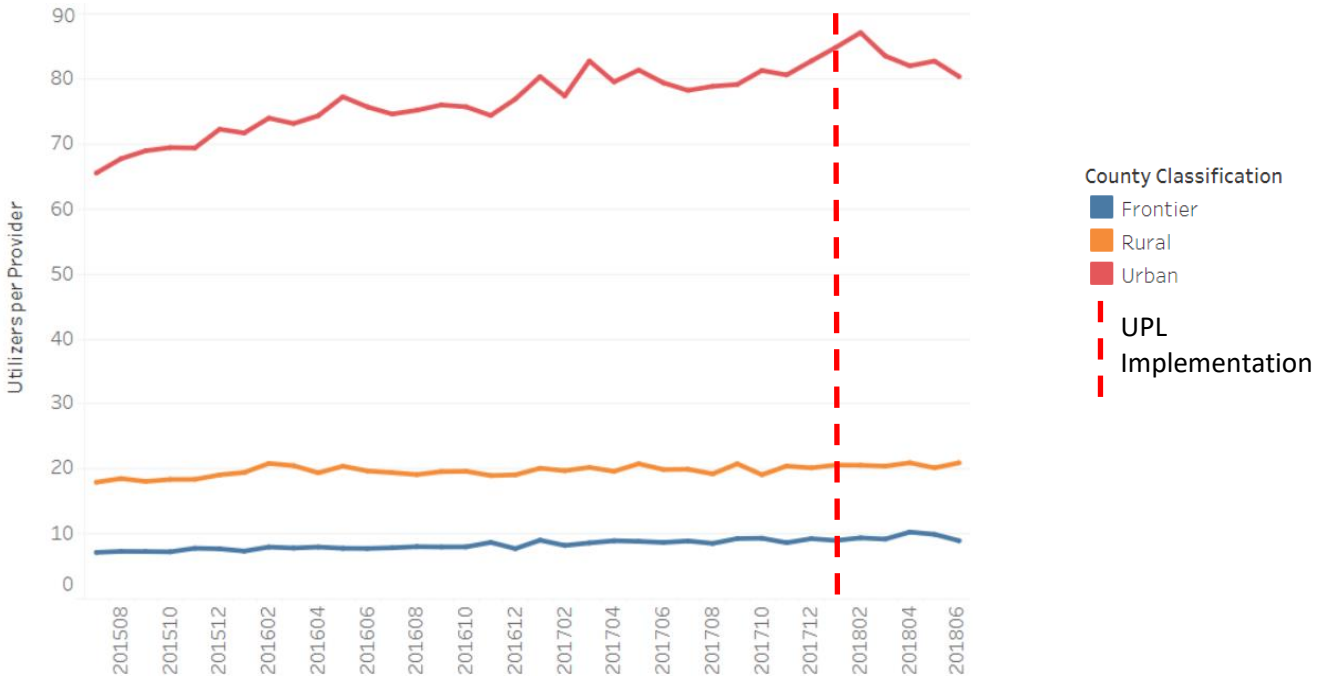


Figure 18. Utilizers per provider (panel size) for DME services between July 2015 and June 2018.

Analysis indicates that there were increases in the number of distinct utilizers and decreases in the number of active providers over this time, which led to the increase in the number of utilizers per provider.[87]

The increase in utilizers per provider in the urban, rural, and frontier counties may indicate changes in access to DME services in these areas.[88]

[87] For data specific to distinct utilizers and active providers, please see Appendix C.

[88] For more information on which counties belong in each urban, rural, and frontier regions, please see Figure 2. Colorado Counties and RAE County Classifications on page 11.

Utilizer Density

The utilizer density metric provides information regarding where utilizers of DME services reside throughout the state. In FY 2017-18, Phillips County had the lowest number of utilizers at 35 and El Paso had the highest number of utilizers at 6,949.

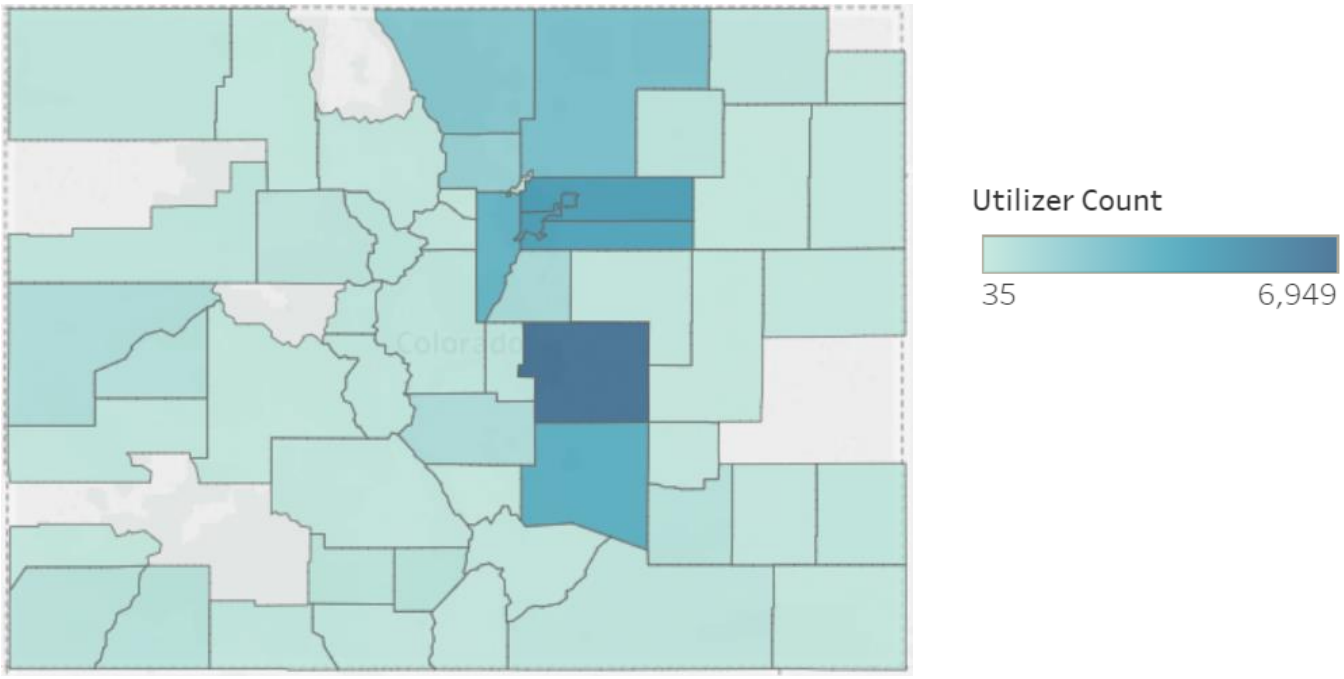


Figure 19. Utilizer density for DME services by county for FY 2017-18.

Counties with low numbers of utilizers might be due to factors including, but not limited to:

- relatively lower demand for DME services, or a low number of Colorado Medicaid members requiring DME services residing in those counties.

Additionally, some counties have been omitted due to PHI. For these counties, the Department intends to use the analysis internally to inform ongoing benefit and program management activities.

Penetration Rate

The penetration rate estimates the percentage of total Colorado Medicaid members in a geographic area that received DME services. Penetration rates in FY 2017-18 ranged from 1.15% in Montrose County to 7.49% in Lake County.

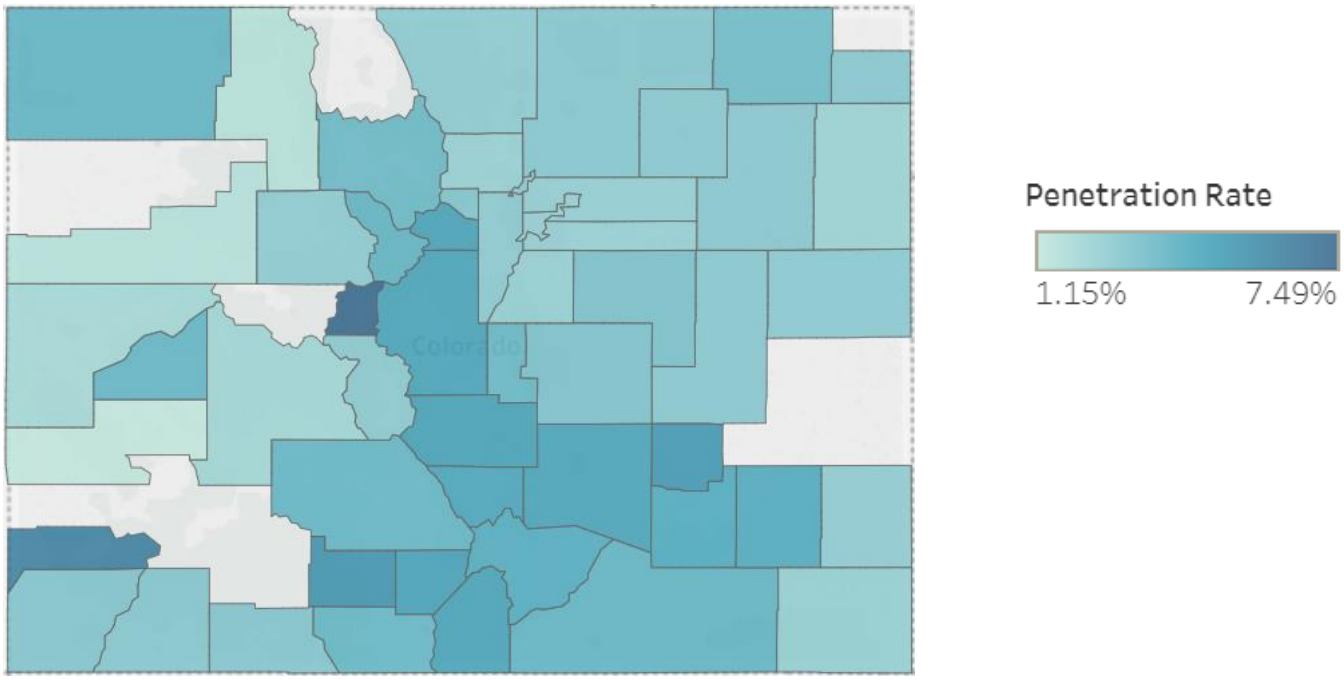


Figure 20. Penetration rates for DME services by county in FY 2017-18.

Counties with relatively higher penetration rates indicate that, as a share of total Colorado Medicaid members residing in that county, a larger percentage are receiving DME services.

Member-to-Provider Ratio

The member-to-provider ratio indicates the total number of DME service providers for all Colorado Medicaid members in a geographic area. This ratio is calculated as providers per 1,000 members.

DME Member-to-Provider Ratio			
Region	**FY 2017-18 Providers**	**FY 2017-18 Members**	**Providers per 1,000 Members**
Frontier	123	41,742	2.95
Rural	158	162,003	0.98
Urban	210	1,217,439	0.17
Statewide	**217**	**1,408,747**	**0.15**

Table 25. Member-to-provider ratio for DME expressed as providers per 1,000 members by county classification.

The member-to-provider ratio results indicate that there are more providers per 1,000 members in frontier counties than there are in rural counties, and more providers per 1,000 members in rural counties than there are in urban counties. The primary driver of these results is the fact that, while there are more providers in urban counties, there are significantly more Colorado Medicaid members in these counties when compared to other areas.[89]

[89] Currently, the Department does not use member-to-provider ratio standards specific to DME services. The Department will explore the development of these standards going forward. Comparison of these results with future analyses may assist the Department to determine whether the supply of providers is changing over time.

Drive Times

The drive times metric calculates the percentage of DME services utilizers that live within certain drive time bands from where DME services have been provided.

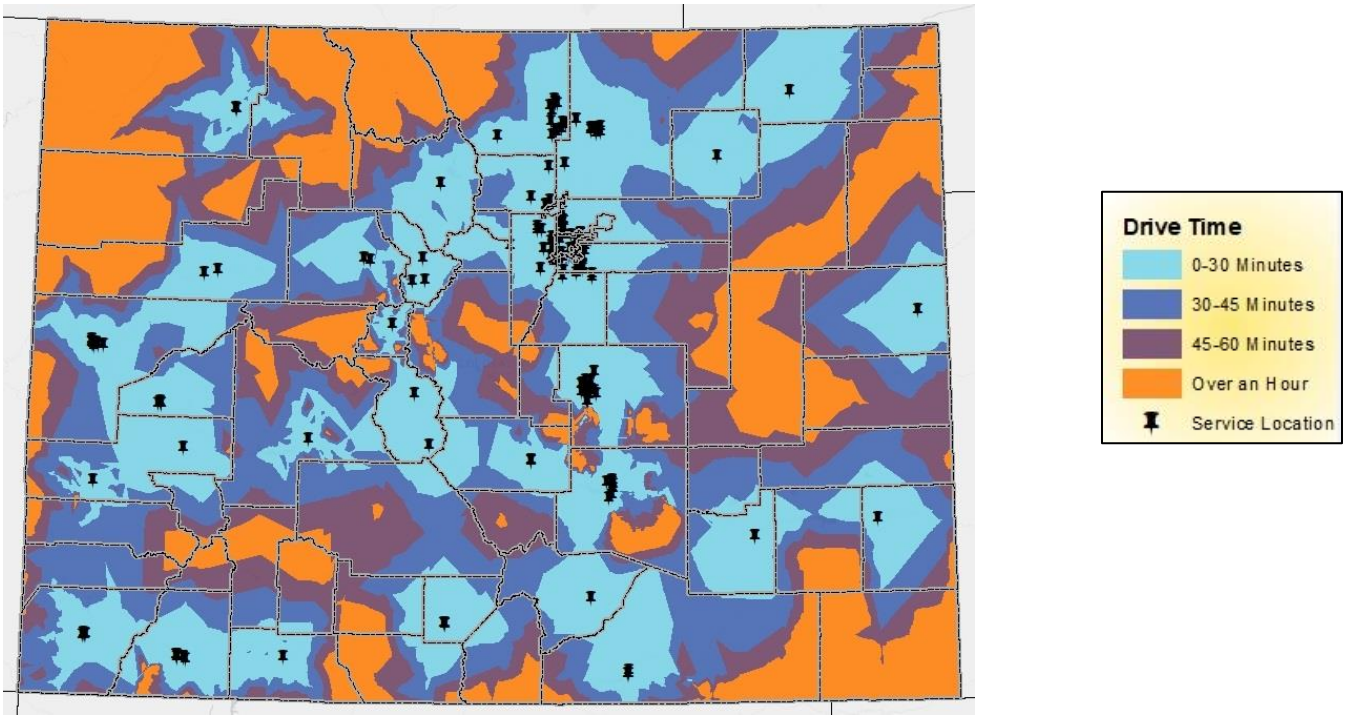


Figure 21. ArcGIS map of drive times for utilizers of DME services in FY 2017-18.

Overall, 94% of the total utilizers of DME services in FY 2017-18 needed to travel approximately 30 minutes or less to reach a location where one of these services had been provided. Additionally, 4% of the total utilizers needed to travel approximately 30-45 minutes; 1% of the total utilizers needed to travel approximately 45-60 minutes. Finally, 1% of utilizers needed to travel over an hour to reach a location where one of these services had been delivered. It should be noted that DME suppliers sometimes travel to members' locations, and the drive times may be indicative of provider travel as well.

Stakeholder Feedback

While the Department did not receive stakeholder feedback during the rate review process, the Department previously received feedback through other outreach methods. Feedback themes include, but are not limited to:

- Colorado Medicaid rates for certain DME supplies, such as wheelchairs (procedure code K0004) and hospital beds (procedure codes E0184 and E0260), are not sufficient for provider retention.
- Colorado Medicaid members are encountering barriers to receiving oxygen, Continuous Positive Airway Pressure (CPAP), and Bilevel Positive Airway Pressure (BiPAP) supplies.[90]

[90] For more information regarding Oxygen and CPAP/BiPAP utilization and provider data, please see Appendix C.

Additional Research

The Department has been aware of the potential impact of, and stakeholder concerns regarding, UPL implementation since before the UPL implementation. Since this time, the Department has:

- provided state-level feedback to our federal partner, the Centers for Medicare and Medicaid Services (CMS), regarding UPL implementation;
- shared information through existing state legislative processes;
- established a team to monitor recent claims data regarding oxygen-related supplies in response to stakeholder concerns;[91]
- closely evaluated data for changes in utilization and provider retention and will continue to do so over the next year; [92] and
- conducted a second annual survey of DME suppliers, and a 2019 survey of DME providers. Results of the ongoing data analysis, survey results, and stakeholder feedback will be included in the 2019 Access Monitoring Review Plan that will be submitted to CMS October 1, 2019.

Conclusions

Analyses suggest that the DME payments at 104.56% of the benchmark were sufficient to allow for member access. The decrease in active providers, in addition to stakeholder feedback, has indicated that the UPL rates could lead to issues regarding provider retention. Current data suggest that UPL rates are sufficient for provider retention, however, future claims data may reveal a trend over time that could lead to a different conclusion.

[91] Please refer to Appendix C for data regarding oxygen-related supplies.
[92] This will be done in alignment with the rate review and access to care processes.

Appendices

A. Glossary

Appendix A provides explanations of common terms used throughout the 2019 Analysis Report.

B. Rate Comparison Analysis and Access to Care Methodologies and Data

Appendix B includes details of the Year Four services benchmark creation and payment comparison methodology and data, as well as the access to care methodology and data. Appendix B does not include any additional data for Psychiatric Residential Treatment Facilities (PRTFs), due to protected health information, or Special Connections, due to unavailable claims data.

C. Service Grouping Data Book

Appendix C contains, for each service grouping (except PRTFs), the following information:

- Top 10 procedure or revenue codes by total paid.
- Rate benchmark comparison scatterplots and bar graphs.
- Additional access to care information, including access to care visuals and charts.

2019 Medicaid Provider Rate Review Analysis Report

Appendix A – Glossary

Appendix A provides explanations of common terms used throughout the 2019 Medicaid Provider Rate Review Analysis Report (2019 Analysis Report).

Active Provider – Any provider with at least one Colorado Medicaid paid claim in a given month between July 2015-June 2018 for one of the services under review.

Benchmark Rates – Rates to which Colorado Medicaid rates are compared.

Billing Provider – Based on the billing provider ID, which is generally associated with the entity enrolled with Medicaid. This can be agencies, large provider groups, or individuals.

Colorado Repriced – This amount represents the application of current Colorado Medicaid rates to the most recent and complete Colorado utilization data, obtained from claims data.

Comparison Repriced – This amount represents the application of comparators' most recently-available fee schedule rates to the most recent and complete Colorado utilization data, obtained from claims data.

County Classification – Three regional descriptors applied to counties by the Regional Accountable Entities (RAEs).

Distinct Utilizers – The total number of distinct utilizers.

Drive Time – Measures the percent of Colorado Medicaid members who are estimated to have traveled within four drive time bands (e.g. 0-30 minutes, 30-45 minutes, 45-60 minutes, over an hour) to receive services.

Member-to-Provider Ratio – The total number of Colorado Medicaid members residing in a geographic area compared to the total number of active providers in that geographic area; calculated as providers per 1,000 members. It allows for comparison across areas with large differences in population size.

Penetration Rate – The estimated percentage of total Colorado Medicaid members that received the service in a geographic area (by county).

Professional Portion of Services – Services submitted on a CMS-1500 claim form, which is the form used for submitting physician and professional claims for providers. This form is different from the UB-04 form, which is the claim form for institutional facilities, such as hospitals and outpatient facilities.

Provider Count – A distinct count of the number of providers who billed for the service. Whether the provider is a billing provider or rendering provider is identified in the report.

Rate Benchmark Comparison – This percentage represents how Colorado Medicaid payments compare to other payers. It is calculated by dividing the Colorado Repriced amount by the Comparison Repriced amount.

Rate Ratio – The rate ratio is the division of the corresponding Colorado rate to the Benchmark Rate. For example, if procedure code 99217 has a Colorado Medicaid rate of $56.08 and Medicare has a rate of $73.94 then the resulting rate ratio is $56.08/$73.94 = 0.7585, expressed as a percentage as 75.85%.

Regional Accountable Entity (RAE) – A regional organization that assists in the management of physical and behavioral health care. Many behavioral health services are managed and reimbursed through RAEs.

Rendering Provider – The provider who rendered the service.

Units – Quantities associated with a procedure; they may vary depending on type of service. The most common unit is one and represents the delivery of one unit of a service. Other services, such as physician-administered drugs, have a denomination reflected by the drug dosage (e.g., 1 mL, 5 mL, etc.). Some therapy and radiology services define units by time (e.g., 15 minutes). Not all payers share the same unit definitions and adjustments are sometimes incorporated to account for payer differences.

Utilizer Density – The number of distinct utilizers in each county.

Utilizers per Provider – The average number of members seen per active provider, also called Panel Size.

2019 Medicaid Provider Rate Review Analysis Report

Appendix B – Rate Comparison and Access to Care Analysis Methodologies and Data

Appendix B includes details of the Year Four services benchmark creation and payment comparison methodology and data, as well as the access to care methodology and data. Appendix B does not include any additional data for Psychiatric Residential Treatment Facilities (PRTFs), due to protected health information, or Special Connections, due to unavailable claims data.

Appendix B does not contain any assertions or conclusions on the sufficiency of Medicaid rates to provide adequate access to care. The Department contracted with Optumas, an actuarial firm, to provide support in comparing Colorado Medicaid rates to those of other payers and in analyzing access to care metrics. This appendix was prepared and written by Optumas.

Year Four Services

Executive Summary

The Department contracted with the actuarial firm **Optumas** to provide support in comparing Colorado Medicaid provider rates to those of other payers (a comparable benchmark) and for calculating access to care metrics.

The following service groups were reviewed by **Optumas** as part of the Year Four services:

- Ambulatory Surgical Center (ASC)
- Fee-for-service Behavioral Health (BH)
- Residential Child Care Facility (RCCF)
- Dialysis (facility and professional)
- Durable medical equipment (DME)

The work performed on Year Four services comprised three analyses:

1) Data validation
2) Rate comparison benchmark
3) Access to care

The data validation process includes:

- Volume checks over time to determine completeness and reliability of data
- Determination of relevant utilization base and appropriate exclusions
- Incurred but not reported (IBNR) adjustment

The rate comparison benchmark analysis for July 1, 2017 through June 30, 2018 (FY 2017-18) compares Colorado Medicaid's latest fee schedule estimated reimbursement with the estimated reimbursement of the overall benchmark(s). For all service groups except for RCCFs, the rate comparison benchmark analysis considers Medicare rates the primary comparator. In cases where Medicare rates were not used for comparison, an average rate from a selected group of other states was used. Paying consideration to the younger population of RCCF utilizers, the Department decided to compare RCCF services to other states instead of Medicare.

All else being equal, if Colorado Medicaid were to reimburse at 100.00% of the overall benchmark, expenditures for FY 2017-18 would see the estimated total funds impacts summarized in **Table 1**:

Table 1. Colorado as a Percent of the Benchmark and Estimated FY 2017-18 Fund Impact

Service Group	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark	Estimated FY 2017-18 Total Funds Impact
ASC	$12,339,335	$19,293,926	63.95%	$6,954,591
BH	$8,824,473	$9,321,763	94.67%	$497,290
RCCF	$8,200,219	$11,960,022	68.56%	$3,759,803
Dialysis (facility)	$8,773,641	$10,537,036	83.26%	$1,763,395
Dialysis (professional)	$59,507	$77,269	77.01%	$17,762
DME	$47,036,079	$46,686,135	100.75%	($349,944)

The access to care analyses consist of a set of metrics to assist the Department in determining the ease in which members can obtain needed medical services by county classification over time and for the FY 2017-18 time period. **Table 2** lists the access to care metrics, definitions, and the time period for which the metric was evaluated when available.

Table 2. Access to Care Definitions[93]

Metric	Definition	Time Period
Utilizers	The count of distinct utilizers	July 2015 – June 2018, Monthly
Providers	The count of active providers	July 2015 – June 2018, Monthly
Utilizers Per Provider (Panel Size)	Panel size is the ratio of utilizers to active providers, and estimates average Medicaid members seen per provider	July 2015 – June 2018, Monthly
Member-to-Provider Ratio	Expressed as providers per 1,000 members, and allows for comparison across areas with large differences in population size	FY 2017-18
Utilizer Density Map	Utilizer count by county of residence	FY 2017-18
Penetration Rate Map	The estimated share of total Medicaid members that received the service by county of residence	FY 2017-18

All metrics are screened for personal health information (PHI).

Data Validation

The Department provided three years of fee-for-service (FFS) claims data, July 2015 through June 2018 for DME, dialysis, and BH services to **Optumas**. RCCF and ASC data prior to March 2017 was not available at the time of the analysis, thus ASC and RCCF base data includes March 2017 through June 2018 claims only. The data validation process included utilization and dollar volume summaries over time which were validated against the Department's expectations, as well as **Optumas'** expectations based on prior analyses in order to identify potential inconsistencies. In addition, a frequency analysis was performed to examine valid values appearing across all fields contained in the data. Results of this process suggested that the data for ASC, BH, RCCF, dialysis (facility and professional), and DME was both complete and reliable in FY 2017-18.

Next, the data was reviewed to determine the relevant utilization after accounting for applicable exclusions. The exclusion criteria adhere to the general guidelines set forth in the Rate Review Schedule:[94]

- Claims with denied status,
- Claims attributed to members with no corresponding eligibility span,
- Claims associated with members enrolled in Medicaid and Medicare (dual membership), and
- Claims in the capitated Child Health Plan *Plus* (CHP+) program.

[93] The access to care analyses for some services also included drive time estimates. Drive time estimates were completed by the Department.

[94] See the Rate Review Schedule on the Department's website.

Furthermore, for the rate comparison benchmark, the validation process included three additional exclusions:

- Procedure codes that are manually priced, and therefore not comparable,
- Procedure codes that are not covered benefits, and do not have a current Colorado Medicaid rate for comparison, and
- Procedure codes that do not have a comparable Medicare or other states' average rate.

The number of excluded codes for each service group is shown in **Table 3**:

Table 3. Count of Procedure Codes

Service Group	Manually Priced	No Colorado Medicaid Rate	No Comparable Rate Available
ASC	0	0	0
BH	0	4	0
RCCF	0	0	0
Dialysis (facility)	0	0	0
Dialysis (professional)	0	0	0
DME	40, (270*)	81, (126*)	15, (32*)

*Please note, the figures marked with an asterisk (*) represent unique combinations of procedure codes and modifiers in the claims data. Services were priced to the Colorado Medicaid fee schedules at the procedure code and modifier level. The summary of exclusions from the FY 2017-18 base data can be found in **Appendix B1**.

FY 2017-18 claims data was selected to be the base data of the repricing analysis because it yields an annualized result derived from the most recent experience. There is an inherent processing lag in claims between the time a claim is incurred and is billed. Claims rendered in any given month can take weeks or months to be reported in the claims system. The claims data for Year Four services was provided with six months of claims runout. While the raw claims data reflects the vast majority of FFS experience for Year Four services in FY 2017-18, a small incurred but not reported (IBNR) adjustment was performed to better estimate an annualized level of utilization after all services rendered have been fully realized. The IBNR utilization completion factors derived from this analysis for each service group can be found in **Appendix B2**.

A subset of procedure codes required further adjustments to account for utilization changes and discontinued codes. For more information on these adjustments, please see the service-specific sections under the rate comparison benchmark analysis below.

After the data validations steps, the rate comparison benchmark analysis is performed.

Rate Comparison Benchmark Analysis

The first steps in the rate comparison benchmark analysis were identifying the other payer sources, and the repricing validations. Most of the Year Four services (excluding RCCF) offered by Colorado Medicaid are covered by Medicare. To identify comparable rates, publicly available documentation on reimbursement policy was referenced, and the analysis employed a fee schedule specific to Colorado to produce a more valid

comparison.[95] With the exception of dialysis services performed at a facility which are paid per diem, rates were assigned by considering the combination of procedure code and modifier present on each claim. DME and dialysis (facility) services under review also include a geographic component. Zip codes, county, and place of service codes were considered in order to compare an appropriate rate.

For the RCCF service category and procedure codes without a comparable Medicare rate, supplemental rates were drawn from other state Medicaid programs. The states included will be listed in each service specific section below.[96] These rates were also linked to Colorado Medicaid claims on a procedure code-modifier basis.

This left a small portion of the data for which a comparable rate could not be found under the Year Four service categories. The utilization in the base data associated with these non-comparable claims were excluded for the remainder of the rate comparison benchmark analysis. The distribution of unique procedure codes compared across benchmark sources for each service group is shown in **Table 4**:

Table 4. Count of Codes by Comparison Source

Service Group	Medicare	Other States	No Comparable Rate
ASC	796	28	0
BH	25	8	0
RCCF	n/a	15	0
Dialysis (facility)	6*	0	0
Dialysis (professional)	4	1	0
DME	276	182	15

*Please note that the count of codes for dialysis (facility) claims shown here represents unique revenue codes instead of procedure codes.

The range of ratios derived from comparing Colorado Medicaid rates to those of either Medicare or other states is shown by service group in **Table 5**:

Table 5. Rate Ratio Ranges by Comparison Source

Service Group	Medicare	Other States
ASC	26.72% - 81.67%	75.47% - 193.88%
BH	42.57% - 244.63%	22.72% - 231.23%
RCCF	n/a	47.00% - 169.45%
Dialysis (facility)	49.51% - 199.01%	n/a
Dialysis (professional)	68.36% - 95.63%	109.35%
DME	13.55% - 286.91%	3.92% - 1478.03%

[95] The payment rate comparison is influenced by the choice of fee schedule since Colorado-specific Medicare rates are higher than those derived from unadjusted national relative value units. All Medicare rates and relevant information were effective January 1, 2019.

[96] Other states selected for this analysis were provided by the Department.

As an example, the first set of figures in Table 5 can be interpreted to mean that when comparing ASC services to Medicare at the procedure code-level, the Colorado Medicaid rates were between 26.72% to 81.67% of the Medicare rates.

The final step consisted of applying the base utilization to reprice claims at Colorado Medicaid's latest available fee schedule, as well as the matched rates from Medicare or other states. This entailed multiplication of utilization and the corresponding rates from each source, followed by subtraction of third-party liability (TPL) and copayments, to calculate the estimated total dollars that would theoretically be reimbursed by each source.[97]

Estimated expenditures were only compared for the subset of Year Four services that are common between Colorado Medicaid and another source. In other words, if no comparable rate could be found for a specific service offered by Colorado Medicaid, then the associated utilization and costs were not shown within the comparison results.

In the service-specific payment comparison sections of the narrative that follow, more detailed information can be found on the Medicare and other states portions of the rate comparison benchmark.

ASC Payment Comparison

The rate comparison analysis for ASC services first assigns Medicare rates to the base utilization, and in cases where Medicare rates were not available for comparison, an average rate from a selected group of other states was used.

Colorado Medicaid pays ASC claims based on the highest severity procedure code billed on a claim, which is typically found on the first line. For each claim, the highest severity procedure is assigned one of ten rates from the Colorado Medicaid ASC Grouper fee schedule effective July 1st, 2018. Each ASC claim is assigned a single rate using this grouping method to obtain a Colorado Repriced amount. The ten Colorado Medicaid ASC grouper rates are shown in **Table 6**:

Table 6. Colorado Medicaid FY 2018-19 ASC Grouper Payment Rates

Grouper	FY 2018-19 Rate
A01	$267.86
A02	$358.73
A03	$410.26
A04	$506.77
A05	$576.77
A06	$664.45
A07	$800.39
A08	$782.70
A09	$1,077.13
A10	$1,786.57

[97] ASC and BH services do not require a copayment.

Medicare pays for ASC claims based on an ASC-specific fee schedule and the wage index region in which the service was performed. There were two Medicare repricing scenarios considered in the rate comparison analysis. The first scenario is a procedure code level comparison between the highest severity procedure codes on each claim at a header (HDR) level. The second Medicare repricing scenario reflects additional payments made for additional lines on the claim, a methodology called Multiple Procedure Discounting (MPD). The results of Medicare MPD are deemed a more valid comparison and are shown in this narrative because it is a more accurate reflection of what Medicare would have paid for the ASC utilization. Of Colorado's repriced dollars, 81.93% were compared against a Medicare benchmark.

Table 7 gives an example of the two Medicare repricing scenarios applied to one example claim.

Table 7. Example Claim Illustrating Two Medicare Repricing Scenarios:

Claim Line	Grouper	Procedure Code	Procedure Description	Colorado Repriced	1. Medicare HDR Repriced	2. Medicare MPD Repriced
1	A05	31255	REMOVAL OF ETHMOID SINUS	$576.77	$1,813.44	$1,813.44
2	A05	31255	REMOVAL OF ETHMOID SINUS	$0.00	$0.00	$906.72
3	A03	31267	ENDOSCOPY MAXILLARY SINUS	$0.00	$0.00	$906.72
4	A03	31288	NASAL/SINUS ENDOSCOPY SURG	$0.00	$0.00	$906.72
Total				**$576.77**	**$1,813.44**	**$4,533.60**

In this example, Colorado Medicaid-Medicare-Scenario 1, sees no additional payments made for additional procedures billed in claims lines 2-4; however, under Medicare-Scenario 2, each of the secondary lines receive additional, potentially discounted payments shown that are based on the respective rates found in the Medicare ASC fee schedule.

For the remainder of this document, Medicare results shown for the ASC rate comparison benchmark analysis reflect Scenario 2 because it is a more accurate reflection of Medicare reimbursement.

For instances where there was no Medicare rate, a simple average of the other states' rates obtained from ASC-specific fee schedules is applied. Other states rates are matched on a procedure code and modifier basis. Arizona, Nebraska, Wyoming were previously compared, and this year the Department has decided to supplement these fee schedules with Alaska, Alabama, Connecticut, Idaho, Indiana, Montana, Nevada, South Dakota, and Texas Medicaid FFS fee schedules for validity due to the high variation of ASC-specific coverage across states. The remaining 18.07% of Colorado's repriced dollars were compared to the other states' averages. **Table 8** summarizes the ASC rate benchmark by the comparison sources.

Table 8. Count of Codes and Rate Benchmark by Comparison Source

Comparison Source	Procedure Code Count	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark
Other States	28	$2,229,202	$1,358,568	164.08%
Medicare	796	$10,110,132	$17,935,358	56.37%
Total	**824**	**$12,339,335**	**$19,293,926**	**63.95%**

Repricing results for ASC were also reviewed by grouper rate type and can be found in **Table 9:**

Table 9. ASC - Benchmark Comparison Results (Grouper Rate Type Split)

Grouper	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark
A01	$1,734,758	$2,874,968	60.34%
A02	$3,816,935	$5,494,475	69.47%
A03	$900,472	$3,030,534	29.71%
A04	$466,138	$1,346,641	34.61%
A05	$561,935	$1,385,398	40.56%
A06	$168,330	$442,358	38.05%
A07	$257,627	$552,674	46.61%
A08	$1,526,222	$1,875,691	81.37%
A09	$2,510,538	$1,805,822	139.02%
A10	$396,380	$485,366	81.67%
Total	**$12,339,335**	**$19,293,926**	**63.95%**

Table 10 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 10. Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	63.95%
Colorado Repriced Amount	$12,339,335
Benchmark Repriced Amount	$19,293,926
Est. FY 2017-18 Total Funds Impact	**$6,954,591**

Table 10 can be interpreted to mean that for ASC services under review, Colorado Medicaid pays an estimated 36.05% less than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of the benchmark rates in FY 2017-18, the estimated total funds impact would be $6,954,591. Additional information on ASC rate comparison can be found in **Appendix B8**.

BH Payment Comparison

The rate comparison analysis for BH services first assigns Medicare rates to the base utilization and in cases where Medicare rates were not available for comparison, an average rate from a selected group of other states was used.

The Colorado Medicaid physician fee schedule rates effective January 1st, 2019 are applied to the procedure codes to obtain a Colorado Repriced amount.

Additionally, five BH procedure codes used in the rate comparison benchmark analysis were discontinued during the FY 2017-18 time period and have transitioned to new procedure codes. In the rate comparison benchmark analysis, the utilization associated with these five discontinued codes in the base data are compared to benchmarks using the rates associated with their replacements. A list of these codes and their respective replacements is shown in **Table 11**:

Table 11. BH Transitioned Procedure Codes

Procedure Code	Procedure Description	Replacement Procedure Code
96118	NEUROPSYCH TST BY PSYCH/PHYS	96132
96101	PSYCHO TESTING BY PSYCH/PHYS	96136
96111	DEVELOPMENTAL TEST EXTEND	96112
96119	NEUROPSYCH TESTING BY TEC	96132
96102	PSYCHO TESTING BY TECHNICIAN	96130

Note: In **Appendix B3**, which contains detailed procedure code level rate comparison results, these five transitioned procedure codes are shown with the Colorado Medicaid rates of the respective replacement codes. For example, procedure code 96101 is compared using a Colorado rate of $62.01, corresponding to the 96136 rate found in the Colorado Medicaid General Fee Schedule effective January 2019.

The January 2019 Medicare Physician Fee Schedule (PFS) lists both facility and non-facility specific rates. For this subset of professional services, the place of service code on the claim determined whether the facility or non-facility rate was used. Of Colorado's repriced dollars, 60.62% were compared against a Medicare benchmark.

For instances where there was no Medicare rate, a simple average of the other states rates is applied. Other states rates are matched on a procedure code and modifier basis. Arizona, Nebraska, Oklahoma, Oregon, and Wyoming were previously compared, and this year the Department has decided to supplement these fee schedules with California, Iowa, Idaho, Louisiana, North Carolina, and Washington Medicaid FFS fee schedules for validity due to the large variation in covered benefits across states. The remaining 39.38% of Colorado repriced dollars were compared against the other states' average.

Table 12 summarizes the BH rate benchmark by the comparison sources.

Table 12. Count of Codes and Rate Benchmark by Comparison Source

Comparison Source	Procedure Code Count	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark
Other States	8	$3,475,411	$3,193,796	108.82%
Medicare	25	$5,349,061	$6,127,967	87.29%
Total	**33**	**$8,824,473**	**$9,321,763**	**94.67%**

Table 13 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 13. Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	94.67%
Colorado Repriced Amount	$8,824,473
Benchmark Repriced Amount	$9,321,763
Est. FY 2017-18 Total Funds Impact	**$497,290**

Table 13 can be interpreted to mean that for BH services under review, Colorado Medicaid pays an estimated 5.33% less than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of the benchmark rates in FY 2017-18, the estimated total funds impact would be $497,290. Detailed comparison results at the procedure code level can be found in **Appendix B3.**

RCCF Payment Comparison

The rate comparison analysis for RCCF services assigns an average rate from a selected group of other states. The Department has decided to compare these youth-specific services to other states because of differences in the Medicare population underlying the Medicare rates.

The Colorado Medicaid physician fee schedule rates effective January 1st, 2019 are applied to the procedure codes to obtain a Colorado Repriced amount.

Additionally, out of the five BH procedure codes that were discontinued during the FY 2017-18 time period and have transitioned to new procedure codes, one applicable code was found in the RCCF data and its replacement is presented in **Table 14**:

Table 14. RCCF Transitioned Procedure Code

Procedure Code	Procedure Description	Replacement Procedure Code
96101	PSYCHO TESTING BY PSYCH/PHYS	96136

Note: In **Appendix B4**, which contains detailed procedure code level rate comparison results, this transitioned procedure code is shown with the Colorado Medicaid rate of the replacement code. For example, procedure code 96101 is compared using a Colorado rate of $62.01, corresponding to the 96136 rate found in the Colorado Medicaid General Fee Schedule effective January 2019.

A simple average of the other states rates is applied to obtain a Benchmark Repriced amount. Other states' rates are matched on a procedure code and modifier basis. Arizona, Oklahoma, Oregon, and Wyoming were previously compared, and this year the Department has decided to supplement these fee schedules with California, Iowa, Idaho, Louisiana, North Carolina, and Washington Medicaid FFS fee schedules for validity.

For the RCCF services, youth-specific rates in other states' fee schedules were expressly found to incorporate in the comparison benchmark. California, Louisiana, Washington, and Wyoming are examples of states with what appear to be youth-specific fees that were included in the RCCF analysis.

Table 15 summarizes the RCCF rate benchmark by the comparison sources.

Table 15. Count of Codes and Rate Benchmark by Comparison Source

Comparison Source	Procedure Code Count	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark
Other States	**15**	**$8,200,219**	**$11,960,022**	**68.56%**

Table 16 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 16. Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	68.56%
Colorado Repriced Amount	$8,200,219
Benchmark Repriced Amount	$11,960,022
Est. FY 2017-18 Total Funds Impact	**$3,759,803**

Table 16 can be interpreted to mean that for RCCF services under review, Colorado Medicaid pays an estimated 31.44% less than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of the benchmark rates in FY 2017-18, the estimated total funds impact would be $3,759,803. Detailed comparison results at the procedure code level can be found in **Appendix B4**.

Dialysis (Facility) Payment Comparison

The rate comparison analysis for dialysis claims performed in a facility assigns Medicare rates to the base utilization based on information available on the claim. For this service group, 100.00% of the services were compared to a Medicare benchmark.

Dialysis treatment performed at dialysis centers is bundled into a single per diem facility payment that includes geographic adjustment based on the county where the dialysis facility is located.

The FY 2018-19 Colorado Medicaid dialysis fee schedule assigns a single rate per dialysis service that is split by geographic region, and prescribes which counties are categorized into the different regions. The per diem rate based on the county where the service was performed is applied to the paid units for these services to obtain a Colorado Repriced amount. The Colorado Medicaid dialysis per diem rates are shown in **Table 17**:

Table 17. Colorado Medicaid FY 2018-19 Dialysis (Facility) Per Diem Rates

Wage Index Region	FY 2018-19 Rate
Boulder, CO	$197.41
Colorado Springs, CO	$188.54
Denver, Aurora, Lakewood	$203.23
Fort Collins, CO	$202.61
Grand Junction, CO	$195.23
Greeley, CO	$192.30
Pueblo, CO	$177.09
Rural Colorado	$196.01

Medicare reimburses dialysis facility claims using a Prospective Payment System (PPS). The Medicare PPS prices dialysis with a national base rate, currently at $235.27 and applies three types of payment adjustments: provider adjustments, claims adjustments, and patient adjustments. A subset of the adjustments is included in the Medicare benchmark analysis based on the data fields available. **Table 18** lists the Medicare PPS Adjustments applied and those adjustments not incorporated:

Table 18. Dialysis PPS Adjustments

Adjustment Group	Medicare PPS Adjustments Applied
Provider	Wage Index Adjustment, Rural Adjustment
Claim	Training Add-On, Home Dialysis, Acute Kidney Failure Adjustment, Modality Adjustment
Patient	Age, Comorbidity

Adjustment Group	Medicare PPS Adjustments Not Incorporated
Provider	Low Volume Adjustment, Blended Payment Adjustment, QIP Reduction
Claim	Dialysis Onset, High-Cost Outlier Payments, Transitional Drug Add-On Payment Adjustment
Patient	Body Mass Index (BMI), Body Surface Area (BSA)

Table 19 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 19. Estimated Fiscal Impact

Colorado as a Percentage of Medicare PPS Benchmark	83.26%
Colorado Repriced Amount	$8,773,641
Medicare PPS Benchmark Repriced Amount	$10,537,036

Est. FY 2017-18 Total Funds Impact	$1,763,395

Table 19 can be interpreted to mean that for dialysis facility services under review, Colorado Medicaid pays an estimated 16.74% less than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of the benchmark rates in FY 2017-18, the estimated total funds impact would be $1,763,395. Detailed comparison results can be found in **Appendix B5.**

Dialysis (Professional) Payment Comparison

The rate comparison analysis for dialysis professional services first assigns Medicare rates to the base utilization and in cases where Medicare rates were not available for comparison, an average rate from a selected group of other states was used.

The Colorado Medicaid physician fee schedule rates effective January 1st, 2019 are applied to the procedure codes to obtain a Colorado Repriced amount.

The January 2019 Medicare Physician Fee Schedule (PFS) lists both facility and non-facility specific rates. For this subset of professional services, only the non-facility rates were considered in our payment comparison. Of Colorado's repriced dollars, 80.50% were compared against a Medicare benchmark.

For instances where there was no Medicare rate, a simple average of the other states rates is applied. Other states rates are matched on a procedure code and modifier basis. Arizona, Nebraska, Oklahoma, Oregon, and Wyoming were previously compared, and this year the Department has decided to supplement these fee schedules with California and Idaho Medicaid FFS fee schedules for validity. The remaining 19.50% of Colorado repriced dollars were compared against the other states' average.

Table 20 summarizes the dialysis (professional) rate benchmark by the comparison sources.

Table 20. Count of Codes and Rate Benchmark by Comparison Source

Comparison Source	Procedure Code Count	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark
Other States	1	$11,603	$10,611	109.35%
Medicare	3	$47,904	$66,657	71.87%
Total	**4**	**$59,507**	**$77,269**	**77.01%**

Table 21 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 21. Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	77.01%
Colorado Repriced Amount	$59,507
Benchmark Repriced Amount	$77,269

Est. FY 2017-18 Total Funds Impact	$17,762

Table 21 can be interpreted to mean that for all Year Four services under review, Colorado Medicaid pays an estimated 22.99% less than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of the benchmark rates in FY 2017-18, the estimated total funds impact would be $17,762. Detailed comparison results at the procedure code level can be found in **Appendix B6**.

DME Payment Comparison

The rate comparison analysis for DME services first assigns Medicare rates to the base utilization and in cases where Medicare rates were not available for comparison, an average rate from a selected group of other states was used. Additional consideration is made for the implementation of the DME Upper Payment Limit (UPL) in January 2018, a federal requirement for State Medicaid programs to reimburse a subset of DME procedure codes at a level no greater than Medicare rates.

Due to the implementation of the DME UPL, there were observed temporary changes to the utilization for E0441, E0442, E0431, and K0738 procedure codes. These procedure codes were adjusted to better reflect an annual level of utilization.

Another two DME specific procedure codes, E1390 and E2402, were previously coded with an hourly or daily rental basis and transitioned to a monthly basis during the FY 2017-18 base data. A smoothing adjustment was made to utilization of these two procedure codes to reflect billing practices that are expected going forward.

The Colorado Medicaid physician fee schedule rates effective January 1st, 2019 are applied to the Non-UPL procedure codes, while Colorado Medicaid UPL codes are set equal to the Medicare rates as per the federal UPL requirement. These calculations produce the Colorado Repriced amount that is compared to a benchmark.

There are two DME Medicare fee schedules used in the rate comparison benchmark analysis; The January 2019 Competitive Bidding Program areas (CBA) fee schedule, and the January 2019 Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. A member's zip code is utilized to determine the CBA as Colorado Springs or Denver. If the zip code is not a CBA, then the zip code determines the Colorado-specific rural or non-rural rates on the DMEPOS fee schedule. Of Colorado's repriced dollars, 89.95% were compared against a Medicare benchmark.

For instances where there was no Medicare rate, a simple average of the other states rates is applied. Other states rates are matched on a procedure code and modifier basis and include the following: Arizona, California, Nebraska, Oklahoma, Oregon, and Wyoming. The remaining 10.05% of Colorado's repriced dollars were compared against the other states' average.

Table 22 summarizes the DME rate benchmark by the comparison sources.

Table 22. Count of Codes and Rate Benchmark by Comparison Source

Comparison Source	Procedure Code Count	Colorado Repriced	Benchmark Repriced	Colorado as a Percent of Benchmark

Other States	182	$4,726,646	$4,760,257	99.29%
Medicare Non-UPL	139	$2,858,705	$2,475,150	115.50%
Medicare UPL	137	$39,450,727	$39,450,727	100.00%
Total	**458**	**$47,036,079**	**$46,686,135**	**100.75%**

Table 23 summarizes the payment comparison and estimated fiscal impact in aggregate.

Table 23. Estimated Fiscal Impact

Colorado as a Percentage of Benchmark	100.75%
Colorado Repriced Amount	$47,036,079
Benchmark Repriced Amount	$46,686,135
Est. FY 2017-18 Total Funds Impact	**($349,944)**

Table 23 can be interpreted to mean that for all Year Four services under review, Colorado Medicaid pays an estimated 0.75% more than the combined benchmark of Medicare and other states. Had Colorado Medicaid reimbursed at 100.00% of this combined benchmark's rates in FY 2017-18, the estimated total funds impact would be ($349,994).

Detailed comparison results at the procedure code and benchmark rate level can be found in **Appendix B7.**

Access to Care

This year, the Department contracted with **Optumas** to analyze access to care metrics for Year Four services. These metrics inform the Department about the ease with which members can access these services and patterns over time. The metrics analyzed included the following:

1) Distinct utilizers over time by county classification
2) Active providers over time by county classification
3) Utilizer per Provider (Panel Size) over time by county classification
4) Member-to-Provider Ratios by county classification in FY 2017-18
5) Utilizer Density by county in FY 2017-18
6) Penetration Rates by county in FY 2017-18

For the definition of each metric, please view **Table 2** above. More detailed information including data visualization is included in the main body of the Department's 2019 Medicaid Provider Rate Review Analysis Report (the report).

A discussion of each access to care metric is provided below:

1) **Distinct utilizers over time by county classification** show the monthly number of members that receive a service in each county classification of residence. Utilizers are identified by their unique Member ID.
2) **Active providers over time by county classification** show the monthly number of providers providing services to members residing in each county classification residence. Providers are identified by their

rendering provider Medicaid ID for all service groups except for dialysis (facility), for which the billing provider's Medicaid ID was considered the unique provider identifier.

3) **Panel size over time by county classification** estimates the number of utilizers per provider actively servicing members who reside in that county classification.
4) **Member-to-Provider Ratios by county classification** are useful in normalizing, and eventually standardizing, the supply of active providers relative to total membership in different county classifications.
5) **Utilizer Density by county** shows on a map the geographic distribution and prevalence of members utilizing each service group.
6) **Penetration Rates by county** shows on a map the relative share of total members utilizing each service group across different counties, normalizing for the total number of Medicaid members residing in each county.

Data Included

All time periods deemed appropriate after the data validation are included in access to care analyses. To improve the quality and reliability of the data, members determined to be Dual, CHP+, or ineligible are excluded from access to care analysis. For the DME service group, the same adjustments made for E0441, E0442, E0431, and K0738 procedure codes in the rate comparison benchmark analysis to account for temporary changes to the utilization were also made to the data underlying the access to care analysis. The smoothing adjustment made to utilization of procedure codes E1390 and E2402 to reflect billing practices that are expected going forward is also done to mirror the adjustment made in the rate comparison benchmark analysis. No other adjustments are made to the access to care data.

Additional DME Data Excluded

In response to feedback from providers and stakeholders surrounding the DME services and the impact of the UPL implementation, the Department has dedicated attention to this service group in the access to care work. In addition to July 2015 through June 2018 data, the Department provided additional months of claims data to examine access to DME services rendered more recently, from July 2018 through November 2018. However, due to persistent challenges with eligibility data for this more recent time period, these additional months could not be incorporated into the access to care analysis with the degree of reliability with which the Department and **Optumas** are comfortable. Three years of FFS DME data originally received were incorporated in the access to care analysis.

Interpretation of Results

To address access to care for Year Four services, different partitions in the data are analyzed to enhance the value and actionability of the results. There are considerations to be made at different levels of aggregation and data partitioning to accurately interpret what the summarized figures and distinct counts represent. Distinct counts of members and providers, when grouped by different dimensions, will have varying degrees of duplication and may not be directly summed to arrive back at total, undivided distinct utilizer and provider counts. The two main types of data partition are discussed below, along with considerations one should make when accurately interpreting access to care results.

Geographic Partitions

Geographic partitions are arranged in the access metrics because they provide important distinctions when comparing and evaluating access to care for members residing in similar and dissimilar geographic locations. The utilizer and member counts grouped by county and county classification are non-duplicative when analyzed over

time on a monthly basis and may be duplicative at the FY 2017-18 aggregate level. However, the active provider counts grouped by county and county classification maintain potential for duplication even within a single month because these geographic partitions represent the county of residence for the utilizers in the data.

For example, if a member resided in both an urban and rural county during the FY 2017-18 time period, that member would contribute to both the urban FY 2017-18 total utilizer counts as well as the rural FY 2017-18 total utilizer counts for the service groups applicable to this member. To the degree that members residing in multiple counties were able to access a single provider within a given month, that provider contributes to the active provider counts for all counties in which that provider's panel resides. Although this duplication does not adversely impact the informational value of the annualized access metrics, it should be considered when interpreting the aggregated results.

Oxygen-related and CPAP/BiPAP Partitions (DME Only)

In addition to the geographic partitions considered, the Department has received feedback regarding oxygen-related as well as CPAP/BiPAP services specific to the DME service group. In response, the Department has focused attention on analyzing over-time Access metrics for these services. These services are flagged in the data for additional utilizer count, provider count, and panel size evaluation across time against all other DME services. Aggregation for these oxygen-related and CPAP/BiPAP specific metrics have separate considerations than for geographic partitions.

While members are only attributed to one county per month, the same member can receive a variety of DME services in a given month. For example, a member can receive both oxygen-related and other DME services in January 2018. Likewise, providers can provide both oxygen-related and other DME services in January 2018. For these cases, the member and the provider would contribute to both the "Oxygen Services" distinct counts as well as "All Other DME" distinct counts for January 2018. The oxygen-related and CPAP-BiPAP partitions in the access to care analysis can be used to evaluate the access to these services relative to all other DME services over time.

For more detailed visualizations and information on the access to care work performed on oxygen-related and CPAP/BiPAP services, please reference Appendix C.

The following appendices provide more detailed rate comparison benchmark summaries and results that were introduced and discussed in the narrative.

Appendix B1: Base Data Summary

	ASC	BH	RCCF	Dialysis (facility)	Dialysis (professional)	DME
FY 2017-18 Raw Data	$13,350,822	$7,960,851	$6,645,090	$8,804,195	$59,198	$71,190,356
Exclusions						
No Eligibility Span	$16,244	$8,139	$40,526	$30,321	$0	$161,458
Dual Membership	$22,558	$9,747	$6,252	$163,616	$799	$5,689,255
CHP+	$0	$26	$0	$0	$0	$0
Manually Priced	$0	$0	$0	$0	$0	$9,120,381
No Colorado Rate	$0	$8,400	$0	$0	$0	$591,814
No Comparison Rate	$0	$0	$0	$0	$0	$309,498
Total Exclusions	$38,802	$26,313	$46,778	$193,937	$799	$15,872,407
Repricing Base						
Year Four Base Data	$13,312,020	$7,934,539	$6,598,312	$8,610,258	$58,399	$55,317,949
Percentage of Raw	99.71%	99.67%	99.30%	97.80%	98.65%	77.70%

Note: as an example, the ASC final figures in the above table can be interpreted to mean that 99.71% (accounting for $13,312,020 in raw, unadjusted paid dollars) of the FY 2017-18 data provided by the Department was appropriate for use in the payment rate comparison analysis.

Appendix B2: Utilization IBNR

Service Group	Utilization Factor
ASC	0.9879
BH	0.9980
RCCF	0.9365
Dialysis (facility)	0.9912
Dialysis (professional)	0.9912
DME	0.9707

Note: as an example, the first figure in this table can be interpreted as an estimate that the raw utilization data for DME represents 97.07% of the true total expected for FY 2017-18 after all claims run-out has been reported in the payment system.

Appendix B3: BH Detailed Comparison Results

These appendices show the rate ratios for all unique combinations of Colorado Medicaid and benchmark comparison rates found in the rate comparison benchmark analysis at a procedure code level. Procedure codes are duplicated to the extent that the modifiers, place of service code, service county, or other data elements impact the Colorado Medicaid or benchmark rate that the procedure code receives.

The services analyzed in the BH rate comparison benchmark analysis was repriced using methodology that incorporates the following data elements:

- Procedure Code
- Modifiers
- Place of Service Code

HCPCS Code	Procedure Description	Benchmark Source	Colorado Rate	Benchmark Rate	Rate Ratio
90791	PSYCH DIAGNOSTIC EVALUATION	Medicare PFS	$108.62	$128.02	84.85%
90791	PSYCH DIAGNOSTIC EVALUATION	Medicare PFS	$108.62	$140.86	77.11%
90791	PSYCH DIAGNOSTIC EVALUATION	Medicare PFS	$113.62	$140.86	80.66%
90792	PSYCH DIAG EVAL W/MED SRVCS	Medicare PFS	$132.03	$145.15	90.96%
90792	PSYCH DIAG EVAL W/MED SRVCS	Medicare PFS	$132.03	$158.36	83.37%
90832	PSYTX W PT 30 MINUTES	Medicare PFS	$54.80	$63.64	86.11%
90832	PSYTX W PT 30 MINUTES	Medicare PFS	$54.80	$68.78	79.67%
90832	PSYTX W PT 30 MINUTES	Medicare PFS	$59.80	$68.78	86.94%
90833	PSYTX W PT W E/M 30 MIN	Medicare PFS	$36.29	$66.59	54.50%
90833	PSYTX W PT W E/M 30 MIN	Medicare PFS	$36.29	$71.36	50.85%
90834	PSYTX W PT 45 MINUTES	Medicare PFS	$70.54	$84.98	83.01%
90834	PSYTX W PT 45 MINUTES	Medicare PFS	$70.54	$91.58	77.03%
90834	PSYTX W PT 45 MINUTES	Medicare PFS	$75.54	$84.98	88.89%
90834	PSYTX W PT 45 MINUTES	Medicare PFS	$75.54	$91.58	82.49%
90836	PSYTX W PT W E/M 45 MIN	Medicare PFS	$58.92	$84.32	69.88%
90836	PSYTX W PT W E/M 45 MIN	Medicare PFS	$58.92	$90.19	65.33%
90837	PSYTX W PT 60 MINUTES	Medicare PFS	$103.23	$127.66	80.86%
90837	PSYTX W PT 60 MINUTES	Medicare PFS	$103.23	$137.56	75.04%
90837	PSYTX W PT 60 MINUTES	Medicare PFS	$108.23	$137.56	78.68%
90838	PSYTX W PT W E/M 60 MIN	Medicare PFS	$95.19	$111.47	85.40%
90838	PSYTX W PT W E/M 60 MIN	Medicare PFS	$95.19	$119.18	79.87%
90839	PSYTX CRISIS INITIAL 60 MIN	Medicare PFS	$98.23	$143.35	68.52%
90846	FAMILY PSYTX W/O PT 50 MIN	Medicare PFS	$58.57	$103.08	56.82%
90846	FAMILY PSYTX W/O PT 50 MIN	Medicare PFS	$58.57	$110.79	52.87%
90847	FAMILY PSYTX W/PT 50 MIN	Medicare PFS	$61.44	$107.05	57.39%
90847	FAMILY PSYTX W/PT 50 MIN	Medicare PFS	$61.44	$115.12	53.37%
90853	GROUP PSYCHOTHERAPY	Medicare PFS	$12.12	$25.32	47.87%
90853	GROUP PSYCHOTHERAPY	Medicare PFS	$12.12	$27.52	44.04%
96101	PSYCHO TESTING BY PSYCH/PHYS	Medicare PFS	$62.01	$25.35	244.63%
96101	PSYCHO TESTING BY PSYCH/PHYS	Medicare PFS	$62.01	$48.46	127.97%
96102	PSYCHO TESTING BY TECHNICIAN	Medicare PFS	$120.56	$119.50	100.88%
96105	ASSESSMENT OF APHASIA	Medicare PFS	$45.78	$107.54	42.57%
96110	DEVELOPMENTAL SCREEN W/SCORE	Other States	$17.85	$14.97	119.27%
96110	DEVELOPMENTAL SCREEN W/SCORE	Other States	$18.21	$14.97	121.68%
96111	DEVELOPMENTAL TEST EXTEND	Medicare PFS	$103.76	$130.90	79.27%
96111	DEVELOPMENTAL TEST EXTEND	Medicare PFS	$103.76	$138.97	74.66%
96116	NEUROBEHAVIORAL STATUS EXAM	Medicare PFS	$73.12	$87.29	83.77%
96116	NEUROBEHAVIORAL STATUS EXAM	Medicare PFS	$73.12	$97.93	74.67%
96116	NUBHVL XM PHYS/QHP 1ST HR	Medicare PFS	$73.12	$97.93	74.67%
96118	NEUROPSYCH TST BY PSYCH/PHYS	Medicare PFS	$120.56	$109.95	109.65%
96118	NEUROPSYCH TST BY PSYCH/PHYS	Medicare PFS	$120.56	$134.53	89.61%
96119	NEUROPSYCH TESTING BY TEC	Medicare PFS	$120.56	$109.95	109.65%
96119	NEUROPSYCH TESTING BY TEC	Medicare PFS	$120.56	$134.53	89.61%
96125	COGNITIVE TEST BY HC PRO	Medicare PFS	$60.18	$113.42	53.06%
96127	BRIEF EMOTIONAL/BEHAV ASSMT	Medicare PFS	$4.20	$5.51	76.23%
H0001	ALCOHOL AND/OR DRUG ASSESS	Other States	$102.58	$105.37	97.35%
H0001	ALCOHOL AND/OR DRUG ASSESS	Other States	$102.58	$112.14	91.47%

H0004	ALCOHOL AND/OR DRUG SERVICES	Other States	$22.77	$28.52	79.84%
H0005	ALCOHOL AND/OR DRUG SERVICES	Other States	$30.16	$13.04	231.23%
H0006	ALCOHOL AND/OR DRUG SERVICES	Other States	$17.10	$21.03	81.31%
H0020	ALCOHOL AND/OR DRUG SERVICES	Other States	$14.83	$16.33	90.84%
S9445	PT EDUCATION NOC INDIVID	Other States	$12.89	$56.75	22.72%
T1019	PERSONAL CARE SER PER 15 MIN	Other States	$4.87	$4.98	97.89%

Appendix B4: RCCF Detailed Comparison Results

These appendices show the rate ratios for all unique combinations of Colorado Medicaid and Benchmark comparison rates found in the rate comparison benchmark analysis at a procedure code level. Procedure codes are duplicated to the extent that the modifiers, place of service code, service county, or other data elements impact the Colorado Medicaid or benchmark rate that the procedure code receives.

The services analyzed in the RCCF rate comparison benchmark analysis are repriced using a methodology that incorporates the following data elements:

- Procedure Code
- Modifiers
- Place of Service Code

HCPCS Code	Procedure Description	Benchmark Source	Colorado Rate	Benchmark Rate	Rate Ratio
90785	PSYTX COMPLEX INTERACTIVE	Other States	$4.14	$8.68	47.68%
90791	PSYCH DIAGNOSTIC EVALUATION	Other States	$108.62	$117.91	92.13%
90791	PSYCH DIAGNOSTIC EVALUATION	Other States	$108.62	$122.25	88.85%
90792	PSYCH DIAG EVAL W/MED SRVCS	Other States	$132.03	$132.46	99.68%
90792	PSYCH DIAG EVAL W/MED SRVCS	Other States	$132.03	$132.90	99.35%
90832	PSYTX W PT 30 MINUTES	Other States	$54.80	$52.79	103.81%
90832	PSYTX W PT 30 MINUTES	Other States	$54.80	$54.54	100.47%
90833	PSYTX W PT W E/M 30 MIN	Other States	$36.29	$46.96	77.28%
90834	PSYTX W PT 45 MINUTES	Other States	$70.54	$77.52	91.00%
90836	PSYTX W PT W E/M 45 MIN	Other States	$58.92	$67.32	87.53%
90837	PSYTX W PT 60 MINUTES	Other States	$103.23	$107.41	96.11%
90839	PSYTX CRISIS INITIAL 60 MIN	Other States	$98.23	$122.06	80.48%
90840	PSYTX CRISIS EA ADDL 30 MIN	Other States	$53.17	$73.91	71.94%
90846	FAMILY PSYTX W/O PT 50 MIN	Other States	$58.57	$82.89	70.66%
90847	FAMILY PSYTX W/PT 50 MIN	Other States	$61.44	$94.34	65.13%
90847	FAMILY PSYTX W/PT 50 MIN	Other States	$61.44	$95.18	64.55%
90853	GROUP PSYCHOTHERAPY	Other States	$12.12	$25.79	47.00%
90863	PHARMACOLOGIC MGMT W/PSYTX	Other States	$33.20	$40.68	81.62%
96101	PSYCHO TESTING BY PSYCH/PHYS	Other States	$62.01	$36.60	169.45%

Appendix B5: Dialysis (Facility) Detailed Comparison Results

Colorado Medicaid does not pay for dialysis (facility) services using a procedure code fee schedule, and thus rate ratios for procedure codes are not included in an appendix. However, it is possible to show rate ratios at the level of detail incorporated in the rate comparison benchmark analysis.

The services analyzed in the dialysis (facility) rate comparison benchmark analysis are repriced using methodology that incorporates the following data elements:

- Service county
- Revenue code
- Condition codes
- Procedure code
- Diagnosis codes
- Member age

Wage Index Region	Revenue Code	Condition Code	Procedure Description	Comorbidity Type	Age Band	Colorado Rate	Medicare PPS Rate	Rate Ratio
Boulder, CO	821	73			18 - 44	$197.41	$398.74	49.51%
Boulder, CO	821	84	DIALYSIS ACU KIDNEY NO ESRD		18 - 44	$197.41	$238.91	82.63%
Boulder, CO	821	84	DIALYSIS ACU KIDNEY NO ESRD		45 - 59	$197.41	$238.91	82.63%
Boulder, CO	821	84	DIALYSIS PROCEDURE		18 - 44	$197.41	$300.31	65.73%
Boulder, CO	821				18 - 44	$197.41	$300.31	65.73%
Boulder, CO	821				45 - 59	$197.41	$255.16	77.37%
Boulder, CO	821				60 - 69	$197.41	$255.64	77.22%
Boulder, CO	841	74			18 - 44	$197.41	$128.71	153.38%
Boulder, CO	851	73			18 - 44	$197.41	$398.74	49.51%
Boulder, CO	851	74			18 - 44	$197.41	$128.71	153.38%
Colorado Springs, CO	821				18 - 44	$188.54	$288.62	65.32%
Colorado Springs, CO	821				45 - 59	$188.54	$245.22	76.89%
Colorado Springs, CO	821				60 - 69	$188.54	$245.68	76.74%
Colorado Springs, CO	841	73			18 - 44	$188.54	$379.82	49.64%
Colorado Springs, CO	841	73			45 - 59	$188.54	$336.43	56.04%
Colorado Springs, CO	841	74			18 - 44	$188.54	$123.69	152.42%
Colorado Springs, CO	851	73			18 - 44	$188.54	$379.82	49.64%
Colorado Springs, CO	851	73			45 - 59	$188.54	$336.43	56.04%
Colorado Springs, CO	851	73			60 - 69	$188.54	$336.88	55.97%
Colorado Springs, CO	851	74			18 - 44	$188.54	$123.69	152.42%
Colorado Springs, CO	851	74			45 - 59	$188.54	$105.10	179.40%
Colorado Springs, CO	851	74			60 - 69	$188.54	$105.29	179.06%
Colorado Springs, CO	881				18 - 44	$188.54	$288.62	65.32%
Colorado Springs, CO	881				45 - 59	$188.54	$245.22	76.89%
Denver, Aurora, Lakewood	821	73			18 - 44	$203.23	$397.47	51.13%
Denver, Aurora, Lakewood	821	73			60 - 69	$203.23	$352.91	57.59%
Denver, Aurora, Lakewood	821	74			18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	821	74			45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	821	84	DIALYSIS ACU KIDNEY NO ESRD		18 - 44	$203.23	$238.28	85.29%
Denver, Aurora, Lakewood	821	84	DIALYSIS ACU KIDNEY NO ESRD		45 - 59	$203.23	$238.28	85.29%
Denver, Aurora, Lakewood	821	84	DIALYSIS ACU KIDNEY NO ESRD		60 - 69	$203.23	$238.28	85.29%
Denver, Aurora, Lakewood	821	84	DIALYSIS PROCEDURE		18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	821	84	DIALYSIS PROCEDURE		45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	821	84	DIALYSIS PROCEDURE		60 - 69	$203.23	$254.96	79.71%

Denver, Aurora, Lakewood	821				0 - 12	$203.23	$311.20	65.31%
Denver, Aurora, Lakewood	821				13 - 17	$203.23	$316.20	64.27%
Denver, Aurora, Lakewood	821				18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	821				60 - 69	$203.23	$254.96	79.71%
Denver, Aurora, Lakewood	821				70 - 79	$203.23	$238.28	85.29%
Denver, Aurora, Lakewood	821				80+	$203.23	$264.26	76.91%
Denver, Aurora, Lakewood	821			Hereditary Hemolytic and Sickle Cell Anemia	18 - 44	$203.23	$357.03	56.92%
Denver, Aurora, Lakewood	821				45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	829				18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	829				45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	831				18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	841	73			18 - 44	$203.23	$397.47	51.13%
Denver, Aurora, Lakewood	841	73			45 - 59	$203.23	$352.43	57.67%
Denver, Aurora, Lakewood	841	73			60 - 69	$203.23	$352.91	57.59%
Denver, Aurora, Lakewood	841	74			18 - 44	$203.23	$128.37	158.32%
Denver, Aurora, Lakewood	841	74			45 - 59	$203.23	$109.07	186.34%
Denver, Aurora, Lakewood	841	74			60 - 69	$203.23	$109.27	185.99%
Denver, Aurora, Lakewood	841	74			70 - 79	$203.23	$102.12	199.01%
Denver, Aurora, Lakewood	851	73			13 - 17	$203.23	$360.53	56.37%
Denver, Aurora, Lakewood	851	73			18 - 44	$203.23	$397.47	51.13%
Denver, Aurora, Lakewood	851	73			45 - 59	$203.23	$352.43	57.67%
Denver, Aurora, Lakewood	851	73			60 - 69	$203.23	$352.91	57.59%
Denver, Aurora, Lakewood	851	74			0 - 12	$203.23	$108.56	187.21%
Denver, Aurora, Lakewood	851	74			13 - 17	$203.23	$112.54	180.59%
Denver, Aurora, Lakewood	851	74			18 - 44	$203.23	$128.37	158.32%
Denver, Aurora, Lakewood	851	74			45 - 59	$203.23	$109.07	186.34%
Denver, Aurora, Lakewood	851	74			60 - 69	$203.23	$109.27	185.99%
Denver, Aurora, Lakewood	851	74			70 - 79	$203.23	$102.12	199.01%
Denver, Aurora, Lakewood	851				45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	851				60 - 69	$203.23	$254.96	79.71%
Denver, Aurora, Lakewood	881				18 - 44	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	881				45 - 59	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	881				60 - 69	$203.23	$254.96	79.71%
Fort Collins, CO	821				18 - 44	$202.61	$293.97	68.92%
Fort Collins, CO	821				45 - 59	$202.61	$249.77	81.12%
Fort Collins, CO	821				60 - 69	$202.61	$250.24	80.97%
Fort Collins, CO	821				70 - 79	$202.61	$233.87	86.63%
Fort Collins, CO	841	73			45 - 59	$202.61	$344.28	58.85%
Fort Collins, CO	841	74			45 - 59	$202.61	$107.04	189.28%
Fort Collins, CO	851	73			45 - 59	$202.61	$344.28	58.85%
Fort Collins, CO	851	74			60 - 69	$202.61	$107.24	188.92%
Grand Junction, CO	821				18 - 44	$195.23	$289.27	67.49%
Grand Junction, CO	821				45 - 59	$195.23	$245.78	79.43%
Grand Junction, CO	821				60 - 69	$195.23	$246.24	79.29%
Grand Junction, CO	821				80+	$195.23	$255.21	76.50%
Greeley, CO	821	73			18 - 44	$192.30	$367.76	52.29%

Greeley, CO	821				18 - 44	$192.30	$281.16	68.39%
Greeley, CO	821				45 - 59	$192.30	$238.89	80.50%
Greeley, CO	821				60 - 69	$192.30	$239.34	80.35%
Greeley, CO	821				70 - 79	$192.30	$223.68	85.97%
Greeley, CO	841	73			18 - 44	$192.30	$367.76	52.29%
Pueblo, CO	821				18 - 44	$177.09	$270.96	65.36%
Pueblo, CO	821				45 - 59	$177.09	$230.22	76.92%
Pueblo, CO	821				60 - 69	$177.09	$230.65	76.78%
Pueblo, CO	821				70 - 79	$177.09	$215.56	82.15%
Pueblo, CO	841	73			18 - 44	$177.09	$351.24	50.42%
Pueblo, CO	841	73			45 - 59	$177.09	$310.50	57.03%
Pueblo, CO	841	74			18 - 44	$177.09	$116.12	152.50%
Pueblo, CO	841	74			45 - 59	$177.09	$98.66	179.49%
Pueblo, CO	841				45 - 59	$177.09	$230.22	76.92%
Pueblo, CO	851	73			18 - 44	$177.09	$351.24	50.42%
Pueblo, CO	851	73			45 - 59	$177.09	$310.50	57.03%
Pueblo, CO	851	74			18 - 44	$177.09	$116.12	152.50%
Pueblo, CO	851	74			45 - 59	$177.09	$98.66	179.49%
Rural Colorado	821				18 - 44	$196.01	$298.44	65.68%
Rural Colorado	821				45 - 59	$196.01	$253.56	77.30%
Rural Colorado	821				60 - 69	$196.01	$254.04	77.16%
Rural Colorado	841	73			18 - 44	$196.01	$394.33	49.71%
Rural Colorado	841	73			45 - 59	$196.01	$349.46	56.09%
Rural Colorado	841	74			18 - 44	$196.01	$127.90	153.25%
Rural Colorado	841				60 - 69	$196.01	$254.04	77.16%
Rural Colorado	851	73			45 - 59	$196.01	$349.46	56.09%
Rural Colorado	851	74			18 - 44	$196.01	$127.90	153.25%
Rural Colorado	851	74			45 - 59	$196.01	$108.67	180.37%
Rural Colorado	851	74			60 - 69	$196.01	$108.87	180.03%
Rural Colorado	851				60 - 69	$196.01	$254.04	77.16%

Appendix B6: Dialysis (Professional) Detailed Comparison Results

These appendices show the rate ratios for all unique combinations of Colorado Medicaid and Benchmark comparison rates found in the rate comparison benchmark analysis at a procedure code level. Procedure codes are duplicated to the extent that the modifiers, place of service code, service county, or other data elements impact the Colorado Medicaid or benchmark rate that the procedure code receives.

The services analyzed in the dialysis (professional) rate comparison benchmark analysis are repriced using methodology that incorporates the following data elements:

- Procedure code

HCPCS Code	Procedure Description	Benchmark Source	Colorado Rate	Benchmark Rate	Rate Ratio
90937	HEMODIALYSIS REPEATED EVAL	Medicare PFS	$102.29	$106.96	95.63%
90963	ESRD HOME PT SERV P MO <2YRS	Medicare PFS	$403.01	$559.79	71.99%
90966	ESRD HOME PT SERV P MO 20+	Medicare PFS	$166.78	$243.99	68.36%
90989	DIALYSIS TRAINING COMPLETE	Other States	$500.05	$457.30	109.35%

Appendix B7: DME Detailed Comparison Results

These appendices show the rate ratios for all unique combinations of Colorado Medicaid and Benchmark comparison rates found in the rate comparison benchmark analysis at a procedure code level. Procedure codes are duplicated to the extent that the modifiers, place of service code, service county, or other data elements impact the Colorado Medicaid or benchmark rate that the procedure code receives.

The services analyzed in the DME rate comparison benchmark analysis are repriced using methodology that incorporates the following data elements:

- Procedure code
- Modifiers
- Member zip code

HCPCS Code	Procedure Description	UPL Status	Benchmark Fee Schedule	Colorado Rate	Benchmark Rate	Rate Ratio
A7007	LG VOL NEBULIZER DISPOSABLE	UPL	Medicare CBA CO Spgs	$3.10	$3.10	100.00%
A7007	LG VOL NEBULIZER DISPOSABLE	UPL	Medicare CBA Denver	$3.10	$3.10	100.00%
A7007	LG VOL NEBULIZER DISPOSABLE	UPL	Medicare DMEPOS	$3.24	$3.24	100.00%
A7007	LG VOL NEBULIZER DISPOSABLE	UPL	Medicare DMEPOS	$4.25	$4.25	100.00%
E0100	CANE ADJUST/FIXED WITH TIP	UPL	Medicare DMEPOS	$24.27	$24.27	100.00%
E0105	CANE ADJUST/FIXED QUAD/3 PRO	UPL	Medicare DMEPOS	$54.75	$54.75	100.00%
E0110	CRUTCH FOREARM PAIR	UPL	Medicare DMEPOS	$75.94	$75.94	100.00%
E0111	CRUTCH FOREARM EACH	UPL	Medicare DMEPOS	$59.27	$59.27	100.00%
E0114	CRUTCH UNDERARM PAIR NO WOOD	UPL	Medicare DMEPOS	$9.86	$9.86	100.00%
E0114	CRUTCH UNDERARM PAIR NO WOOD	UPL	Medicare DMEPOS	$41.08	$41.08	100.00%
E0114	CRUTCH UNDERARM PAIR NO WOOD	UPL	Medicare DMEPOS	$54.34	$54.34	100.00%
E0116	CRUTCH UNDERARM EACH NO WOOD	UPL	Medicare DMEPOS	$27.16	$27.16	100.00%
E0117	UNDERARM SPRINGASSIST CRUTCH	Non-UPL	Other States	$196.95	$179.06	109.99%
E0130	WALKER RIGID ADJUST/FIXED HT	UPL	Medicare DMEPOS	$44.90	$44.90	100.00%
E0130	WALKER RIGID ADJUST/FIXED HT	UPL	Medicare DMEPOS	$59.09	$59.09	100.00%
E0135	WALKER FOLDING ADJUST/FIXED	UPL	Medicare CBA CO Spgs	$42.73	$42.73	100.00%
E0135	WALKER FOLDING ADJUST/FIXED	UPL	Medicare CBA Denver	$43.10	$43.10	100.00%
E0135	WALKER FOLDING ADJUST/FIXED	UPL	Medicare DMEPOS	$44.90	$44.90	100.00%
E0135	WALKER FOLDING ADJUST/FIXED	UPL	Medicare DMEPOS	$62.43	$62.43	100.00%
E0140	WALKER W TRUNK SUPPORT	UPL	CO DME UPL	$261.60	$261.60	100.00%
E0141	RIGID WHEELED WALKER ADJ/FIX	UPL	Medicare CBA Denver	$74.85	$74.85	100.00%
E0141	RIGID WHEELED WALKER ADJ/FIX	UPL	Medicare DMEPOS	$44.90	$44.90	100.00%
E0141	RIGID WHEELED WALKER ADJ/FIX	UPL	Medicare DMEPOS	$82.52	$82.52	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare CBA CO Spgs	$4.72	$4.72	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare CBA CO Spgs	$47.10	$47.10	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare CBA Denver	$4.72	$4.72	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare CBA Denver	$47.10	$47.10	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare DMEPOS	$13.25	$13.25	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare DMEPOS	$44.90	$44.90	100.00%
E0143	WALKER FOLDING WHEELED W/O S	UPL	Medicare DMEPOS	$84.96	$84.96	100.00%
E0144	ENCLOSED WALKER W REAR SEAT	UPL	CO DME UPL	$268.30	$268.30	100.00%
E0144	ENCLOSED WALKER W REAR SEAT	UPL	CO DME UPL	$292.20	$292.20	100.00%
E0147	WALKER VARIABLE WHEEL RESIST	UPL	Medicare DMEPOS	$397.92	$397.92	100.00%
E0147	WALKER VARIABLE WHEEL RESIST	UPL	Medicare DMEPOS	$502.73	$502.73	100.00%
E0148	HEAVYDUTY WALKER NO WHEELS	UPL	Medicare CBA CO Spgs	$81.81	$81.81	100.00%
E0148	HEAVYDUTY WALKER NO WHEELS	UPL	Medicare CBA Denver	$8.18	$8.18	100.00%
E0148	HEAVYDUTY WALKER NO WHEELS	UPL	Medicare CBA Denver	$81.81	$81.81	100.00%
E0148	HEAVYDUTY WALKER NO WHEELS	UPL	Medicare DMEPOS	$80.30	$80.30	100.00%
E0149	HEAVY DUTY WHEELED WALKER	UPL	CO DME UPL	$111.10	$111.10	100.00%
E0149	HEAVY DUTY WHEELED WALKER	UPL	CO DME UPL	$173.30	$173.30	100.00%
E0149	HEAVY DUTY WHEELED WALKER	UPL	Medicare CBA Denver	$12.32	$12.32	100.00%
E0153	FOREARM CRUTCH PLATFORM ATTA	Non-UPL	Medicare DMEPOS	$59.91	$68.86	87.00%
E0154	WALKER PLATFORM ATTACHMENT	Non-UPL	Medicare CBA CO Spgs	$58.40	$42.83	136.35%
E0154	WALKER PLATFORM ATTACHMENT	Non-UPL	Medicare CBA Denver	$58.40	$46.79	124.81%
E0154	WALKER PLATFORM ATTACHMENT	Non-UPL	Medicare DMEPOS	$58.40	$46.55	125.46%
E0154	WALKER PLATFORM ATTACHMENT	Non-UPL	Medicare DMEPOS	$58.40	$59.66	97.89%
E0154	WALKER PLATFORM ATTACHMENT	Non-UPL	Other States	$58.40	$57.77	101.09%

E0155	WALKER WHEEL ATTACHMENT,PAIR	Non-UPL	Medicare CBA CO Spgs	$26.81	$18.88	142.00%
E0155	WALKER WHEEL ATTACHMENT,PAIR	Non-UPL	Medicare CBA Denver	$26.81	$18.88	142.00%
E0155	WALKER WHEEL ATTACHMENT,PAIR	Non-UPL	Medicare DMEPOS	$26.81	$21.12	126.94%
E0155	WALKER WHEEL ATTACHMENT,PAIR	Non-UPL	Medicare DMEPOS	$26.81	$26.53	101.06%
E0155	WALKER WHEEL ATTACHMENT,PAIR	Non-UPL	Other States	$26.81	$25.63	104.60%
E0156	WALKER SEAT ATTACHMENT	Non-UPL	Medicare DMEPOS	$19.40	$15.09	128.56%
E0156	WALKER SEAT ATTACHMENT	Non-UPL	Medicare DMEPOS	$19.40	$19.54	99.28%
E0156	WALKER SEAT ATTACHMENT	Non-UPL	Other States	$19.40	$20.02	96.89%
E0158	WALKER LEG EXTENDERS SET OF4	Non-UPL	Medicare DMEPOS	$25.22	$21.56	116.98%
E0159	BRAKE FOR WHEELED WALKER	Non-UPL	Medicare CBA Denver	$15.41	$13.68	112.65%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare CBA CO Spgs	$51.25	$51.25	100.00%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare CBA Denver	$50.83	$50.83	100.00%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare DMEPOS	$5.27	$5.27	100.00%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare DMEPOS	$16.87	$16.87	100.00%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare DMEPOS	$52.73	$52.73	100.00%
E0163	COMMODE CHAIR WITH FIXED ARM	UPL	Medicare DMEPOS	$89.15	$89.15	100.00%
E0165	COMMODE CHAIR WITH DETACHARM	UPL	CO DME UPL	$124.70	$124.70	100.00%
E0165	COMMODE CHAIR WITH DETACHARM	UPL	CO DME UPL	$172.30	$172.30	100.00%
E0168	HEAVYDUTY/WIDE COMMODE CHAIR	UPL	Medicare CBA CO Spgs	$120.19	$120.19	100.00%
E0168	HEAVYDUTY/WIDE COMMODE CHAIR	UPL	Medicare CBA Denver	$115.53	$115.53	100.00%
E0168	HEAVYDUTY/WIDE COMMODE CHAIR	UPL	Medicare DMEPOS	$120.61	$120.61	100.00%
E0168	HEAVYDUTY/WIDE COMMODE CHAIR	UPL	Medicare DMEPOS	$149.31	$149.31	100.00%
E0175	COMMODE CHAIR FOOT REST	Non-UPL	Medicare DMEPOS	$66.35	$76.26	87.00%
E0175	COMMODE CHAIR FOOT REST	Non-UPL	Other States	$66.35	$64.41	103.01%
E0181	PRESS PAD ALTERNATING W/ PUM	UPL	CO DME UPL	$162.10	$162.10	100.00%
E0181	PRESS PAD ALTERNATING W/ PUM	UPL	Medicare CBA CO Spgs	$17.85	$17.85	100.00%
E0181	PRESS PAD ALTERNATING W/ PUM	UPL	Medicare CBA Denver	$16.41	$16.41	100.00%
E0184	DRY PRESSURE MATTRESS	UPL	Medicare CBA CO Spgs	$157.83	$157.83	100.00%
E0184	DRY PRESSURE MATTRESS	UPL	Medicare CBA Denver	$157.89	$157.89	100.00%
E0184	DRY PRESSURE MATTRESS	UPL	Medicare DMEPOS	$16.50	$16.50	100.00%
E0184	DRY PRESSURE MATTRESS	UPL	Medicare DMEPOS	$164.99	$164.99	100.00%
E0184	DRY PRESSURE MATTRESS	UPL	Medicare DMEPOS	$181.09	$181.09	100.00%
E0185	GEL PRESSURE MATTRESS PAD	UPL	Medicare CBA CO Spgs	$160.01	$160.01	100.00%
E0185	GEL PRESSURE MATTRESS PAD	UPL	Medicare CBA Denver	$157.16	$157.16	100.00%
E0185	GEL PRESSURE MATTRESS PAD	UPL	Medicare DMEPOS	$155.27	$155.27	100.00%
E0188	SYNTHETIC SHEEPSKIN PAD	UPL	Medicare CBA CO Spgs	$21.89	$21.89	100.00%
E0188	SYNTHETIC SHEEPSKIN PAD	UPL	Medicare CBA Denver	$22.37	$22.37	100.00%
E0188	SYNTHETIC SHEEPSKIN PAD	UPL	Medicare DMEPOS	$23.23	$23.23	100.00%
E0188	SYNTHETIC SHEEPSKIN PAD	UPL	Medicare DMEPOS	$25.87	$25.87	100.00%
E0189	LAMBSWOOL SHEEPSKIN PAD	UPL	Medicare CBA Denver	$48.44	$48.44	100.00%
E0189	LAMBSWOOL SHEEPSKIN PAD	UPL	Medicare DMEPOS	$48.32	$48.32	100.00%
E0189	LAMBSWOOL SHEEPSKIN PAD	UPL	Medicare DMEPOS	$50.86	$50.86	100.00%
E0190	POSITIONING CUSHION	Non-UPL	Other States	$263.04	$75.64	347.75%
E0191	PROTECTOR HEEL OR ELBOW	Non-UPL	Medicare DMEPOS	$10.01	$11.51	86.97%
E0197	AIR PRESSURE PAD FOR MATTRES	UPL	CO DME UPL	$179.80	$179.80	100.00%
E0197	AIR PRESSURE PAD FOR MATTRES	UPL	CO DME UPL	$272.80	$272.80	100.00%
E0202	PHOTOTHERAPY LIGHT W/ PHOTOM	Non-UPL	Other States	$51.99	$112.35	46.28%
E0217	WATER CIRC HEAT PAD W PUMP	Non-UPL	Medicare DMEPOS	$507.37	$571.63	88.76%
E0217	WATER CIRC HEAT PAD W PUMP	Non-UPL	Other States	$507.37	$593.77	85.45%

E0218	WATER CIRC COLD PAD W PUMP	Non-UPL	Other States	$45.59	$218.45	20.87%
E0218	WATER CIRC COLD PAD W PUMP	Non-UPL	Other States	$354.75	$431.30	82.25%
E0221	INFRARED HEATING PAD SYSTEM	Non-UPL	Other States	$2,285.67	$1,280.99	178.43%
E0221	INFRARED HEATING PAD SYSTEM	Non-UPL	Other States	$2,285.67	$1,593.60	143.43%
E0235	PARAFFIN BATH UNIT PORTABLE	UPL	CO DME UPL	$198.60	$198.60	100.00%
E0241	BATH TUB WALL RAIL	Non-UPL	Other States	$20.32	$31.31	64.90%
E0241	BATH TUB WALL RAIL	Non-UPL	Other States	$20.32	$31.40	64.72%
E0242	BATH TUB RAIL FLOOR	Non-UPL	Other States	$124.84	$54.00	231.19%
E0243	TOILET RAIL	Non-UPL	Other States	$33.56	$47.14	71.20%
E0243	TOILET RAIL	Non-UPL	Other States	$33.56	$48.88	68.66%
E0244	TOILET SEAT RAISED	Non-UPL	Other States	$27.94	$49.28	56.69%
E0244	TOILET SEAT RAISED	Non-UPL	Other States	$27.94	$51.02	54.76%
E0245	TUB STOOL OR BENCH	Non-UPL	Other States	$49.93	$7.86	635.24%
E0245	TUB STOOL OR BENCH	Non-UPL	Other States	$49.93	$68.54	72.85%
E0245	TUB STOOL OR BENCH	Non-UPL	Other States	$49.93	$84.64	58.99%
E0245	TUB STOOL OR BENCH	Non-UPL	Other States	$169.46	$68.54	247.26%
E0246	TRANSFER TUB RAIL ATTACHMENT	Non-UPL	Other States	$47.93	$44.54	107.61%
E0246	TRANSFER TUB RAIL ATTACHMENT	Non-UPL	Other States	$47.93	$45.54	105.25%
E0247	TRANS BENCH W/WO COMM OPEN	Non-UPL	Other States	$94.31	$81.42	115.83%
E0247	TRANS BENCH W/WO COMM OPEN	Non-UPL	Other States	$94.31	$102.14	92.33%
E0247	TRANS BENCH W/WO COMM OPEN	Non-UPL	Other States	$176.54	$81.42	216.83%
E0247	TRANS BENCH W/WO COMM OPEN	Non-UPL	Other States	$176.54	$102.14	172.84%
E0248	HDTRANS BENCH W/WO COMM OPEN	Non-UPL	Other States	$197.54	$147.93	133.54%
E0250	HOSP BED FIXED HT W/ MATTRES	UPL	Medicare CBA Denver	$61.67	$61.67	100.00%
E0250	HOSP BED FIXED HT W/ MATTRES	UPL	Medicare DMEPOS	$59.95	$59.95	100.00%
E0255	HOSPITAL BED VAR HT W/ MATTR	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0255	HOSPITAL BED VAR HT W/ MATTR	UPL	CO DME UPL	$909.70	$909.70	100.00%
E0255	HOSPITAL BED VAR HT W/ MATTR	UPL	Medicare CBA Denver	$68.84	$68.84	100.00%
E0255	HOSPITAL BED VAR HT W/ MATTR	UPL	Medicare DMEPOS	$59.95	$59.95	100.00%
E0256	HOSPITAL BED VAR HT W/O MATT	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	CO DME UPL	$1,024.00	$1,024.00	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	Medicare CBA CO Spgs	$61.39	$61.39	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	Medicare CBA Denver	$60.93	$60.93	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	Medicare DMEPOS	$59.95	$59.95	100.00%
E0260	HOSP BED SEMI-ELECTR W/ MATT	UPL	Medicare DMEPOS	$102.40	$102.40	100.00%
E0261	HOSP BED SEMI-ELECTR W/O MAT	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0261	HOSP BED SEMI-ELECTR W/O MAT	UPL	CO DME UPL	$1,006.20	$1,006.20	100.00%
E0261	HOSP BED SEMI-ELECTR W/O MAT	UPL	Medicare CBA Denver	$59.01	$59.01	100.00%
E0261	HOSP BED SEMI-ELECTR W/O MAT	UPL	Medicare DMEPOS	$59.95	$59.95	100.00%
E0261	HOSP BED SEMI-ELECTR W/O MAT	UPL	Medicare DMEPOS	$100.62	$100.62	100.00%
E0265	HOSP BED TOTAL ELECTR W/ MAT	UPL	CO DME UPL	$1,436.90	$1,436.90	100.00%
E0265	HOSP BED TOTAL ELECTR W/ MAT	UPL	CO DME UPL	$1,710.30	$1,710.30	100.00%
E0265	HOSP BED TOTAL ELECTR W/ MAT	UPL	Medicare DMEPOS	$143.69	$143.69	100.00%
E0266	HOSP BED TOTAL ELEC W/O MATT	UPL	CO DME UPL	$1,250.30	$1,250.30	100.00%
E0266	HOSP BED TOTAL ELEC W/O MATT	UPL	CO DME UPL	$1,446.40	$1,446.40	100.00%
E0266	HOSP BED TOTAL ELEC W/O MATT	UPL	Medicare DMEPOS	$125.03	$125.03	100.00%
E0271	MATTRESS INNERSPRING	Non-UPL	Medicare CBA CO Spgs	$194.77	$127.95	152.22%
E0271	MATTRESS INNERSPRING	Non-UPL	Medicare CBA Denver	$194.77	$127.69	152.53%

E0271	MATTRESS INNERSPRING	Non-UPL	Medicare DMEPOS	$194.77	$131.92	147.64%
E0271	MATTRESS INNERSPRING	Non-UPL	Medicare DMEPOS	$194.77	$135.53	143.71%
E0271	MATTRESS INNERSPRING	Non-UPL	Medicare DMEPOS	$194.77	$176.13	110.58%
E0271	MATTRESS INNERSPRING	Non-UPL	Other States	$194.77	$168.87	115.34%
E0272	MATTRESS FOAM RUBBER	Non-UPL	Medicare CBA Denver	$170.04	$135.67	125.33%
E0272	MATTRESS FOAM RUBBER	Non-UPL	Medicare DMEPOS	$170.04	$135.56	125.44%
E0272	MATTRESS FOAM RUBBER	Non-UPL	Medicare DMEPOS	$170.04	$172.53	98.56%
E0272	MATTRESS FOAM RUBBER	Non-UPL	Other States	$170.04	$163.96	103.71%
E0276	BED PAN FRACTURE	Non-UPL	Medicare CBA Denver	$5.24	$11.88	44.11%
E0277	POWERED PRES-REDU AIR MATTRS	UPL	CO DME UPL	$1,952.00	$1,952.00	100.00%
E0277	POWERED PRES-REDU AIR MATTRS	UPL	CO DME UPL	$4,517.50	$4,517.50	100.00%
E0277	POWERED PRES-REDU AIR MATTRS	UPL	Medicare CBA Denver	$192.91	$192.91	100.00%
E0293	HOSP BED VAR HT NO SR NO MAT	UPL	CO DME UPL	$567.30	$567.30	100.00%
E0294	HOSP BED SEMI-ELECT W/ MATTR	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0295	HOSP BED SEMI-ELECT W/O MATT	UPL	CO DME UPL	$599.50	$599.50	100.00%
E0295	HOSP BED SEMI-ELECT W/O MATT	UPL	CO DME UPL	$958.50	$958.50	100.00%
E0295	HOSP BED SEMI-ELECT W/O MATT	UPL	Medicare CBA Denver	$63.50	$63.50	100.00%
E0296	HOSP BED TOTAL ELECT W/ MATT	UPL	CO DME UPL	$1,121.10	$1,121.10	100.00%
E0297	HOSP BED TOTAL ELECT W/O MAT	Non-UPL	Medicare DMEPOS	$119.10	$98.94	120.38%
E0297	HOSP BED TOTAL ELECT W/O MAT	Non-UPL	Other States	$1,788.76	$1,145.82	156.11%
E0297	HOSP BED TOTAL ELECT W/O MAT	Non-UPL	Other States	$1,788.76	$1,252.44	142.82%
E0300	ENCLOSED PED CRIB HOSP GRADE	UPL	CO DME UPL	$2,498.20	$2,498.20	100.00%
E0301	HD HOSP BED, 350-600 LBS	UPL	CO DME UPL	$1,577.70	$1,577.70	100.00%
E0302	EX HD HOSP BED > 600 LBS	UPL	CO DME UPL	$4,597.60	$4,597.60	100.00%
E0303	HOSP BED HVY DTY XTRA WIDE	UPL	CO DME UPL	$1,585.60	$1,585.60	100.00%
E0304	HOSP BED XTRA HVY DTY X WIDE	UPL	CO DME UPL	$4,645.50	$4,645.50	100.00%
E0305	RAILS BED SIDE HALF LENGTH	Non-UPL	Other States	$175.26	$164.92	106.27%
E0305	RAILS BED SIDE HALF LENGTH	Non-UPL	Other States	$175.26	$174.34	100.53%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Medicare CBA CO Spgs	$142.52	$108.65	131.17%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Medicare CBA Denver	$142.52	$106.58	133.72%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Medicare DMEPOS	$142.52	$110.12	129.42%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Medicare DMEPOS	$142.52	$141.54	100.69%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Other States	$142.52	$153.59	92.79%
E0310	RAILS BED SIDE FULL LENGTH	Non-UPL	Other States	$142.52	$165.50	86.12%
E0316	BED SAFETY ENCLOSURE	Non-UPL	Other States	$1,228.71	$1,491.10	82.40%
E0325	URINAL MALE JUG-TYPE	Non-UPL	Medicare DMEPOS	$4.50	$8.59	52.39%
E0325	URINAL MALE JUG-TYPE	Non-UPL	Other States	$4.50	$9.12	49.32%
E0326	URINAL FEMALE JUG-TYPE	Non-UPL	Medicare CBA Denver	$7.97	$8.96	88.95%
E0326	URINAL FEMALE JUG-TYPE	Non-UPL	Other States	$7.97	$9.98	79.86%
E0371	NONPOWER MATTRESS OVERLAY	UPL	CO DME UPL	$1,952.00	$1,952.00	100.00%
E0372	POWERED AIR MATTRESS OVERLAY	UPL	CO DME UPL	$1,952.00	$1,952.00	100.00%
E0424	STATIONARY COMPRESSED GAS 02	UPL	Medicare CBA CO Spgs	$75.31	$75.31	100.00%
E0424	STATIONARY COMPRESSED GAS 02	UPL	Medicare CBA Denver	$73.88	$73.88	100.00%
E0424	STATIONARY COMPRESSED GAS 02	UPL	Medicare DMEPOS	$73.80	$73.80	100.00%
E0424	STATIONARY COMPRESSED GAS 02	UPL	Medicare DMEPOS	$134.71	$134.71	100.00%
E0431	PORTABLE GASEOUS 02	UPL	Medicare CBA CO Spgs	$16.52	$16.52	100.00%
E0431	PORTABLE GASEOUS 02	UPL	Medicare CBA Denver	$16.49	$16.49	100.00%
E0431	PORTABLE GASEOUS 02	UPL	Medicare CBA Denver	$36.94	$36.94	100.00%
E0431	PORTABLE GASEOUS 02	UPL	Medicare DMEPOS	$16.73	$16.73	100.00%

E0431	PORTABLE GASEOUS 02	UPL	Medicare DMEPOS	$24.00	$24.00	100.00%
E0431	PORTABLE GASEOUS 02	UPL	Medicare DMEPOS	$36.90	$36.90	100.00%
E0434	PORTABLE LIQUID 02	UPL	Medicare CBA CO Spgs	$35.86	$35.86	100.00%
E0434	PORTABLE LIQUID 02	UPL	Medicare CBA Denver	$36.48	$36.48	100.00%
E0434	PORTABLE LIQUID 02	UPL	Medicare DMEPOS	$37.01	$37.01	100.00%
E0434	PORTABLE LIQUID 02	UPL	Medicare DMEPOS	$44.32	$44.32	100.00%
E0439	STATIONARY LIQUID 02	UPL	Medicare CBA CO Spgs	$75.31	$75.31	100.00%
E0439	STATIONARY LIQUID 02	UPL	Medicare CBA Denver	$73.88	$73.88	100.00%
E0439	STATIONARY LIQUID 02	UPL	Medicare DMEPOS	$73.80	$73.80	100.00%
E0439	STATIONARY LIQUID 02	UPL	Medicare DMEPOS	$134.71	$134.71	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	UPL	Medicare CBA CO Spgs	$50.74	$50.74	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	UPL	Medicare CBA Denver	$50.81	$50.81	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	UPL	Medicare DMEPOS	$51.30	$51.30	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	UPL	Medicare DMEPOS	$64.20	$64.20	100.00%
E0442	STATIONARY O2 CONTENTS, LIQ	UPL	Medicare CBA CO Spgs	$50.74	$50.74	100.00%
E0442	STATIONARY O2 CONTENTS, LIQ	UPL	Medicare CBA Denver	$50.81	$50.81	100.00%
E0442	STATIONARY O2 CONTENTS, LIQ	UPL	Medicare DMEPOS	$51.30	$51.30	100.00%
E0442	STATIONARY O2 CONTENTS, LIQ	UPL	Medicare DMEPOS	$64.20	$64.20	100.00%
E0445	OXIMETER NON-INVASIVE	Non-UPL	Other States	$49.93	$24.23	206.07%
E0445	OXIMETER NON-INVASIVE	Non-UPL	Other States	$49.93	$657.72	7.59%
E0445	OXIMETER NON-INVASIVE	Non-UPL	Other States	$367.17	$455.44	80.62%
E0445	OXIMETER NON-INVASIVE	Non-UPL	Other States	$754.40	$1,291.20	58.43%
E0465	HOME VENT INVASIVE INTERFACE	UPL	Medicare DMEPOS	$934.17	$934.17	100.00%
E0466	HOME VENT NON-INVASIVE INTER	UPL	Medicare DMEPOS	$934.17	$934.17	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	CO DME UPL	$1,067.40	$1,067.40	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	CO DME UPL	$1,855.20	$1,855.20	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	Medicare CBA CO Spgs	$109.54	$109.54	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	Medicare CBA Denver	$107.41	$107.41	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	Medicare DMEPOS	$106.74	$106.74	100.00%
E0470	RAD W/O BACKUP NON-INV INTFC	UPL	Medicare DMEPOS	$185.52	$185.52	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	CO DME UPL	$2,712.90	$2,712.90	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	CO DME UPL	$4,232.20	$4,232.20	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	Medicare CBA CO Spgs	$277.78	$277.78	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	Medicare CBA Denver	$271.47	$271.47	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	Medicare DMEPOS	$271.29	$271.29	100.00%
E0471	RAD W/BACKUP NON INV INTRFC	UPL	Medicare DMEPOS	$423.22	$423.22	100.00%
E0480	PERCUSSOR ELECT/PNEUM HOME M	Non-UPL	Medicare DMEPOS	$34.28	$46.07	74.41%
E0482	COUGH STIMULATING DEVICE	UPL	CO DME UPL	$4,951.30	$4,951.30	100.00%
E0482	COUGH STIMULATING DEVICE	UPL	Medicare DMEPOS	$495.13	$495.13	100.00%
E0483	CHEST COMPRESSION GEN SYSTEM	UPL	CO DME UPL	$12,240.70	$12,240.70	100.00%
E0483	CHEST COMPRESSION GEN SYSTEM	UPL	Medicare DMEPOS	$1,224.07	$1,224.07	100.00%
E0500	IPPB ALL TYPES	UPL	Medicare DMEPOS	$107.41	$107.41	100.00%
E0550	HUMIDIF EXTENS SUPPLE W IPPB	Non-UPL	Medicare DMEPOS	$7.82	$57.72	13.55%
E0550	HUMIDIF EXTENS SUPPLE W IPPB	Non-UPL	Other States	$271.17	$501.30	54.09%
E0555	HUMIDIFIER FOR USE W/ REGULA	Non-UPL	Other States	$51.71	$15.45	334.69%
E0560	HUMIDIFIER SUPPLEMENTAL W/ I	Non-UPL	Other States	$53.88	$167.73	32.12%
E0562	HUMIDIFIER HEATED USED W PAP	Non-UPL	Medicare CBA CO Spgs	$239.70	$137.95	173.76%
E0562	HUMIDIFIER HEATED USED W PAP	Non-UPL	Medicare CBA Denver	$239.70	$136.56	175.53%
E0562	HUMIDIFIER HEATED USED W PAP	Non-UPL	Medicare DMEPOS	$239.70	$133.55	179.48%

E0562	HUMIDIFIER HEATED USED W PAP	Non-UPL	Medicare DMEPOS	$239.70	$223.90	107.06%
E0562	HUMIDIFIER HEATED USED W PAP	Non-UPL	Other States	$239.70	$215.27	111.35%
E0565	COMPRESSOR AIR POWER SOURCE	Non-UPL	Other States	$420.64	$579.04	72.64%
E0565	COMPRESSOR AIR POWER SOURCE	Non-UPL	Other States	$420.64	$597.90	70.35%
E0570	NEBULIZER WITH COMPRESSION	UPL	CO DME UPL	$55.90	$55.90	100.00%
E0570	NEBULIZER WITH COMPRESSION	UPL	CO DME UPL	$123.60	$123.60	100.00%
E0570	NEBULIZER WITH COMPRESSION	UPL	Medicare CBA CO Spgs	$5.17	$5.17	100.00%
E0570	NEBULIZER WITH COMPRESSION	UPL	Medicare DMEPOS	$5.59	$5.59	100.00%
E0570	NEBULIZER WITH COMPRESSION	UPL	Medicare DMEPOS	$12.36	$12.36	100.00%
E0574	ULTRASONIC GENERATOR W SVNEB	UPL	CO DME UPL	$463.50	$463.50	100.00%
E0575	NEBULIZER ULTRASONIC	Non-UPL	Other States	$574.27	$87.92	653.17%
E0575	NEBULIZER ULTRASONIC	Non-UPL	Other States	$574.27	$523.48	109.70%
E0580	NEBULIZER FOR USE W/ REGULAT	Non-UPL	Other States	$4.99	$127.28	3.92%
E0600	SUCTION PUMP PORTAB HOM MODL	UPL	CO DME UPL	$527.20	$527.20	100.00%
E0600	SUCTION PUMP PORTAB HOM MODL	UPL	Medicare DMEPOS	$52.72	$52.72	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	CO DME UPL	$397.50	$397.50	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	CO DME UPL	$707.70	$707.70	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	Medicare CBA CO Spgs	$41.00	$41.00	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	Medicare CBA Denver	$39.60	$39.60	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	Medicare DMEPOS	$39.75	$39.75	100.00%
E0601	CONT AIRWAY PRESSURE DEVICE	UPL	Medicare DMEPOS	$70.77	$70.77	100.00%
E0603	ELECTRIC BREAST PUMP	Non-UPL	Other States	$42.72	$133.30	32.05%
E0607	BLOOD GLUCOSE MONITOR HOME	UPL	Medicare DMEPOS	$76.93	$76.93	100.00%
E0619	APNEA MONITOR W RECORDER	Non-UPL	Other States	$166.46	$259.24	64.21%
E0625	PATIENT LIFT BATHROOM OR TOI	Non-UPL	Other States	$798.97	$502.13	159.12%
E0630	PATIENT LIFT HYDRAULIC	UPL	CO DME UPL	$567.70	$567.70	100.00%
E0630	PATIENT LIFT HYDRAULIC	UPL	CO DME UPL	$900.20	$900.20	100.00%
E0630	PATIENT LIFT HYDRAULIC	UPL	Medicare CBA CO Spgs	$58.59	$58.59	100.00%
E0630	PATIENT LIFT HYDRAULIC	UPL	Medicare CBA Denver	$58.47	$58.47	100.00%
E0630	PATIENT LIFT HYDRAULIC	UPL	Medicare DMEPOS	$56.77	$56.77	100.00%
E0630	PATIENT LIFT HYDRAULIC	UPL	Medicare DMEPOS	$90.02	$90.02	100.00%
E0635	PATIENT LIFT ELECTRIC	UPL	CO DME UPL	$1,162.70	$1,162.70	100.00%
E0635	PATIENT LIFT ELECTRIC	UPL	CO DME UPL	$1,197.50	$1,197.50	100.00%
E0635	PATIENT LIFT ELECTRIC	UPL	Medicare CBA Denver	$115.06	$115.06	100.00%
E0635	PATIENT LIFT ELECTRIC	UPL	Medicare DMEPOS	$116.27	$116.27	100.00%
E0639	MOVEABLE PATIENT LIFT SYSTEM	UPL	CO DME UPL	$1,284.40	$1,284.40	100.00%
E0650	PNEUMA COMPRESOR NON-SEGMENT	UPL	Medicare DMEPOS	$86.98	$86.98	100.00%
E0651	PNEUM COMPRESSOR SEGMENTAL	UPL	Medicare DMEPOS	$1,057.44	$1,057.44	100.00%
E0652	PNEUM COMPRES W/CAL PRESSURE	UPL	Medicare DMEPOS	$4,168.00	$4,168.00	100.00%
E0652	PNEUM COMPRES W/CAL PRESSURE	UPL	Medicare DMEPOS	$5,557.35	$5,557.35	100.00%
E0656	SEGMENTAL PNEUMATIC TRUNK	Non-UPL	Other States	$590.41	$590.08	100.06%
E0657	SEGMENTAL PNEUMATIC CHEST	Non-UPL	Other States	$554.66	$554.37	100.05%
E0667	SEG PNEUMATIC APPL FULL LEG	Non-UPL	Medicare DMEPOS	$281.43	$316.86	88.82%
E0667	SEG PNEUMATIC APPL FULL LEG	Non-UPL	Other States	$281.43	$305.62	92.09%
E0668	SEG PNEUMATIC APPL FULL ARM	Non-UPL	Medicare DMEPOS	$383.82	$432.45	88.75%
E0669	SEG PNEUMATIC APPLI HALF LEG	Non-UPL	Medicare DMEPOS	$187.33	$211.07	88.75%
E0673	PRESSURE PNEUM APPL HALF LEG	Non-UPL	Medicare DMEPOS	$274.06	$308.76	88.76%
E0675	PNEUMATIC COMPRESSION DEVICE	Non-UPL	Medicare DMEPOS	$372.17	$442.76	84.06%
E0700	SAFETY EQUIPMENT	Non-UPL	Other States	$78.90	$60.44	130.54%

E0700	SAFETY EQUIPMENT	Non-UPL	Other States	$78.90	$101.83	77.48%
E0710	RESTRAINTS ANY TYPE	Non-UPL	Other States	$115.73	$7.83	1478.03%
E0720	TENS TWO LEAD	UPL	CO DME UPL	$5.22	$5.22	100.00%
E0720	TENS TWO LEAD	UPL	CO DME UPL	$24.56	$24.56	100.00%
E0720	TENS TWO LEAD	UPL	Medicare CBA Denver	$56.66	$56.66	100.00%
E0720	TENS TWO LEAD	UPL	Medicare DMEPOS	$52.23	$52.23	100.00%
E0730	TENS FOUR LEAD	UPL	CO DME UPL	$5.35	$5.35	100.00%
E0730	TENS FOUR LEAD	UPL	CO DME UPL	$24.77	$24.77	100.00%
E0730	TENS FOUR LEAD	UPL	Medicare CBA CO Spgs	$63.55	$63.55	100.00%
E0730	TENS FOUR LEAD	UPL	Medicare CBA Denver	$52.97	$52.97	100.00%
E0730	TENS FOUR LEAD	UPL	Medicare DMEPOS	$53.52	$53.52	100.00%
E0730	TENS FOUR LEAD	UPL	Medicare DMEPOS	$247.66	$247.66	100.00%
E0731	CONDUCTIVE GARMENT FOR TENS/	Non-UPL	Medicare DMEPOS	$184.84	$68.39	270.27%
E0745	NEUROMUSCULAR STIM FOR SHOCK	UPL	CO DME UPL	$1,021.60	$1,021.60	100.00%
E0745	NEUROMUSCULAR STIM FOR SHOCK	UPL	Medicare DMEPOS	$102.16	$102.16	100.00%
E0747	ELEC OSTEOGEN STIM NOT SPINE	UPL	Medicare DMEPOS	$4,508.88	$4,508.88	100.00%
E0748	ELEC OSTEOGEN STIM SPINAL	UPL	Medicare DMEPOS	$4,479.68	$4,479.68	100.00%
E0760	OSTEOGEN ULTRASOUND STIMLTOR	UPL	Medicare DMEPOS	$3,722.53	$3,722.53	100.00%
E0776	IV POLE	Non-UPL	Medicare DMEPOS	$14.70	$14.40	102.08%
E0776	IV POLE	Non-UPL	Medicare DMEPOS	$14.70	$17.48	84.10%
E0776	IV POLE	Non-UPL	Medicare DMEPOS	$99.89	$143.96	69.39%
E0776	IV POLE	Non-UPL	Medicare DMEPOS	$99.89	$154.40	64.70%
E0776	IV POLE	Non-UPL	Other States	$99.89	$120.67	82.78%
E0781	EXTERNAL AMBULATORY INFUS PU	UPL	Medicare DMEPOS	$242.39	$242.39	100.00%
E0781	EXTERNAL AMBULATORY INFUS PU	UPL	Medicare DMEPOS	$273.68	$273.68	100.00%
E0784	EXT AMB INFUSN PUMP INSULIN	UPL	CO DME UPL	$4,370.50	$4,370.50	100.00%
E0784	EXT AMB INFUSN PUMP INSULIN	UPL	CO DME UPL	$4,589.20	$4,589.20	100.00%
E0784	EXT AMB INFUSN PUMP INSULIN	UPL	Medicare DMEPOS	$437.05	$437.05	100.00%
E0849	CERVICAL PNEUM TRAC EQUIP	UPL	CO DME UPL	$593.40	$593.40	100.00%
E0849	CERVICAL PNEUM TRAC EQUIP	UPL	Medicare DMEPOS	$59.34	$59.34	100.00%
E0855	CERVICAL TRACTION EQUIPMENT	UPL	CO DME UPL	$578.70	$578.70	100.00%
E0860	TRACT EQUIP CERVICAL TRACT	UPL	Medicare DMEPOS	$44.37	$44.37	100.00%
E0910	TRAPEZE BAR ATTACHED TO BED	UPL	CO DME UPL	$107.60	$107.60	100.00%
E0910	TRAPEZE BAR ATTACHED TO BED	UPL	Medicare CBA Denver	$10.76	$10.76	100.00%
E0912	HD TRAPEZE BAR FREE STANDING	UPL	CO DME UPL	$785.30	$785.30	100.00%
E0912	HD TRAPEZE BAR FREE STANDING	UPL	Medicare CBA Denver	$80.74	$80.74	100.00%
E0935	CONT PAS MOTION EXERCISE DEV	UPL	Medicare DMEPOS	$26.19	$26.19	100.00%
E0940	TRAPEZE BAR FREE STANDING	UPL	CO DME UPL	$284.70	$284.70	100.00%
E0940	TRAPEZE BAR FREE STANDING	UPL	Medicare CBA Denver	$19.85	$19.85	100.00%
E0941	GRAVITY ASSISTED TRACTION DE	UPL	CO DME UPL	$460.60	$460.60	100.00%
E0942	CERVICAL HEAD HARNESS/HALTER	Non-UPL	Medicare DMEPOS	$18.90	$22.84	82.75%
E0951	LOOP HEEL	Non-UPL	Medicare CBA CO Spgs	$15.00	$13.20	113.64%
E0951	LOOP HEEL	Non-UPL	Medicare CBA Denver	$15.00	$13.47	111.36%
E0951	LOOP HEEL	Non-UPL	Medicare DMEPOS	$15.00	$13.15	114.07%
E0951	LOOP HEEL	Non-UPL	Medicare DMEPOS	$15.00	$15.08	99.47%
E0951	LOOP HEEL	Non-UPL	Other States	$15.00	$16.53	90.76%
E0951	LOOP HEEL	Non-UPL	Other States	$15.00	$17.32	86.63%
E0952	TOE LOOP/HOLDER, EACH	Non-UPL	Medicare DMEPOS	$15.00	$15.89	94.40%
E0952	TOE LOOP/HOLDER, EACH	Non-UPL	Other States	$15.00	$16.97	88.39%

E0952	TOE LOOP/HOLDER, EACH	Non-UPL	Other States	$15.00	$17.53	85.57%
E0953	W/C LATERAL THIGH/KNEE SUP	Non-UPL	Medicare DMEPOS	$72.98	$72.26	101.00%
E0954	FOOT BOX, ANY TYPE EACH FOOT	Non-UPL	Medicare DMEPOS	$51.57	$52.07	99.04%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Medicare CBA CO Spgs	$93.88	$73.06	128.50%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Medicare CBA Denver	$93.88	$75.15	124.92%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Medicare DMEPOS	$93.88	$72.26	129.92%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Medicare DMEPOS	$93.88	$89.07	105.40%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Other States	$93.88	$89.74	104.61%
E0956	W/C LATERAL TRUNK/HIP SUPPOR	Non-UPL	Other States	$93.88	$93.44	100.47%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Medicare CBA CO Spgs	$152.39	$115.43	132.02%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Medicare CBA Denver	$152.39	$126.97	120.02%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Medicare DMEPOS	$152.39	$119.62	127.40%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Medicare DMEPOS	$152.39	$131.62	115.78%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Other States	$152.39	$129.88	117.33%
E0957	W/C MEDIAL THIGH SUPPORT	Non-UPL	Other States	$152.39	$134.19	113.56%
E0958	WHLCHR ATT- CONV 1 ARM DRIVE	Non-UPL	Other States	$510.76	$366.03	139.54%
E0958	WHLCHR ATT- CONV 1 ARM DRIVE	Non-UPL	Other States	$510.76	$394.27	129.55%
E0958	WHLCHR ATT- CONV 1 ARM DRIVE	Non-UPL	Other States	$510.76	$397.87	128.37%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Medicare CBA CO Spgs	$90.02	$68.16	132.07%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Medicare CBA Denver	$90.02	$71.75	125.46%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Medicare DMEPOS	$90.02	$74.25	121.24%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Medicare DMEPOS	$90.02	$83.22	108.17%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Other States	$90.02	$83.27	108.11%
E0960	W/C SHOULDER HARNESS/STRAPS	Non-UPL	Other States	$90.02	$86.59	103.97%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Medicare CBA CO Spgs	$14.99	$19.33	77.55%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Medicare CBA Denver	$14.99	$20.12	74.50%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Medicare DMEPOS	$14.99	$19.60	76.48%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Medicare DMEPOS	$14.99	$27.88	53.77%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Other States	$14.99	$24.52	61.13%
E0961	WHEELCHAIR BRAKE EXTENSION	Non-UPL	Other States	$14.99	$26.14	57.34%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Medicare CBA CO Spgs	$64.92	$64.96	99.94%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Medicare CBA Denver	$64.92	$77.14	84.16%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Medicare DMEPOS	$64.92	$71.23	91.14%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Medicare DMEPOS	$64.92	$78.34	82.87%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Other States	$64.92	$68.89	94.24%
E0966	WHEELCHAIR HEAD REST EXTENSI	Non-UPL	Other States	$64.92	$70.78	91.72%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Medicare CBA CO Spgs	$31.97	$29.94	106.78%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Medicare CBA Denver	$31.97	$29.94	106.78%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Medicare DMEPOS	$31.97	$28.71	111.35%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Medicare DMEPOS	$31.97	$40.85	78.26%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Other States	$31.97	$43.95	72.74%
E0971	WHEELCHAIR ANTI-TIPPING DEVI	Non-UPL	Other States	$31.97	$44.69	71.54%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Medicare CBA CO Spgs	$128.12	$45.87	279.31%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Medicare CBA Denver	$128.12	$47.97	267.08%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Medicare DMEPOS	$128.12	$46.99	272.65%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Medicare DMEPOS	$128.12	$85.10	150.55%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Other States	$128.12	$87.14	147.04%
E0973	W/CH ACCESS DET ADJ ARMREST	Non-UPL	Other States	$128.12	$94.95	134.93%
E0974	W/CH ACCESS ANTI-ROLLBACK	Non-UPL	Medicare CBA CO Spgs	$41.43	$65.60	63.16%

E0974	W/CH ACCESS ANTI-ROLLBACK	Non-UPL	Medicare CBA Denver	$41.43	$71.37	58.05%
E0974	W/CH ACCESS ANTI-ROLLBACK	Non-UPL	Medicare DMEPOS	$41.43	$72.20	57.38%
E0974	W/CH ACCESS ANTI-ROLLBACK	Non-UPL	Medicare DMEPOS	$41.43	$76.74	53.99%
E0974	W/CH ACCESS ANTI-ROLLBACK	Non-UPL	Other States	$41.43	$88.47	46.83%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Medicare CBA CO Spgs	$45.74	$24.07	190.03%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Medicare CBA Denver	$45.74	$24.07	190.03%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Medicare DMEPOS	$45.74	$24.36	187.77%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Medicare DMEPOS	$45.74	$32.22	141.96%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Other States	$45.74	$33.17	137.92%
E0978	W/C ACC,SAF BELT PELV STRAP	Non-UPL	Other States	$45.74	$35.91	127.39%
E0981	SEAT UPHOLSTERY, REPLACEMENT	Non-UPL	Medicare DMEPOS	$71.78	$40.59	176.84%
E0981	SEAT UPHOLSTERY, REPLACEMENT	Non-UPL	Other States	$71.78	$41.85	171.52%
E0981	SEAT UPHOLSTERY, REPLACEMENT	Non-UPL	Other States	$71.78	$44.77	160.32%
E0982	BACK UPHOLSTERY, REPLACEMENT	Non-UPL	Medicare DMEPOS	$67.13	$44.94	149.38%
E0982	BACK UPHOLSTERY, REPLACEMENT	Non-UPL	Medicare DMEPOS	$67.13	$46.52	144.30%
E0982	BACK UPHOLSTERY, REPLACEMENT	Non-UPL	Other States	$67.13	$45.46	147.68%
E0982	BACK UPHOLSTERY, REPLACEMENT	Non-UPL	Other States	$67.13	$48.71	137.82%
E0986	MAN W/C PUSH-RIM POWR SYSTEM	Non-UPL	Other States	$5,374.10	$4,310.76	124.67%
E0986	MAN W/C PUSH-RIM POWR SYSTEM	Non-UPL	Other States	$5,374.10	$4,568.07	117.64%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare CBA CO Spgs	$7.05	$6.40	110.16%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare CBA CO Spgs	$101.40	$63.92	158.64%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare CBA Denver	$7.05	$6.40	110.16%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare CBA Denver	$101.40	$63.92	158.64%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$7.05	$6.35	111.02%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$7.05	$10.25	68.78%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$101.40	$47.57	213.16%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$101.40	$63.43	159.86%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$101.40	$73.19	138.54%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Medicare DMEPOS	$101.40	$95.15	106.57%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Other States	$101.40	$93.39	108.57%
E0990	WHEELCHAIR ELEVATING LEG RES	Non-UPL	Other States	$101.40	$100.50	100.90%
E0992	WHEELCHAIR SOLID SEAT INSERT	Non-UPL	Medicare CBA CO Spgs	$64.92	$80.66	80.49%
E0992	WHEELCHAIR SOLID SEAT INSERT	Non-UPL	Medicare CBA Denver	$64.92	$87.13	74.51%
E0992	WHEELCHAIR SOLID SEAT INSERT	Non-UPL	Medicare DMEPOS	$64.92	$82.02	79.15%
E0992	WHEELCHAIR SOLID SEAT INSERT	Non-UPL	Other States	$64.92	$84.32	76.99%
E0992	WHEELCHAIR SOLID SEAT INSERT	Non-UPL	Other States	$64.92	$88.35	73.48%
E0995	WC CALF REST, PAD REPLACEMNT	Non-UPL	Medicare DMEPOS	$15.33	$26.08	58.78%
E0995	WC CALF REST, PAD REPLACEMNT	Non-UPL	Medicare DMEPOS	$15.33	$28.12	54.52%
E0995	WC CALF REST, PAD REPLACEMNT	Non-UPL	Other States	$15.33	$27.42	55.90%
E0995	WC CALF REST, PAD REPLACEMNT	Non-UPL	Other States	$15.33	$28.61	53.58%
E1002	PWR SEAT TILT	Non-UPL	Other States	$4,298.60	$3,762.18	114.26%
E1002	PWR SEAT TILT	Non-UPL	Other States	$4,298.60	$3,913.48	109.84%
E1002	PWR SEAT TILT	Non-UPL	Other States	$4,298.60	$3,934.05	109.27%
E1004	PWR SEAT RECLINE MECH	Non-UPL	Other States	$4,636.53	$4,675.92	99.16%
E1007	PWR SEAT COMBO W/SHEAR	Non-UPL	Other States	$8,323.83	$8,038.01	103.56%
E1007	PWR SEAT COMBO W/SHEAR	Non-UPL	Other States	$8,323.83	$8,394.56	99.16%
E1008	PWR SEAT COMBO PWR SHEAR	Non-UPL	Other States	$8,324.57	$8,038.72	103.56%
E1008	PWR SEAT COMBO PWR SHEAR	Non-UPL	Other States	$8,324.57	$8,395.31	99.16%
E1010	ADD PWR LEG ELEVATION	Non-UPL	Other States	$1,089.16	$1,075.54	101.27%

E1012	CTR MOUNT PWR ELEV LEG REST	Non-UPL	Other States	$1,089.16	$854.91	127.40%
E1012	CTR MOUNT PWR ELEV LEG REST	Non-UPL	Other States	$1,089.16	$1,054.70	103.27%
E1014	RECLINING BACK ADD PED W/C	Non-UPL	Other States	$275.31	$335.76	82.00%
E1014	RECLINING BACK ADD PED W/C	Non-UPL	Other States	$275.31	$350.66	78.51%
E1020	RESIDUAL LIMB SUPPORT SYSTEM	Non-UPL	Other States	$298.13	$198.89	149.89%
E1020	RESIDUAL LIMB SUPPORT SYSTEM	Non-UPL	Other States	$298.13	$218.79	136.26%
E1028	W/C MANUAL SWINGAWAY	Non-UPL	Other States	$228.19	$163.44	139.61%
E1028	W/C MANUAL SWINGAWAY	Non-UPL	Other States	$228.19	$179.27	127.29%
E1028	W/C MANUAL SWINGAWAY	Non-UPL	Other States	$228.19	$182.46	125.06%
E1031	ROLLABOUT CHAIR WITH CASTERS	UPL	CO DME UPL	$408.60	$408.60	100.00%
E1038	TRANSPORT CHAIR PT WT<=300LB	UPL	CO DME UPL	$143.90	$143.90	100.00%
E1085	HEMI-WHEELCHAIR FIXED ARMS	Non-UPL	Other States	$659.46	$492.28	133.96%
E1130	WHLCHR STAND FXD ARM FT REST	Non-UPL	Other States	$24.00	$235.37	10.20%
E1140	WHEELCHAIR STANDARD DETACH A	Non-UPL	Other States	$374.51	$517.92	72.31%
E1160	WHEELCHAIR FIXED ARMS	UPL	Medicare DMEPOS	$71.97	$71.97	100.00%
E1161	MANUAL ADULT WC W TILTINSPAC	UPL	CO DME UPL	$2,724.20	$2,724.20	100.00%
E1224	WHEELCHAIR SPEC SIZE W/ LEG	Non-UPL	Other States	$696.61	$743.84	93.65%
E1225	MANUAL SEMI-RECLINING BACK	Non-UPL	Other States	$348.19	$384.49	90.56%
E1225	MANUAL SEMI-RECLINING BACK	Non-UPL	Other States	$348.19	$410.79	84.76%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare CBA CO Spgs	$35.28	$38.54	91.54%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare CBA CO Spgs	$349.68	$385.40	90.73%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare CBA Denver	$35.28	$39.21	89.98%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare CBA Denver	$349.68	$392.05	89.19%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare DMEPOS	$35.28	$36.89	95.64%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare DMEPOS	$35.28	$47.37	74.48%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare DMEPOS	$349.68	$368.86	94.80%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Medicare DMEPOS	$349.68	$465.96	75.05%
E1226	MANUAL FULLY RECLINING BACK	Non-UPL	Other States	$349.68	$418.39	83.58%
E1232	FOLDING PED WC TILT-IN-SPACE	UPL	CO DME UPL	$2,462.30	$2,462.30	100.00%
E1233	RIG PED WC TLTNSPC W/O SEAT	UPL	CO DME UPL	$2,551.10	$2,551.10	100.00%
E1234	FLD PED WC TLTNSPC W/O SEAT	UPL	CO DME UPL	$2,221.00	$2,221.00	100.00%
E1235	RIGID PED WC ADJUSTABLE	UPL	CO DME UPL	$2,138.80	$2,138.80	100.00%
E1236	FOLDING PED WC ADJUSTABLE	UPL	CO DME UPL	$1,886.80	$1,886.80	100.00%
E1236	FOLDING PED WC ADJUSTABLE	UPL	Medicare DMEPOS	$188.68	$188.68	100.00%
E1237	RGD PED WC ADJSTABL W/O SEAT	UPL	CO DME UPL	$1,903.30	$1,903.30	100.00%
E1238	FLD PED WC ADJSTABL W/O SEAT	UPL	CO DME UPL	$1,886.80	$1,886.80	100.00%
E1238	FLD PED WC ADJSTABL W/O SEAT	UPL	Medicare DMEPOS	$188.68	$188.68	100.00%
E1297	WHEELCHAIR SPECIAL SEAT DEPT	Non-UPL	Medicare DMEPOS	$106.91	$120.45	88.76%
E1297	WHEELCHAIR SPECIAL SEAT DEPT	Non-UPL	Other States	$106.91	$97.75	109.37%
E1353	OXYGEN SUPPLIES REGULATOR	Non-UPL	Medicare DMEPOS	$28.39	$36.34	78.12%
E1355	OXYGEN SUPPLIES STAND/RACK	Non-UPL	Medicare DMEPOS	$21.37	$27.36	78.11%
E1372	OXY SUPPL HEATER FOR NEBULIZ	Non-UPL	Other States	$166.60	$133.25	125.03%
E1390	OXYGEN CONCENTRATOR	UPL	Medicare CBA CO Spgs	$75.31	$75.31	100.00%
E1390	OXYGEN CONCENTRATOR	UPL	Medicare CBA Denver	$73.88	$73.88	100.00%
E1390	OXYGEN CONCENTRATOR	UPL	Medicare DMEPOS	$73.80	$73.80	100.00%
E1390	OXYGEN CONCENTRATOR	UPL	Medicare DMEPOS	$134.71	$134.71	100.00%
E1392	PORTABLE OXYGEN CONCENTRATOR	UPL	Medicare CBA CO Spgs	$35.86	$35.86	100.00%
E1392	PORTABLE OXYGEN CONCENTRATOR	UPL	Medicare CBA Denver	$36.48	$36.48	100.00%
E1392	PORTABLE OXYGEN CONCENTRATOR	UPL	Medicare DMEPOS	$37.01	$37.01	100.00%

E1392	PORTABLE OXYGEN CONCENTRATOR	UPL	Medicare DMEPOS	$44.32	$44.32	100.00%
E1399	DURABLE MEDICAL EQUIPMENT MI	Non-UPL	Other States	$874.89	$3,200.00	27.34%
E1406	O2/WATER VAPOR ENRICH W/O HE	Non-UPL	Other States	$202.76	$760.70	26.65%
E1700	JAW MOTION REHAB SYSTEM	Non-UPL	Other States	$331.97	$357.29	92.91%
E1800	ADJUST ELBOW EXT/FLEX DEVICE	UPL	CO DME UPL	$1,198.90	$1,198.90	100.00%
E1802	ADJST FOREARM PRO/SUP DEVICE	UPL	CO DME UPL	$3,762.80	$3,762.80	100.00%
E1805	ADJUST WRIST EXT/FLEX DEVICE	UPL	CO DME UPL	$1,236.60	$1,236.60	100.00%
E1805	ADJUST WRIST EXT/FLEX DEVICE	UPL	Medicare DMEPOS	$123.66	$123.66	100.00%
E1810	ADJUST KNEE EXT/FLEX DEVICE	UPL	CO DME UPL	$1,219.30	$1,219.30	100.00%
E1810	ADJUST KNEE EXT/FLEX DEVICE	UPL	Medicare DMEPOS	$121.93	$121.93	100.00%
E1811	SPS KNEE DEVICE	UPL	CO DME UPL	$1,544.20	$1,544.20	100.00%
E1811	SPS KNEE DEVICE	UPL	Medicare DMEPOS	$154.42	$154.42	100.00%
E1815	ADJUST ANKLE EXT/FLEX DEVICE	UPL	CO DME UPL	$1,236.60	$1,236.60	100.00%
E1815	ADJUST ANKLE EXT/FLEX DEVICE	UPL	Medicare DMEPOS	$123.66	$123.66	100.00%
E1825	ADJUST FINGER EXT/FLEX DEVC	UPL	CO DME UPL	$1,236.60	$1,236.60	100.00%
E1830	ADJUST TOE EXT/FLEX DEVICE	UPL	CO DME UPL	$1,236.60	$1,236.60	100.00%
E1840	ADJ SHOULDER EXT/FLEX DEVICE	UPL	CO DME UPL	$4,406.50	$4,406.50	100.00%
E1840	ADJ SHOULDER EXT/FLEX DEVICE	UPL	Medicare DMEPOS	$440.65	$440.65	100.00%
E2201	MAN W/CH ACC SEAT W>=20"<24"	Non-UPL	Medicare CBA CO Spgs	$412.20	$326.98	126.06%
E2201	MAN W/CH ACC SEAT W>=20"<24"	Non-UPL	Medicare CBA Denver	$412.20	$332.05	124.14%
E2201	MAN W/CH ACC SEAT W>=20"<24"	Non-UPL	Medicare DMEPOS	$412.20	$312.01	132.11%
E2201	MAN W/CH ACC SEAT W>=20"<24"	Non-UPL	Medicare DMEPOS	$412.20	$375.68	109.72%
E2201	MAN W/CH ACC SEAT W>=20"<24"	Non-UPL	Other States	$412.20	$347.01	118.79%
E2202	SEAT WIDTH 24-27 IN	Non-UPL	Medicare CBA CO Spgs	$523.65	$448.44	116.77%
E2202	SEAT WIDTH 24-27 IN	Non-UPL	Medicare DMEPOS	$523.65	$468.79	111.70%
E2202	SEAT WIDTH 24-27 IN	Non-UPL	Other States	$523.65	$454.90	115.11%
E2203	FRAME DEPTH LESS THAN 22 IN	Non-UPL	Medicare CBA CO Spgs	$368.28	$410.00	89.82%
E2203	FRAME DEPTH LESS THAN 22 IN	Non-UPL	Medicare CBA Denver	$368.28	$431.33	85.38%
E2203	FRAME DEPTH LESS THAN 22 IN	Non-UPL	Medicare DMEPOS	$368.28	$400.98	91.84%
E2203	FRAME DEPTH LESS THAN 22 IN	Non-UPL	Medicare DMEPOS	$368.28	$495.04	74.39%
E2203	FRAME DEPTH LESS THAN 22 IN	Non-UPL	Other States	$368.28	$452.74	81.35%
E2204	FRAME DEPTH 22 TO 25 IN	Non-UPL	Medicare DMEPOS	$526.11	$703.89	74.74%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Medicare CBA CO Spgs	$44.95	$36.90	121.82%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Medicare CBA Denver	$44.95	$40.59	110.74%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Medicare DMEPOS	$44.95	$38.80	115.85%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Medicare DMEPOS	$44.95	$43.31	103.79%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Other States	$44.95	$37.50	119.87%
E2206	MAN WC WHL LOCK COMP REPL EA	Non-UPL	Other States	$44.95	$38.78	115.90%
E2207	CRUTCH AND CANE HOLDER	Non-UPL	Medicare CBA CO Spgs	$32.68	$39.45	82.84%
E2207	CRUTCH AND CANE HOLDER	Non-UPL	Medicare CBA Denver	$32.68	$46.84	69.77%
E2207	CRUTCH AND CANE HOLDER	Non-UPL	Medicare DMEPOS	$32.68	$43.22	75.61%
E2207	CRUTCH AND CANE HOLDER	Non-UPL	Other States	$32.68	$42.76	76.44%
E2208	CYLINDER TANK CARRIER	Non-UPL	Medicare CBA CO Spgs	$89.57	$77.98	114.86%
E2208	CYLINDER TANK CARRIER	Non-UPL	Medicare CBA Denver	$89.57	$77.98	114.86%
E2208	CYLINDER TANK CARRIER	Non-UPL	Medicare DMEPOS	$89.57	$73.78	121.40%
E2208	CYLINDER TANK CARRIER	Non-UPL	Medicare DMEPOS	$89.57	$98.90	90.57%
E2208	CYLINDER TANK CARRIER	Non-UPL	Other States	$89.57	$101.68	88.09%
E2209	ARM TROUGH EACH	Non-UPL	Medicare CBA CO Spgs	$80.79	$76.88	105.09%
E2209	ARM TROUGH EACH	Non-UPL	Medicare CBA Denver	$80.79	$80.61	100.22%

E2209	ARM TROUGH EACH	Non-UPL	Medicare DMEPOS	$80.79	$78.13	103.40%
E2209	ARM TROUGH EACH	Non-UPL	Medicare DMEPOS	$80.79	$96.77	83.49%
E2209	ARM TROUGH EACH	Non-UPL	Other States	$80.79	$95.76	84.36%
E2209	ARM TROUGH EACH	Non-UPL	Other States	$80.79	$99.75	80.99%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Medicare CBA CO Spgs	$5.04	$5.13	98.25%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Medicare CBA Denver	$5.04	$5.64	89.36%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Medicare DMEPOS	$5.04	$5.50	91.64%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Medicare DMEPOS	$5.04	$6.03	83.58%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Other States	$5.04	$5.98	84.25%
E2210	WHEELCHAIR BEARINGS	Non-UPL	Other States	$5.04	$6.29	80.08%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Medicare CBA CO Spgs	$30.86	$32.57	94.75%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Medicare CBA Denver	$30.86	$34.27	90.05%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Medicare DMEPOS	$30.86	$31.26	98.72%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Medicare DMEPOS	$30.86	$41.29	74.74%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Other States	$30.86	$36.43	84.70%
E2211	PNEUMATIC PROPULSION TIRE	Non-UPL	Other States	$30.86	$38.13	80.94%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Medicare CBA CO Spgs	$4.42	$5.35	82.62%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Medicare CBA Denver	$4.42	$6.34	69.72%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Medicare DMEPOS	$4.42	$5.87	75.30%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Medicare DMEPOS	$4.42	$6.63	66.67%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Other States	$4.42	$5.80	76.17%
E2212	PNEUMATIC PROP TIRE TUBE	Non-UPL	Other States	$4.42	$5.91	74.79%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Medicare CBA CO Spgs	$22.93	$27.68	82.84%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Medicare CBA Denver	$22.93	$27.68	82.84%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Medicare DMEPOS	$22.93	$28.00	81.89%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Medicare DMEPOS	$22.93	$33.01	69.46%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Other States	$22.93	$29.28	78.31%
E2213	PNEUMATIC PROP TIRE INSERT	Non-UPL	Other States	$22.93	$29.99	76.45%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Medicare CBA CO Spgs	$27.15	$30.72	88.38%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Medicare CBA Denver	$27.15	$32.77	82.85%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Medicare DMEPOS	$27.15	$31.79	85.40%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Medicare DMEPOS	$27.15	$37.78	71.86%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Other States	$27.15	$33.96	79.94%
E2214	PNEUMATIC CASTER TIRE EACH	Non-UPL	Other States	$27.15	$34.06	79.72%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Medicare CBA CO Spgs	$27.31	$37.93	72.00%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Medicare CBA Denver	$27.31	$39.13	69.79%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Medicare DMEPOS	$27.31	$38.28	71.34%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Medicare DMEPOS	$27.31	$41.69	65.51%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Other States	$27.31	$38.66	70.65%
E2219	FOAM CASTER TIRE ANY SIZE EA	Non-UPL	Other States	$27.31	$40.11	68.08%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Medicare CBA CO Spgs	$21.50	$25.97	82.79%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Medicare CBA Denver	$21.50	$30.84	69.71%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Medicare DMEPOS	$21.50	$28.22	76.19%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Medicare DMEPOS	$21.50	$31.63	67.97%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Other States	$21.50	$26.70	80.52%
E2220	SOLID PROPULS TIRE, REPL, EA	Non-UPL	Other States	$21.50	$27.26	78.87%
E2221	SOLID CASTER TIRE REPL, EACH	Non-UPL	Medicare CBA CO Spgs	$19.26	$23.58	81.68%
E2221	SOLID CASTER TIRE REPL, EACH	Non-UPL	Medicare CBA Denver	$19.26	$24.34	79.13%
E2221	SOLID CASTER TIRE REPL, EACH	Non-UPL	Other States	$19.26	$25.27	76.20%

E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Medicare CBA CO Spgs	$15.90	$19.48	81.62%
E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Medicare CBA Denver	$15.90	$19.89	79.94%
E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Medicare DMEPOS	$15.90	$20.65	77.00%
E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Medicare DMEPOS	$15.90	$23.71	67.06%
E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Other States	$15.90	$20.74	76.66%
E2222	SOLID CASTER INTEG WHL, REPL	Non-UPL	Other States	$15.90	$21.21	74.95%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Medicare CBA CO Spgs	$73.93	$92.25	80.14%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Medicare CBA Denver	$73.93	$94.80	77.99%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Medicare DMEPOS	$73.93	$89.95	82.19%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Medicare DMEPOS	$73.93	$105.67	69.96%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Other States	$73.93	$89.89	82.25%
E2224	PROPULSION WHL EXCL TIRE REP	Non-UPL	Other States	$73.93	$93.44	79.12%
E2225	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA CO Spgs	$13.12	$16.40	80.00%
E2225	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA Denver	$13.12	$18.81	69.75%
E2225	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare DMEPOS	$13.12	$19.79	66.30%
E2225	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Other States	$13.12	$17.44	75.22%
E2225	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Other States	$13.12	$17.88	73.37%
E2226	CASTER FORK REPLACEMENT ONLY	Non-UPL	Medicare CBA CO Spgs	$28.62	$34.54	82.86%
E2226	CASTER FORK REPLACEMENT ONLY	Non-UPL	Medicare CBA Denver	$28.62	$35.88	79.77%
E2226	CASTER FORK REPLACEMENT ONLY	Non-UPL	Medicare DMEPOS	$28.62	$36.93	77.50%
E2226	CASTER FORK REPLACEMENT ONLY	Non-UPL	Other States	$28.62	$37.50	76.33%
E2226	CASTER FORK REPLACEMENT ONLY	Non-UPL	Other States	$28.62	$38.56	74.22%
E2228	MWC ACC, WHEELCHAIR BRAKE	Non-UPL	Other States	$1,034.39	$821.32	125.94%
E2228	MWC ACC, WHEELCHAIR BRAKE	Non-UPL	Other States	$1,034.39	$912.06	113.41%
E2231	SOLID SEAT SUPPORT BASE	Non-UPL	Medicare CBA CO Spgs	$121.73	$134.87	90.26%
E2231	SOLID SEAT SUPPORT BASE	Non-UPL	Medicare CBA Denver	$121.73	$134.87	90.26%
E2231	SOLID SEAT SUPPORT BASE	Non-UPL	Medicare DMEPOS	$121.73	$133.34	91.29%
E2231	SOLID SEAT SUPPORT BASE	Non-UPL	Medicare DMEPOS	$121.73	$160.91	75.65%
E2231	SOLID SEAT SUPPORT BASE	Non-UPL	Other States	$121.73	$147.58	82.48%
E2291	PLANAR BACK FOR PED SIZE WC	Non-UPL	Other States	$473.49	$348.24	135.97%
E2291	PLANAR BACK FOR PED SIZE WC	Non-UPL	Other States	$473.49	$447.31	105.85%
E2292	PLANAR SEAT FOR PED SIZE WC	Non-UPL	Other States	$473.49	$249.17	190.03%
E2310	ELECTRO CONNECT BTW CONTROL	Non-UPL	Other States	$983.64	$1,076.09	91.41%
E2310	ELECTRO CONNECT BTW CONTROL	Non-UPL	Other States	$983.64	$1,123.82	87.53%
E2311	ELECTRO CONNECT BTW 2 SYS	Non-UPL	Other States	$2,034.90	$2,178.59	93.40%
E2311	ELECTRO CONNECT BTW 2 SYS	Non-UPL	Other States	$2,034.90	$2,275.23	89.44%
E2311	ELECTRO CONNECT BTW 2 SYS	Non-UPL	Other States	$2,034.90	$2,284.18	89.09%
E2312	MINI-PROP REMOTE JOYSTICK	Non-UPL	Other States	$1,521.36	$1,854.97	82.02%
E2312	MINI-PROP REMOTE JOYSTICK	Non-UPL	Other States	$1,521.36	$1,862.30	81.69%
E2313	PWC HARNESS, EXPAND CONTROL	Non-UPL	Other States	$241.60	$282.89	85.40%
E2313	PWC HARNESS, EXPAND CONTROL	Non-UPL	Other States	$241.60	$284.94	84.79%
E2321	HAND INTERFACE JOYSTICK	Non-UPL	Other States	$1,513.21	$1,544.93	97.95%
E2321	HAND INTERFACE JOYSTICK	Non-UPL	Other States	$1,513.21	$1,576.28	96.00%
E2321	HAND INTERFACE JOYSTICK	Non-UPL	Other States	$1,513.21	$1,594.83	94.88%
E2323	SPECIAL JOYSTICK HANDLE	Non-UPL	Medicare DMEPOS	$65.85	$66.31	99.31%
E2323	SPECIAL JOYSTICK HANDLE	Non-UPL	Other States	$65.85	$66.85	98.51%
E2323	SPECIAL JOYSTICK HANDLE	Non-UPL	Other States	$65.85	$68.66	95.91%
E2325	SIP AND PUFF INTERFACE	Non-UPL	Other States	$1,282.51	$1,293.41	99.16%
E2326	BREATH TUBE KIT	Non-UPL	Other States	$330.57	$333.37	99.16%

E2326	BREATH TUBE KIT	Non-UPL	Other States	$330.57	$334.68	98.77%
E2327	HEAD CONTROL INTERFACE MECH	Non-UPL	Other States	$2,487.62	$2,541.93	97.86%
E2330	HEAD CONTROL PROXIMITY SWITC	Non-UPL	Other States	$3,334.31	$3,146.77	105.96%
E2330	HEAD CONTROL PROXIMITY SWITC	Non-UPL	Other States	$3,334.31	$3,286.36	101.46%
E2340	W/C WDTH 20-23 IN SEAT FRAME	Non-UPL	Medicare DMEPOS	$395.92	$412.61	95.96%
E2351	ELECTRONIC SGD INTERFACE	Non-UPL	Medicare DMEPOS	$665.28	$689.45	96.49%
E2359	GR34 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA CO Spgs	$150.23	$158.50	94.78%
E2359	GR34 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA Denver	$150.23	$164.00	91.60%
E2359	GR34 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$150.23	$157.37	95.46%
E2359	GR34 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$150.23	$187.52	80.11%
E2359	GR34 SEALED LEADACID BATTERY	Non-UPL	Other States	$150.23	$171.43	87.63%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Medicare CBA CO Spgs	$135.82	$104.55	129.91%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Medicare CBA Denver	$135.82	$104.55	129.91%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$135.82	$105.66	128.54%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$135.82	$129.39	104.97%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Other States	$135.82	$126.27	107.56%
E2361	22NF SEALED LEADACID BATTERY	Non-UPL	Other States	$135.82	$131.13	103.58%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA CO Spgs	$195.53	$132.23	147.87%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA Denver	$195.53	$132.23	147.87%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$195.53	$135.43	144.38%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$195.53	$168.38	116.12%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Other States	$195.53	$160.41	121.89%
E2363	GR24 SEALED LEADACID BATTERY	Non-UPL	Other States	$195.53	$168.48	116.05%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA CO Spgs	$113.95	$74.57	152.81%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Medicare CBA Denver	$113.95	$74.57	152.81%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$113.95	$72.91	156.29%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$113.95	$95.77	118.98%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Other States	$113.95	$96.30	118.33%
E2365	U1 SEALED LEADACID BATTERY	Non-UPL	Other States	$113.95	$101.26	112.54%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Medicare CBA CO Spgs	$264.35	$145.57	181.60%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Medicare CBA Denver	$264.35	$145.57	181.60%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Medicare DMEPOS	$264.35	$141.10	187.35%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Medicare DMEPOS	$264.35	$212.64	124.32%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Other States	$264.35	$212.47	124.42%
E2366	BATTERY CHARGER, SINGLE MODE	Non-UPL	Other States	$264.35	$227.85	116.02%
E2368	PWR WC DRIVEWHEEL MOTOR REPL	Non-UPL	Other States	$696.24	$463.76	150.13%
E2368	PWR WC DRIVEWHEEL MOTOR REPL	Non-UPL	Other States	$696.24	$468.67	148.56%
E2370	PWR WC DR WH MOTOR/GEAR COMB	Non-UPL	Other States	$886.99	$635.03	139.68%
E2370	PWR WC DR WH MOTOR/GEAR COMB	Non-UPL	Other States	$886.99	$665.99	133.18%
E2370	PWR WC DR WH MOTOR/GEAR COMB	Non-UPL	Other States	$886.99	$696.62	127.33%
E2370	PWR WC DR WH MOTOR/GEAR COMB	Non-UPL	Other States	$886.99	$709.07	125.09%
E2371	GR27 SEALED LEADACID BATTERY	Non-UPL	Medicare DMEPOS	$113.67	$132.89	85.54%
E2373	HAND/CHIN CTRL SPEC JOYSTICK	Non-UPL	Other States	$704.34	$740.15	95.16%
E2373	HAND/CHIN CTRL SPEC JOYSTICK	Non-UPL	Other States	$704.34	$765.46	92.01%
E2373	HAND/CHIN CTRL SPEC JOYSTICK	Non-UPL	Other States	$704.34	$773.27	91.09%
E2374	HAND/CHIN CTRL STD JOYSTICK	Non-UPL	Other States	$547.93	$465.50	117.71%
E2374	HAND/CHIN CTRL STD JOYSTICK	Non-UPL	Other States	$547.93	$475.32	115.28%
E2374	HAND/CHIN CTRL STD JOYSTICK	Non-UPL	Other States	$547.93	$495.69	110.54%
E2374	HAND/CHIN CTRL STD JOYSTICK	Non-UPL	Other States	$547.93	$497.50	110.14%

E2375	NON-EXPANDABLE CONTROLLER	Non-UPL	Other States	$646.18	$661.86	97.63%
E2375	NON-EXPANDABLE CONTROLLER	Non-UPL	Other States	$646.18	$698.81	92.47%
E2375	NON-EXPANDABLE CONTROLLER	Non-UPL	Other States	$646.18	$731.48	88.34%
E2375	NON-EXPANDABLE CONTROLLER	Non-UPL	Other States	$646.18	$747.11	86.49%
E2376	EXPANDABLE CONTROLLER, REPL	Non-UPL	Other States	$1,012.59	$1,256.27	80.60%
E2376	EXPANDABLE CONTROLLER, REPL	Non-UPL	Other States	$1,012.59	$1,258.77	80.44%
E2377	EXPANDABLE CONTROLLER, INITL	Non-UPL	Other States	$366.40	$423.38	86.54%
E2377	EXPANDABLE CONTROLLER, INITL	Non-UPL	Other States	$366.40	$452.49	80.97%
E2381	PNEUM DRIVE WHEEL TIRE	Non-UPL	Medicare CBA Denver	$59.95	$57.39	104.46%
E2383	INSERT, PNEUM WHEEL DRIVE	Non-UPL	Medicare CBA Denver	$114.57	$131.35	87.22%
E2384	PNEUMATIC CASTER TIRE	Non-UPL	Medicare CBA Denver	$61.03	$60.48	100.91%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Medicare CBA CO Spgs	$113.53	$103.30	109.90%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Medicare CBA Denver	$113.53	$107.71	105.40%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Medicare DMEPOS	$113.53	$101.15	112.24%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Medicare DMEPOS	$113.53	$128.22	88.54%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Other States	$113.53	$130.77	86.82%
E2386	FOAM FILLED DRIVE WHEEL TIRE	Non-UPL	Other States	$113.53	$138.02	82.26%
E2387	FOAM FILLED CASTER TIRE	Non-UPL	Medicare CBA CO Spgs	$50.92	$47.36	107.52%
E2387	FOAM FILLED CASTER TIRE	Non-UPL	Medicare CBA Denver	$50.92	$47.36	107.52%
E2387	FOAM FILLED CASTER TIRE	Non-UPL	Medicare DMEPOS	$50.92	$49.10	103.71%
E2387	FOAM FILLED CASTER TIRE	Non-UPL	Other States	$50.92	$58.11	87.62%
E2388	FOAM DRIVE WHEEL TIRE	Non-UPL	Medicare DMEPOS	$38.01	$46.48	81.78%
E2388	FOAM DRIVE WHEEL TIRE	Non-UPL	Other States	$38.01	$46.34	82.03%
E2388	FOAM DRIVE WHEEL TIRE	Non-UPL	Other States	$38.01	$48.44	78.46%
E2389	FOAM CASTER TIRE	Non-UPL	Medicare DMEPOS	$20.63	$25.98	79.41%
E2389	FOAM CASTER TIRE	Non-UPL	Other States	$20.63	$25.10	82.20%
E2389	FOAM CASTER TIRE	Non-UPL	Other States	$20.63	$26.25	78.58%
E2390	SOLID DRIVE WHEEL TIRE	Non-UPL	Medicare DMEPOS	$32.27	$40.22	80.23%
E2390	SOLID DRIVE WHEEL TIRE	Non-UPL	Other States	$32.27	$39.58	81.54%
E2390	SOLID DRIVE WHEEL TIRE	Non-UPL	Other States	$32.27	$41.32	78.10%
E2391	SOLID CASTER TIRE	Non-UPL	Medicare CBA CO Spgs	$15.46	$16.07	96.20%
E2391	SOLID CASTER TIRE	Non-UPL	Medicare CBA Denver	$15.46	$16.91	91.43%
E2391	SOLID CASTER TIRE	Non-UPL	Medicare DMEPOS	$15.46	$16.95	91.21%
E2391	SOLID CASTER TIRE	Non-UPL	Medicare DMEPOS	$15.46	$19.39	79.73%
E2391	SOLID CASTER TIRE	Non-UPL	Other States	$15.46	$18.24	84.78%
E2391	SOLID CASTER TIRE	Non-UPL	Other States	$15.46	$19.22	80.45%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Medicare CBA CO Spgs	$49.74	$38.81	128.16%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Medicare CBA Denver	$49.74	$38.95	127.70%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Medicare DMEPOS	$49.74	$39.38	126.31%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Medicare DMEPOS	$49.74	$48.78	101.97%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Other States	$49.74	$48.02	103.59%
E2392	SOLID CASTER TIRE, INTEGRATE	Non-UPL	Other States	$49.74	$50.57	98.35%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA CO Spgs	$57.88	$54.65	105.91%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA Denver	$57.88	$55.35	104.57%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Medicare DMEPOS	$57.88	$54.36	106.48%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Medicare DMEPOS	$57.88	$68.50	84.50%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Other States	$57.88	$66.27	87.34%
E2394	DRIVE WHEEL EXCLUDES TIRE	Non-UPL	Other States	$57.88	$70.34	82.28%
E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA CO Spgs	$41.15	$41.00	100.37%

E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare CBA Denver	$41.15	$41.00	100.37%
E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare DMEPOS	$41.15	$42.75	96.26%
E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Medicare DMEPOS	$41.15	$49.83	82.58%
E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Other States	$41.15	$47.78	86.12%
E2395	CASTER WHEEL EXCLUDES TIRE	Non-UPL	Other States	$41.15	$50.54	81.43%
E2396	CASTER FORK	Non-UPL	Medicare CBA CO Spgs	$42.64	$48.18	88.50%
E2396	CASTER FORK	Non-UPL	Medicare CBA Denver	$42.64	$52.43	81.33%
E2396	CASTER FORK	Non-UPL	Medicare DMEPOS	$42.64	$50.48	84.47%
E2396	CASTER FORK	Non-UPL	Other States	$42.64	$57.65	73.97%
E2396	CASTER FORK	Non-UPL	Other States	$42.64	$61.13	69.76%
E2402	NEG PRESS WOUND THERAPY PUMP	UPL	CO DME UPL	$12,032.70	$12,032.70	100.00%
E2402	NEG PRESS WOUND THERAPY PUMP	UPL	Medicare CBA CO Spgs	$558.01	$558.01	100.00%
E2402	NEG PRESS WOUND THERAPY PUMP	UPL	Medicare CBA Denver	$850.24	$850.24	100.00%
E2402	NEG PRESS WOUND THERAPY PUMP	UPL	Medicare DMEPOS	$587.93	$587.93	100.00%
E2402	NEG PRESS WOUND THERAPY PUMP	UPL	Medicare DMEPOS	$1,203.27	$1,203.27	100.00%
E2500	SGD DIGITIZED PRE-REC <=8MIN	UPL	Medicare DMEPOS	$450.24	$450.24	100.00%
E2510	SGD W MULTI METHODS MSG/ACCS	UPL	Medicare DMEPOS	$7,792.82	$7,792.82	100.00%
E2512	SGD ACCESSORY, MOUNTING SYS	Non-UPL	Other States	$479.80	$513.50	93.44%
E2512	SGD ACCESSORY, MOUNTING SYS	Non-UPL	Other States	$479.80	$550.80	87.11%
E2601	GEN W/C CUSHION WDTH < 22 IN	Non-UPL	Medicare CBA CO Spgs	$99.96	$34.84	286.91%
E2601	GEN W/C CUSHION WDTH < 22 IN	Non-UPL	Medicare CBA Denver	$99.96	$34.85	286.83%
E2601	GEN W/C CUSHION WDTH < 22 IN	Non-UPL	Medicare DMEPOS	$99.96	$35.47	281.82%
E2601	GEN W/C CUSHION WDTH < 22 IN	Non-UPL	Medicare DMEPOS	$99.96	$50.70	197.16%
E2601	GEN W/C CUSHION WDTH < 22 IN	Non-UPL	Other States	$99.96	$59.34	168.46%
E2602	GEN W/C CUSHION WDTH >=22 IN	Non-UPL	Medicare CBA CO Spgs	$131.92	$81.95	160.98%
E2602	GEN W/C CUSHION WDTH >=22 IN	Non-UPL	Medicare CBA Denver	$131.92	$85.46	154.36%
E2602	GEN W/C CUSHION WDTH >=22 IN	Non-UPL	Medicare DMEPOS	$131.92	$82.81	159.30%
E2602	GEN W/C CUSHION WDTH >=22 IN	Non-UPL	Other States	$131.92	$115.35	114.37%
E2603	SKIN PROTECT WC CUS WD <22IN	Non-UPL	Medicare CBA CO Spgs	$168.93	$102.61	164.63%
E2603	SKIN PROTECT WC CUS WD <22IN	Non-UPL	Medicare CBA Denver	$168.93	$102.61	164.63%
E2603	SKIN PROTECT WC CUS WD <22IN	Non-UPL	Medicare DMEPOS	$168.93	$98.08	172.24%
E2603	SKIN PROTECT WC CUS WD <22IN	Non-UPL	Medicare DMEPOS	$168.93	$129.02	130.93%
E2603	SKIN PROTECT WC CUS WD <22IN	Non-UPL	Other States	$168.93	$150.60	112.17%
E2604	SKIN PROTECT WC CUS WD>=22IN	Non-UPL	Medicare CBA Denver	$208.16	$150.80	138.04%
E2604	SKIN PROTECT WC CUS WD>=22IN	Non-UPL	Other States	$208.16	$203.23	102.43%
E2605	POSITION WC CUSH WDTH <22 IN	Non-UPL	Medicare CBA CO Spgs	$285.83	$210.13	136.03%
E2605	POSITION WC CUSH WDTH <22 IN	Non-UPL	Medicare CBA Denver	$285.83	$210.13	136.03%
E2605	POSITION WC CUSH WDTH <22 IN	Non-UPL	Medicare DMEPOS	$285.83	$203.87	140.20%
E2605	POSITION WC CUSH WDTH <22 IN	Non-UPL	Medicare DMEPOS	$285.83	$243.36	117.45%
E2605	POSITION WC CUSH WDTH <22 IN	Non-UPL	Other States	$285.83	$257.03	111.21%
E2607	SKIN PRO/POS WC CUS WD <22IN	Non-UPL	Medicare CBA CO Spgs	$334.52	$206.34	162.12%
E2607	SKIN PRO/POS WC CUS WD <22IN	Non-UPL	Medicare CBA Denver	$334.52	$210.13	159.20%
E2607	SKIN PRO/POS WC CUS WD <22IN	Non-UPL	Medicare DMEPOS	$334.52	$200.97	166.45%
E2607	SKIN PRO/POS WC CUS WD <22IN	Non-UPL	Medicare DMEPOS	$334.52	$250.12	133.74%
E2607	SKIN PRO/POS WC CUS WD <22IN	Non-UPL	Other States	$334.52	$257.58	129.87%
E2608	SKIN PRO/POS WC CUS WD>=22IN	Non-UPL	Medicare CBA CO Spgs	$387.90	$247.80	156.54%
E2608	SKIN PRO/POS WC CUS WD>=22IN	Non-UPL	Medicare CBA Denver	$387.90	$247.80	156.54%
E2608	SKIN PRO/POS WC CUS WD>=22IN	Non-UPL	Medicare DMEPOS	$387.90	$243.13	159.54%
E2608	SKIN PRO/POS WC CUS WD>=22IN	Non-UPL	Other States	$387.90	$313.66	123.67%

E2611	GEN USE BACK CUSH WDTH <22IN	Non-UPL	Medicare CBA CO Spgs	$345.09	$151.58	227.66%
E2611	GEN USE BACK CUSH WDTH <22IN	Non-UPL	Medicare CBA Denver	$345.09	$151.58	227.66%
E2611	GEN USE BACK CUSH WDTH <22IN	Non-UPL	Medicare DMEPOS	$345.09	$145.38	237.37%
E2611	GEN USE BACK CUSH WDTH <22IN	Non-UPL	Medicare DMEPOS	$345.09	$236.80	145.73%
E2611	GEN USE BACK CUSH WDTH <22IN	Non-UPL	Other States	$345.09	$256.62	134.48%
E2612	GEN USE BACK CUSH WDTH>=22IN	Non-UPL	Medicare CBA CO Spgs	$466.83	$300.81	155.19%
E2612	GEN USE BACK CUSH WDTH>=22IN	Non-UPL	Medicare CBA Denver	$466.83	$312.90	149.19%
E2612	GEN USE BACK CUSH WDTH>=22IN	Non-UPL	Medicare DMEPOS	$466.83	$295.09	158.20%
E2612	GEN USE BACK CUSH WDTH>=22IN	Non-UPL	Other States	$466.83	$374.87	124.53%
E2613	POSITION BACK CUSH WD <22IN	Non-UPL	Medicare CBA CO Spgs	$434.23	$308.32	140.84%
E2613	POSITION BACK CUSH WD <22IN	Non-UPL	Medicare CBA Denver	$434.23	$333.13	130.35%
E2613	POSITION BACK CUSH WD <22IN	Non-UPL	Medicare DMEPOS	$434.23	$304.32	142.69%
E2613	POSITION BACK CUSH WD <22IN	Non-UPL	Medicare DMEPOS	$434.23	$356.61	121.77%
E2613	POSITION BACK CUSH WD <22IN	Non-UPL	Other States	$434.23	$356.26	121.89%
E2614	POSITION BACK CUSH WD>=22IN	Non-UPL	Medicare CBA Denver	$600.95	$446.49	134.59%
E2614	POSITION BACK CUSH WD>=22IN	Non-UPL	Medicare DMEPOS	$600.95	$432.62	138.91%
E2614	POSITION BACK CUSH WD>=22IN	Non-UPL	Other States	$600.95	$501.09	119.93%
E2615	POS BACK POST/LAT WDTH <22IN	Non-UPL	Medicare CBA CO Spgs	$538.93	$344.23	156.56%
E2615	POS BACK POST/LAT WDTH <22IN	Non-UPL	Medicare CBA Denver	$538.93	$346.45	155.56%
E2615	POS BACK POST/LAT WDTH <22IN	Non-UPL	Medicare DMEPOS	$538.93	$336.67	160.08%
E2615	POS BACK POST/LAT WDTH <22IN	Non-UPL	Medicare DMEPOS	$538.93	$408.76	131.85%
E2615	POS BACK POST/LAT WDTH <22IN	Non-UPL	Other States	$538.93	$409.30	131.67%
E2619	REPLACE COVER W/C SEAT CUSH	Non-UPL	Medicare DMEPOS	$49.93	$47.86	104.33%
E2619	REPLACE COVER W/C SEAT CUSH	Non-UPL	Medicare DMEPOS	$49.93	$49.39	101.09%
E2619	REPLACE COVER W/C SEAT CUSH	Non-UPL	Other States	$49.93	$49.20	101.49%
E2619	REPLACE COVER W/C SEAT CUSH	Non-UPL	Other States	$49.93	$50.62	98.63%
E2620	WC PLANAR BACK CUSH WD <22IN	Non-UPL	Medicare CBA CO Spgs	$605.11	$375.94	160.96%
E2620	WC PLANAR BACK CUSH WD <22IN	Non-UPL	Medicare CBA Denver	$605.11	$389.90	155.20%
E2620	WC PLANAR BACK CUSH WD <22IN	Non-UPL	Medicare DMEPOS	$605.11	$370.61	163.27%
E2620	WC PLANAR BACK CUSH WD <22IN	Non-UPL	Medicare DMEPOS	$605.11	$469.33	128.93%
E2620	WC PLANAR BACK CUSH WD <22IN	Non-UPL	Other States	$605.11	$490.27	123.42%
E2621	WC PLANAR BACK CUSH WD>=22IN	Non-UPL	Medicare CBA Denver	$635.01	$432.33	146.88%
E2622	ADJ SKIN PRO W/C CUS WD<22IN	Non-UPL	Medicare DMEPOS	$365.40	$303.58	120.36%
E2622	ADJ SKIN PRO W/C CUS WD<22IN	Non-UPL	Medicare DMEPOS	$365.40	$316.26	115.54%
E2622	ADJ SKIN PRO W/C CUS WD<22IN	Non-UPL	Other States	$365.40	$300.30	121.68%
E2623	ADJ SKIN PRO WC CUS WD>=22IN	Non-UPL	Medicare DMEPOS	$303.98	$383.89	79.18%
E2623	ADJ SKIN PRO WC CUS WD>=22IN	Non-UPL	Medicare DMEPOS	$303.98	$401.23	75.76%
E2623	ADJ SKIN PRO WC CUS WD>=22IN	Non-UPL	Other States	$303.98	$381.39	79.70%
E2624	ADJ SKIN PRO/POS CUS<22IN	Non-UPL	Medicare DMEPOS	$385.98	$308.48	125.12%
E2624	ADJ SKIN PRO/POS CUS<22IN	Non-UPL	Medicare DMEPOS	$385.98	$320.06	120.60%
E2624	ADJ SKIN PRO/POS CUS<22IN	Non-UPL	Other States	$385.98	$303.49	127.18%
E2625	ADJ SKIN PRO/POS WC CUS>=22	Non-UPL	Medicare DMEPOS	$304.89	$381.78	79.86%
E2625	ADJ SKIN PRO/POS WC CUS>=22	Non-UPL	Medicare DMEPOS	$304.89	$400.81	76.07%
E2627	ARM SUPP ATT TO WC RANCHO TY	Non-UPL	Medicare CBA Denver	$855.02	$1,071.22	79.82%
E2628	MOBILE ARM SUPPORTS RECLININ	Non-UPL	Medicare CBA CO Spgs	$644.12	$686.75	93.79%
E2631	ELEVAT PROXIMAL ARM SUPPORT	Non-UPL	Medicare CBA CO Spgs	$228.02	$253.18	90.06%
E2631	ELEVAT PROXIMAL ARM SUPPORT	Non-UPL	Medicare CBA Denver	$228.02	$285.67	79.82%
K0001	STANDARD WHEELCHAIR	UPL	CO DME UPL	$217.00	$217.00	100.00%
K0001	STANDARD WHEELCHAIR	UPL	CO DME UPL	$429.10	$429.10	100.00%

K0001	STANDARD WHEELCHAIR	UPL	Medicare CBA CO Spgs	$21.42	$21.42	100.00%
K0001	STANDARD WHEELCHAIR	UPL	Medicare CBA Denver	$21.42	$21.42	100.00%
K0001	STANDARD WHEELCHAIR	UPL	Medicare DMEPOS	$21.70	$21.70	100.00%
K0001	STANDARD WHEELCHAIR	UPL	Medicare DMEPOS	$42.91	$42.91	100.00%
K0002	STND HEMI (LOW SEAT) WHLCHR	UPL	CO DME UPL	$418.20	$418.20	100.00%
K0002	STND HEMI (LOW SEAT) WHLCHR	UPL	Medicare CBA CO Spgs	$43.01	$43.01	100.00%
K0002	STND HEMI (LOW SEAT) WHLCHR	UPL	Medicare CBA Denver	$42.99	$42.99	100.00%
K0002	STND HEMI (LOW SEAT) WHLCHR	UPL	Medicare DMEPOS	$41.82	$41.82	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	CO DME UPL	$323.90	$323.90	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	CO DME UPL	$699.50	$699.50	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	Medicare CBA CO Spgs	$32.29	$32.29	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	Medicare CBA Denver	$32.29	$32.29	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	Medicare DMEPOS	$32.39	$32.39	100.00%
K0003	LIGHTWEIGHT WHEELCHAIR	UPL	Medicare DMEPOS	$69.95	$69.95	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	CO DME UPL	$392.20	$392.20	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	CO DME UPL	$880.20	$880.20	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	Medicare CBA CO Spgs	$36.90	$36.90	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	Medicare CBA Denver	$36.90	$36.90	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	Medicare DMEPOS	$39.22	$39.22	100.00%
K0004	HIGH STRENGTH LTWT WHLCHR	UPL	Medicare DMEPOS	$88.02	$88.02	100.00%
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	UPL	Medicare DMEPOS	$2,128.64	$2,128.64	100.00%
K0006	HEAVY DUTY WHEELCHAIR	UPL	CO DME UPL	$662.20	$662.20	100.00%
K0006	HEAVY DUTY WHEELCHAIR	UPL	CO DME UPL	$1,057.80	$1,057.80	100.00%
K0006	HEAVY DUTY WHEELCHAIR	UPL	Medicare CBA CO Spgs	$70.20	$70.20	100.00%
K0006	HEAVY DUTY WHEELCHAIR	UPL	Medicare CBA Denver	$70.20	$70.20	100.00%
K0006	HEAVY DUTY WHEELCHAIR	UPL	Medicare DMEPOS	$66.22	$66.22	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	CO DME UPL	$871.30	$871.30	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	CO DME UPL	$1,499.20	$1,499.20	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	Medicare CBA CO Spgs	$84.56	$84.56	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	Medicare CBA Denver	$84.56	$84.56	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	Medicare DMEPOS	$87.13	$87.13	100.00%
K0007	EXTRA HEAVY DUTY WHEELCHAIR	UPL	Medicare DMEPOS	$149.92	$149.92	100.00%
K0010	STND WT FRAME POWER WHLCHR	UPL	CO DME UPL	$4,904.80	$4,904.80	100.00%
K0015	DETACH NON-ADJ HT ARMRST REP	Non-UPL	Other States	$156.91	$143.80	109.11%
K0015	DETACH NON-ADJ HT ARMRST REP	Non-UPL	Other States	$156.91	$150.62	104.18%
K0015	DETACH NON-ADJ HT ARMRST REP	Non-UPL	Other States	$156.91	$154.27	101.71%
K0017	DETACH ADJUST ARMREST BASE	Non-UPL	Medicare DMEPOS	$44.12	$46.07	95.77%
K0017	DETACH ADJUST ARMREST BASE	Non-UPL	Medicare DMEPOS	$44.12	$48.39	91.18%
K0017	DETACH ADJUST ARMREST BASE	Non-UPL	Other States	$44.12	$44.44	99.29%
K0017	DETACH ADJUST ARMREST BASE	Non-UPL	Other States	$44.12	$46.58	94.71%
K0018	DETACH ADJUST ARMRST UPPER	Non-UPL	Medicare DMEPOS	$24.66	$26.04	94.70%
K0018	DETACH ADJUST ARMRST UPPER	Non-UPL	Medicare DMEPOS	$24.66	$27.19	90.70%
K0018	DETACH ADJUST ARMRST UPPER	Non-UPL	Other States	$24.66	$24.93	98.94%
K0018	DETACH ADJUST ARMRST UPPER	Non-UPL	Other States	$24.66	$26.11	94.46%
K0019	ARM PAD REPL, EACH	Non-UPL	Medicare CBA CO Spgs	$14.71	$11.84	124.24%
K0019	ARM PAD REPL, EACH	Non-UPL	Medicare CBA Denver	$14.71	$12.67	116.10%
K0019	ARM PAD REPL, EACH	Non-UPL	Medicare DMEPOS	$14.71	$13.56	108.48%
K0019	ARM PAD REPL, EACH	Non-UPL	Medicare DMEPOS	$14.71	$15.51	94.84%
K0019	ARM PAD REPL, EACH	Non-UPL	Other States	$14.71	$14.83	99.21%

K0019	ARM PAD REPL, EACH	Non-UPL	Other States	$14.71	$15.65	94.02%
K0037	HI MOUNT FLIP-UP FTREST REPL	Non-UPL	Medicare DMEPOS	$48.25	$43.35	111.30%
K0037	HI MOUNT FLIP-UP FTREST REPL	Non-UPL	Medicare DMEPOS	$48.25	$45.57	105.88%
K0038	LEG STRAP EACH	Non-UPL	Medicare DMEPOS	$24.30	$23.03	105.51%
K0038	LEG STRAP EACH	Non-UPL	Medicare DMEPOS	$24.30	$23.56	103.14%
K0038	LEG STRAP EACH	Non-UPL	Other States	$24.30	$22.58	107.62%
K0038	LEG STRAP EACH	Non-UPL	Other States	$24.30	$23.30	104.30%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Medicare CBA CO Spgs	$84.21	$51.97	162.04%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Medicare CBA Denver	$84.21	$53.93	156.15%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Medicare DMEPOS	$84.21	$50.85	165.60%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Medicare DMEPOS	$84.21	$64.51	130.54%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Other States	$84.21	$63.70	132.19%
K0040	ADJUSTABLE ANGLE FOOTPLATE	Non-UPL	Other States	$84.21	$67.08	125.54%
K0041	LARGE SIZE FOOTPLATE EACH	Non-UPL	Medicare DMEPOS	$53.07	$47.25	112.32%
K0041	LARGE SIZE FOOTPLATE EACH	Non-UPL	Other States	$53.07	$48.38	109.70%
K0042	STANDARD SIZE FTPLATE REP EA	Non-UPL	Medicare DMEPOS	$36.79	$30.34	121.26%
K0042	STANDARD SIZE FTPLATE REP EA	Non-UPL	Medicare DMEPOS	$36.79	$33.25	110.65%
K0042	STANDARD SIZE FTPLATE REP EA	Non-UPL	Other States	$36.79	$31.02	118.62%
K0042	STANDARD SIZE FTPLATE REP EA	Non-UPL	Other States	$36.79	$31.61	116.39%
K0043	FTRST LOWR EXTEN TUBE REP EA	Non-UPL	Medicare DMEPOS	$20.05	$18.73	107.05%
K0043	FTRST LOWR EXTEN TUBE REP EA	Non-UPL	Medicare DMEPOS	$20.05	$19.05	105.25%
K0043	FTRST LOWR EXTEN TUBE REP EA	Non-UPL	Other States	$20.05	$18.13	110.62%
K0043	FTRST LOWR EXTEN TUBE REP EA	Non-UPL	Other States	$20.05	$18.71	107.14%
K0044	FTRST UPR HANGER BRAC REP EA	Non-UPL	Medicare DMEPOS	$30.77	$16.41	187.51%
K0044	FTRST UPR HANGER BRAC REP EA	Non-UPL	Other States	$30.77	$15.63	196.93%
K0045	FTRST COMPL ASSEMBLY REPL EA	Non-UPL	Medicare DMEPOS	$138.93	$53.61	259.15%
K0045	FTRST COMPL ASSEMBLY REPL EA	Non-UPL	Other States	$138.93	$51.68	268.84%
K0045	FTRST COMPL ASSEMBLY REPL EA	Non-UPL	Other States	$138.93	$51.91	267.65%
K0047	ELEV LEGRST UPR HANGR REP EA	Non-UPL	Medicare DMEPOS	$79.89	$66.63	119.90%
K0047	ELEV LEGRST UPR HANGR REP EA	Non-UPL	Other States	$79.89	$67.35	118.62%
K0051	CAM REL ASM FT/LEGRST REP EA	Non-UPL	Medicare DMEPOS	$11.49	$48.91	23.49%
K0051	CAM REL ASM FT/LEGRST REP EA	Non-UPL	Other States	$11.49	$47.99	23.94%
K0051	CAM REL ASM FT/LEGRST REP EA	Non-UPL	Other States	$11.49	$49.74	23.10%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Medicare CBA CO Spgs	$65.51	$67.99	96.35%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Medicare CBA Denver	$65.51	$71.52	91.60%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Medicare DMEPOS	$65.51	$72.11	90.85%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Medicare DMEPOS	$65.51	$83.04	78.89%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Other States	$65.51	$74.91	87.46%
K0052	SWINGAWAY DETACH FTREST REPL	Non-UPL	Other States	$65.51	$79.88	82.01%
K0053	ELEVATE FOOTREST ARTICULATE	Non-UPL	Medicare CBA Denver	$112.70	$81.39	138.47%
K0053	ELEVATE FOOTREST ARTICULATE	Non-UPL	Medicare DMEPOS	$112.70	$94.86	118.81%
K0065	SPOKE PROTECTORS	Non-UPL	Medicare CBA CO Spgs	$44.55	$40.46	110.11%
K0065	SPOKE PROTECTORS	Non-UPL	Medicare CBA Denver	$44.55	$48.04	92.74%
K0065	SPOKE PROTECTORS	Non-UPL	Medicare DMEPOS	$44.55	$44.80	99.44%
K0065	SPOKE PROTECTORS	Non-UPL	Other States	$44.55	$42.54	104.72%
K0065	SPOKE PROTECTORS	Non-UPL	Other States	$44.55	$43.90	101.48%
K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Medicare CBA CO Spgs	$100.13	$86.60	115.62%
K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Medicare CBA Denver	$100.13	$90.20	111.01%
K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Medicare DMEPOS	$100.13	$91.70	109.19%

K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Medicare DMEPOS	$100.13	$107.10	93.49%
K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Other States	$100.13	$92.90	107.78%
K0069	RR WHL COMPL SOL TIRE REP EA	Non-UPL	Other States	$100.13	$95.89	104.42%
K0070	RR WHL COMPL PNE TIRE REP EA	Non-UPL	Other States	$183.53	$149.05	123.13%
K0070	RR WHL COMPL PNE TIRE REP EA	Non-UPL	Other States	$183.53	$161.22	113.84%
K0070	RR WHL COMPL PNE TIRE REP EA	Non-UPL	Other States	$183.53	$163.02	112.58%
K0071	FR CSTR COMP PNE TIRE REP EA	Non-UPL	Medicare CBA Denver	$120.70	$99.44	121.38%
K0071	FR CSTR COMP PNE TIRE REP EA	Non-UPL	Medicare DMEPOS	$120.70	$100.86	119.67%
K0071	FR CSTR COMP PNE TIRE REP EA	Non-UPL	Medicare DMEPOS	$120.70	$120.06	100.53%
K0071	FR CSTR COMP PNE TIRE REP EA	Non-UPL	Other States	$120.70	$101.31	119.14%
K0071	FR CSTR COMP PNE TIRE REP EA	Non-UPL	Other States	$120.70	$104.63	115.36%
K0072	FR CSTR SEMI-PNE TIRE REP EA	Non-UPL	Medicare CBA Denver	$72.65	$67.93	106.95%
K0072	FR CSTR SEMI-PNE TIRE REP EA	Non-UPL	Medicare DMEPOS	$72.65	$64.63	112.41%
K0072	FR CSTR SEMI-PNE TIRE REP EA	Non-UPL	Other States	$72.65	$62.18	116.84%
K0072	FR CSTR SEMI-PNE TIRE REP EA	Non-UPL	Other States	$72.65	$63.08	115.16%
K0073	CASTER PIN LOCK EACH	Non-UPL	Other States	$34.87	$32.15	108.46%
K0077	FR CSTR ASMB SOL TIRE REP EA	Non-UPL	Medicare CBA CO Spgs	$65.01	$50.21	129.48%
K0077	FR CSTR ASMB SOL TIRE REP EA	Non-UPL	Medicare CBA Denver	$65.01	$54.04	120.30%
K0077	FR CSTR ASMB SOL TIRE REP EA	Non-UPL	Medicare DMEPOS	$65.01	$55.30	117.56%
K0077	FR CSTR ASMB SOL TIRE REP EA	Non-UPL	Other States	$65.01	$52.46	123.92%
K0077	FR CSTR ASMB SOL TIRE REP EA	Non-UPL	Other States	$65.01	$54.67	118.92%
K0105	IV HANGER	Non-UPL	Medicare CBA CO Spgs	$99.61	$90.50	110.07%
K0105	IV HANGER	Non-UPL	Medicare CBA Denver	$99.61	$92.25	107.98%
K0105	IV HANGER	Non-UPL	Medicare DMEPOS	$99.61	$94.07	105.89%
K0105	IV HANGER	Non-UPL	Medicare DMEPOS	$99.61	$109.39	91.06%
K0105	IV HANGER	Non-UPL	Other States	$99.61	$93.71	106.30%
K0195	ELEVATING WHLCHAIR LEG RESTS	Non-UPL	Medicare CBA CO Spgs	$7.04	$11.31	62.25%
K0195	ELEVATING WHLCHAIR LEG RESTS	Non-UPL	Medicare CBA Denver	$7.04	$11.31	62.25%
K0195	ELEVATING WHLCHAIR LEG RESTS	Non-UPL	Medicare DMEPOS	$7.04	$10.47	67.24%
K0195	ELEVATING WHLCHAIR LEG RESTS	Non-UPL	Medicare DMEPOS	$7.04	$16.18	43.51%
K0195	ELEVATING WHLCHAIR LEG RESTS	Non-UPL	Other States	$35.34	$218.10	16.20%
K0462	TEMPORARY REPLACEMENT EQPMNT	Non-UPL	Other States	$146.86	$589.71	24.90%
K0552	SUP/EXT NON-INS INF PUMP SYR	Non-UPL	Medicare DMEPOS	$2.70	$2.72	99.26%
K0552	SUP/EXT NON-INS INF PUMP SYR	Non-UPL	Medicare DMEPOS	$2.70	$2.88	93.75%
K0605	REPL BATT LITHIUM 4.5 V	Non-UPL	Other States	$14.92	$14.46	103.18%
K0606	AED GARMENT W ELEC ANALYSIS	Non-UPL	Medicare DMEPOS	$1,591.43	$2,899.50	54.89%
K0606	AED GARMENT W ELEC ANALYSIS	Non-UPL	Other States	$1,591.43	$2,319.21	68.62%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Medicare CBA CO Spgs	$21.57	$28.15	76.63%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Medicare CBA Denver	$21.57	$28.70	75.16%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Medicare DMEPOS	$21.57	$28.06	76.87%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Medicare DMEPOS	$21.57	$29.93	72.07%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Other States	$21.57	$27.34	78.91%
K0733	12-24HR SEALED LEAD ACID	Non-UPL	Other States	$21.57	$28.50	75.68%
K0738	PORTABLE GAS OXYGEN SYSTEM	UPL	Medicare CBA CO Spgs	$35.86	$35.86	100.00%
K0738	PORTABLE GAS OXYGEN SYSTEM	UPL	Medicare CBA Denver	$36.48	$36.48	100.00%
K0738	PORTABLE GAS OXYGEN SYSTEM	UPL	Medicare CBA Denver	$36.94	$36.94	100.00%
K0738	PORTABLE GAS OXYGEN SYSTEM	UPL	Medicare DMEPOS	$37.01	$37.01	100.00%
K0738	PORTABLE GAS OXYGEN SYSTEM	UPL	Medicare DMEPOS	$44.32	$44.32	100.00%
K0739	REPAIR/SVC DME NON-OXYGEN EQ	Non-UPL	Other States	$26.57	$13.77	192.98%

K0739	REPAIR/SVC DME NON-OXYGEN EQ	Non-UPL	Other States	$163.31	$13.77	1186.16%
K0800	POV GROUP 1 STD UP TO 300LBS	UPL	Medicare CBA CO Spgs	$830.69	$830.69	100.00%
K0800	POV GROUP 1 STD UP TO 300LBS	UPL	Medicare CBA Denver	$830.69	$830.69	100.00%
K0800	POV GROUP 1 STD UP TO 300LBS	UPL	Medicare DMEPOS	$108.30	$108.30	100.00%
K0800	POV GROUP 1 STD UP TO 300LBS	UPL	Medicare DMEPOS	$794.35	$794.35	100.00%
K0800	POV GROUP 1 STD UP TO 300LBS	UPL	Medicare DMEPOS	$1,082.89	$1,082.89	100.00%
K0801	POV GROUP 1 HD 301-450 LBS	UPL	Medicare CBA CO Spgs	$1,537.50	$1,537.50	100.00%
K0801	POV GROUP 1 HD 301-450 LBS	UPL	Medicare CBA Denver	$1,558.12	$1,558.12	100.00%
K0801	POV GROUP 1 HD 301-450 LBS	UPL	Medicare DMEPOS	$1,486.30	$1,486.30	100.00%

K0801	POV GROUP 1 HD 301-450 LBS	UPL	Medicare DMEPOS	$1,841.43	$1,841.43	100.00%
K0806	POV GROUP 2 STD UP TO 300LBS	UPL	Medicare DMEPOS	$136.57	$136.57	100.00%
K0806	POV GROUP 2 STD UP TO 300LBS	UPL	Medicare DMEPOS	$1,365.68	$1,365.68	100.00%
K0821	PWC GP 2 STD PORT CAP CHAIR	UPL	CO DME UPL	$1,780.80	$1,780.80	100.00%
K0822	PWC GP 2 STD SEAT/BACK	UPL	CO DME UPL	$1,869.13	$1,869.13	100.00%
K0823	PWC GP 2 STD CAP CHAIR	UPL	CO DME UPL	$1,780.80	$1,780.80	100.00%
K0823	PWC GP 2 STD CAP CHAIR	UPL	CO DME UPL	$2,978.93	$2,978.93	100.00%
K0825	PWC GP 2 HD CAP CHAIR	UPL	CO DME UPL	$2,551.53	$2,551.53	100.00%
K0825	PWC GP 2 HD CAP CHAIR	UPL	CO DME UPL	$3,602.67	$3,602.67	100.00%
K0827	PWC GP VHD CAP CHAIR	UPL	CO DME UPL	$3,986.13	$3,986.13	100.00%
K0827	PWC GP VHD CAP CHAIR	UPL	CO DME UPL	$4,884.93	$4,884.93	100.00%
K0848	PWC GP 3 STD SEAT/BACK	UPL	CO DME UPL	$5,244.20	$5,244.20	100.00%
K0849	PWC GP 3 STD CAP CHAIR	UPL	CO DME UPL	$5,041.87	$5,041.87	100.00%
K0850	PWC GP 3 HD SEAT/BACK	UPL	CO DME UPL	$6,082.93	$6,082.93	100.00%
K0851	PWC GP 3 HD CAP CHAIR	UPL	CO DME UPL	$5,848.80	$5,848.80	100.00%
K0853	PWC GP 3 VHD CAP CHAIR	UPL	CO DME UPL	$7,220.07	$7,220.07	100.00%
K0856	PWC GP3 STD SING POW OPT S/B	UPL	CO DME UPL	$5,628.93	$5,628.93	100.00%
K0858	PWC GP3 HD SING POW OPT S/B	UPL	CO DME UPL	$6,983.93	$6,983.93	100.00%
K0860	PWC GP3 VHD SING POW OPT S/B	UPL	CO DME UPL	$9,977.47	$9,977.47	100.00%
K0861	PWC GP3 STD MULT POW OPT S/B	UPL	CO DME UPL	$5,637.93	$5,637.93	100.00%
K0861	PWC GP3 STD MULT POW OPT S/B	UPL	Medicare DMEPOS	$845.69	$845.69	100.00%
K0862	PWC GP3 HD MULT POW OPT S/B	UPL	CO DME UPL	$6,983.93	$6,983.93	100.00%

Appendix B8: ASC Additional Information

While Colorado Medicaid pays for ASC services using a procedure code grouper, only the first line of a claim is considered eligible for Colorado repricing. Most of these services were compared to Medicare as a benchmark, which entails secondary lines generating additional payments that Colorado Medicaid would otherwise not pay. The Department has elected not to show rate ratios for ASC services at a procedure code level as it can misrepresent the difference in reimbursement levels for these services when considering multiple procedure discounting.

The services analyzed in the ASC rate comparison benchmark analysis are repriced using methodology that incorporates the following data elements:

- Procedure code
- Service county
- Primary or secondary line status

Appendix C – Service Grouping Data Book

Appendix C contains, for each service grouping, the following information:

- Top 10 procedure or revenue codes by total paid.
- Distinct utilizers over time.
- Active providers over time.
- Population age and gender.
- Rate comparison visuals.

Appendix C does not include any additional data for Psychiatric Residential Treatment Facilities (PRTF), due to protected health information. Appendix C does not include the above information for Special Connections due to the lack of available claims data; Special Connections code descriptions and rate unit definitions are included in Appendix C.

Appendix C does not contain any assertions or conclusions on the sufficiency of Medicaid rates to provide adequate access to care. Refer to Appendix B – Rate Comparison and Access to Care Analysis Methodologies and Data for a complete list of individual procedure codes reviewed in this report.

Data Book Instructions

For each service grouping (except PRTF and Special Connections), Appendix C contains additional, detailed information regarding rate comparison and access to care analyses.

Top 10 Procedure or Revenue Codes by Total Paid

The Top Procedure or Revenue Codes by Total Paid table displays the top 10 codes, in descending order, by total expenditures (also referred to as total paid). This table includes:

- Procedure or revenue code information
- Procedure description
- Benchmark source
- Paid dollars
- Colorado Medicaid rates
- Rate comparison by total paid units and dollars
- Benchmark rates

Distinct Utilizers Over Time by Month

The Distinct Utilizers Over Time by Month line graph displays changes in the number of distinct members utilizing services.

Active Providers Over Time by Month

The Active Providers Over Time by Month line graph displays changes in the number of providers actively providing services.

Population Age and Gender

The Population Age and Gender Stacked-band bar graph displays the age and gender of members utilizing services.

Rate Comparison Visuals

Rate Comparison by Total Paid Units and Dollars scatterplots display the rate ratio, utilization, and total paid amount for individual Ambulatory Surgical Center (ASC) code groupings, procedure codes (fee-for-service behavioral health, Residential Child Care Facilities (RCCF), and durable medical equipment (DME)), and dialysis facility wage index regions[98], specifically:

- Vertical axis (y-axis) – the rate ratio of Colorado Medicaid rates to the benchmark rates. The dark horizontal line represents the rate benchmark comparison percentage for the service grouping.
- Horizontal axis (x-axis) – the total paid amount.
- Circles – The size of the circle indicates the total paid units, which is a proxy for utilization.

Rate comparison bar graphs display Colorado's repriced rates as a percentage of the rate comparison benchmark. This graph is only included for the following services:

- ASC services, broken down by code grouping.
- Dialysis and end-stage renal disease (ESRD) services, broken down by wage index region.

[98] For more information on the ASC code grouping and dialysis facility rate comparison methodologies, please see Appendix B.

DME, broken down by other states, Medicare upper pay limit (UPL), and Medicare non-UPL codes.

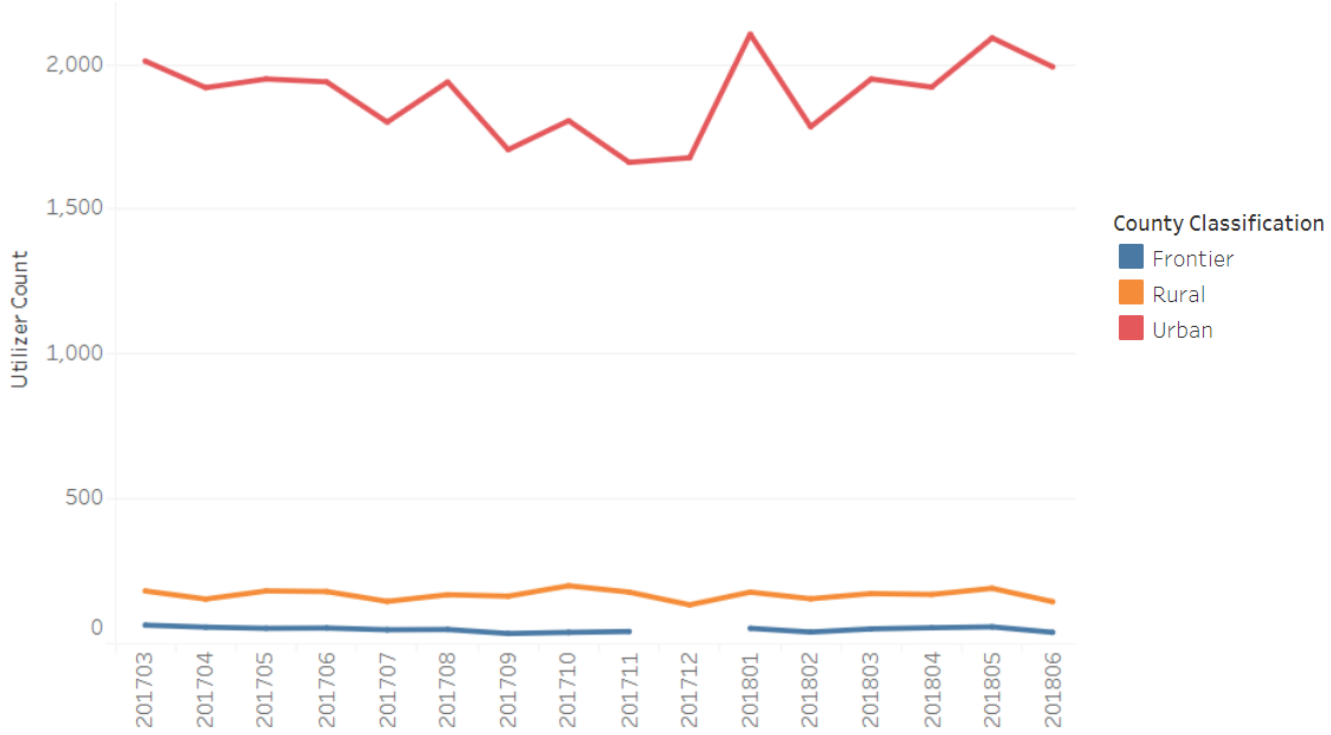
Ambulatory Surgical Centers

Top 10 Procedure Codes by Total Paid

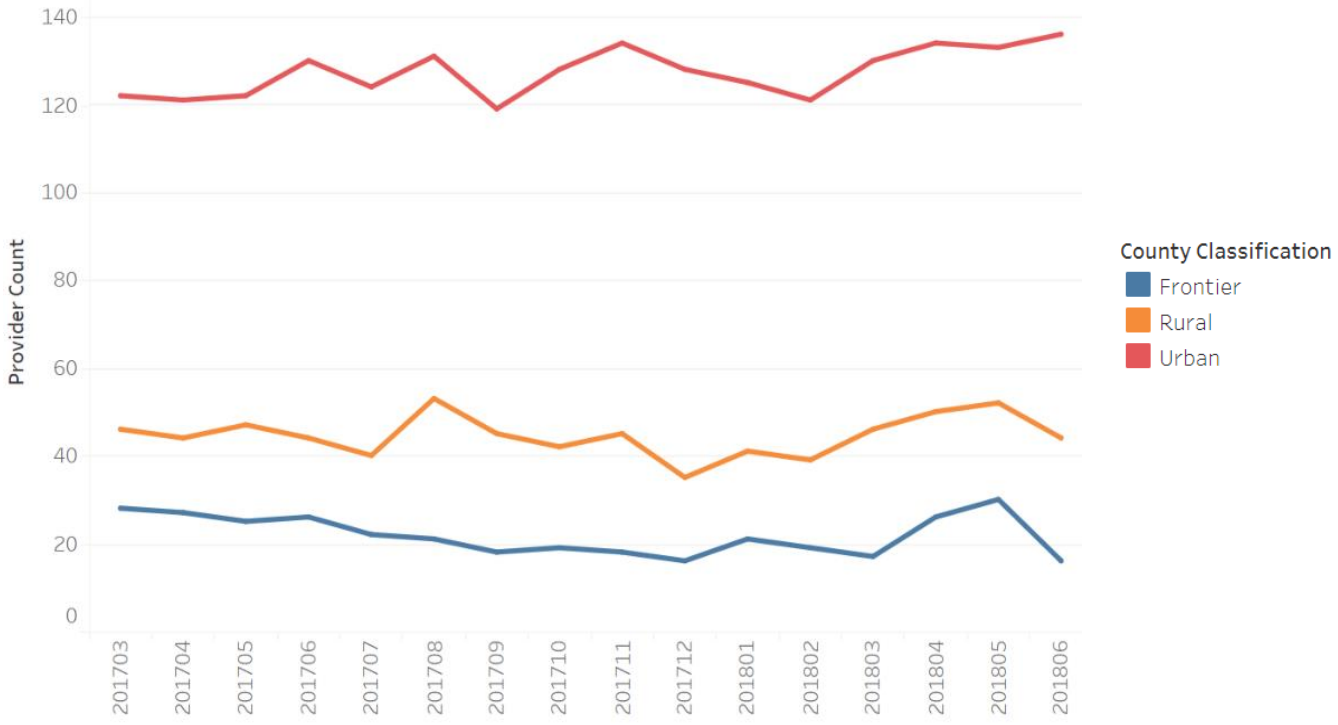
ASC Top 10 Procedure Codes							
Procedure Code	**Procedure Description**	**Wage Index Region**	**Benchmark Source**	**Paid Amount***	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
41899	DENTAL SURGERY PROCEDURE	All Colorado	Other States	$2,088,941	$1,077.13	$650.61	165.56%
66984	CATARACT SURG W/IOL 1 STAGE	Denver, Aurora, Lakewood	Medicare	$571,504	$782.70	$989.30	79.12%
43239	EGD BIOPSY SINGLE/MULTIPLE	Denver, Aurora, Lakewood	Medicare	$496,908	$358.73	$397.11	90.34%
43239	EGD BIOPSY SINGLE/MULTIPLE	Colorado Springs, CO	Medicare	$495,295	$358.73	$383.28	93.60%
66984	CATARACT SURG W/IOL 1 STAGE	Colorado Springs, CO	Medicare	$329,852	$782.70	$954.85	81.97%
45380	COLONOSCOPY AND BIOPSY	Denver, Aurora, Lakewood	Medicare	$327,038	$358.73	$510.91	70.21%
45380	COLONOSCOPY AND BIOPSY	Colorado Springs, CO	Medicare	$317,756	$358.73	$493.12	72.75%
45378	DIAGNOSTIC COLONOSCOPY	Denver, Aurora, Lakewood	Medicare	$239,978	$358.73	$388.42	92.36%
64483	INJ FORAMEN EPIDURAL L/S	Denver, Aurora, Lakewood	Medicare	$220,920	$267.86	$398.83	67.16%
45385	COLONOSCOPY W/LESION REMOVAL	Denver, Aurora, Lakewood	Medicare	$211,246	$358.73	$510.91	70.21%

*Adjusted for claims incurred but not reported.

Distinct Utilizers Over Time by Month



Active Providers Over Time by Month



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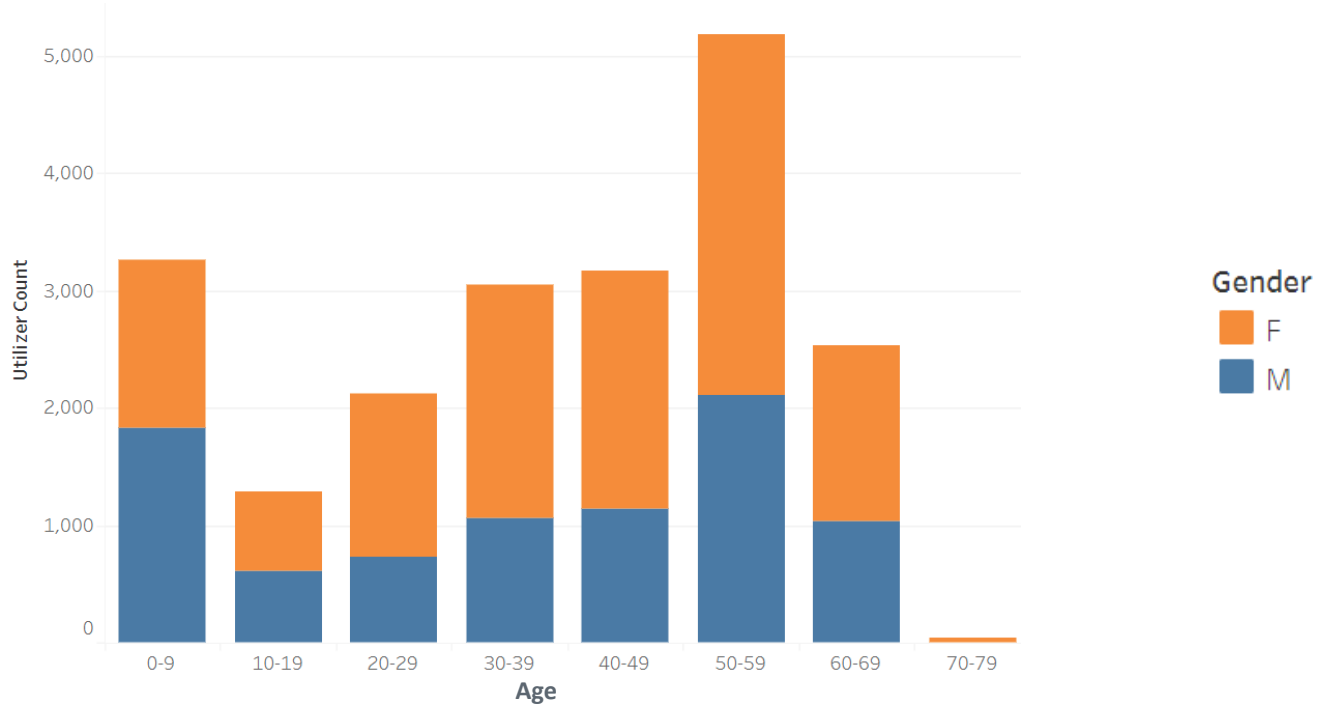
Population Age and Gender



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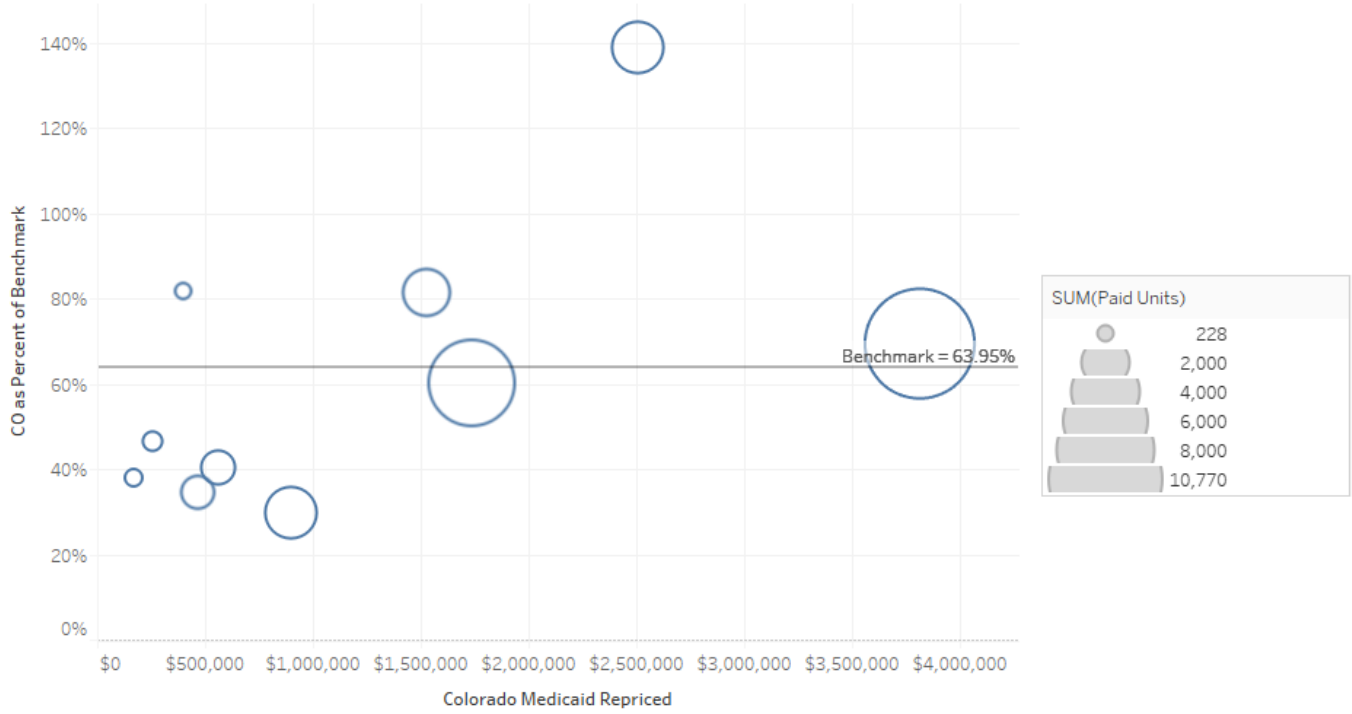
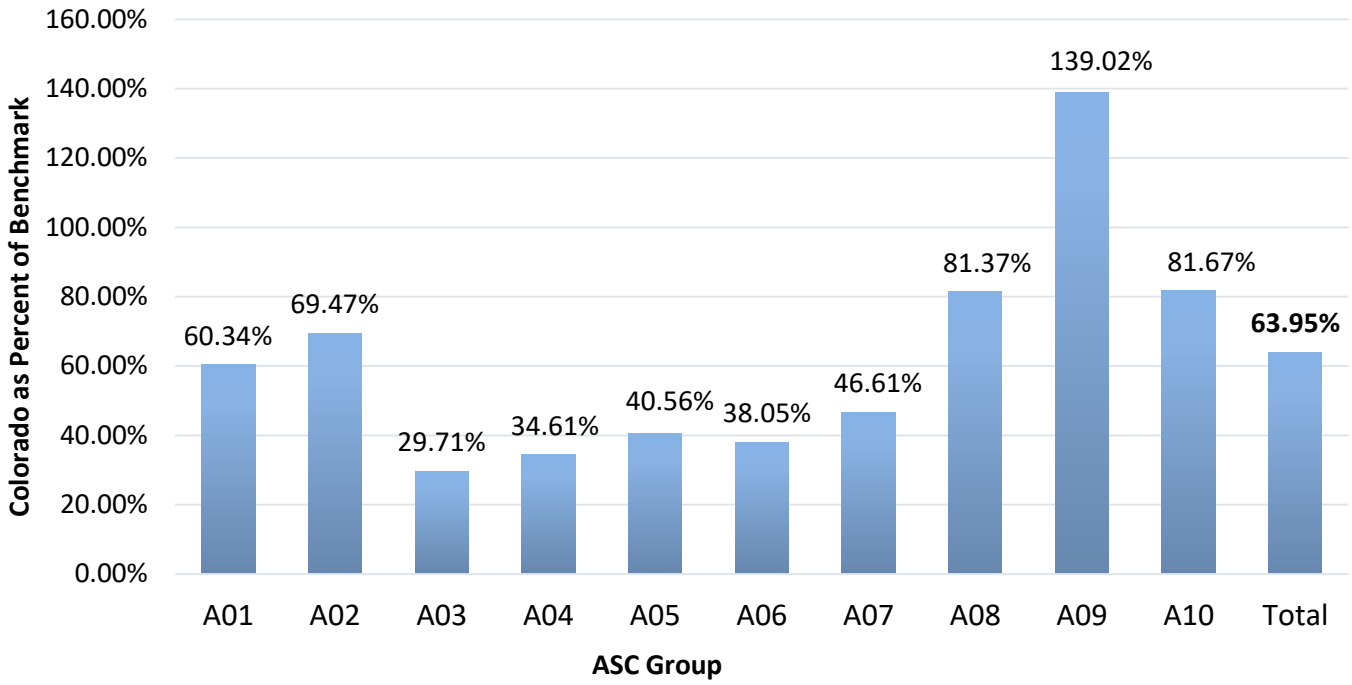
Rate Comparison by Total Paid Units and Dollars[99]



[99] For the ASC scatterplot, circles represent total paid units for each ASC code grouping.

Rate Comparisons by Code Grouping[100]



[100] The ASC rate comparison benchmark is broken down to show the percentage of each ASC code grouping compared to the benchmark. For more details regarding the ASC rate comparison methodology, please see Appendix B.

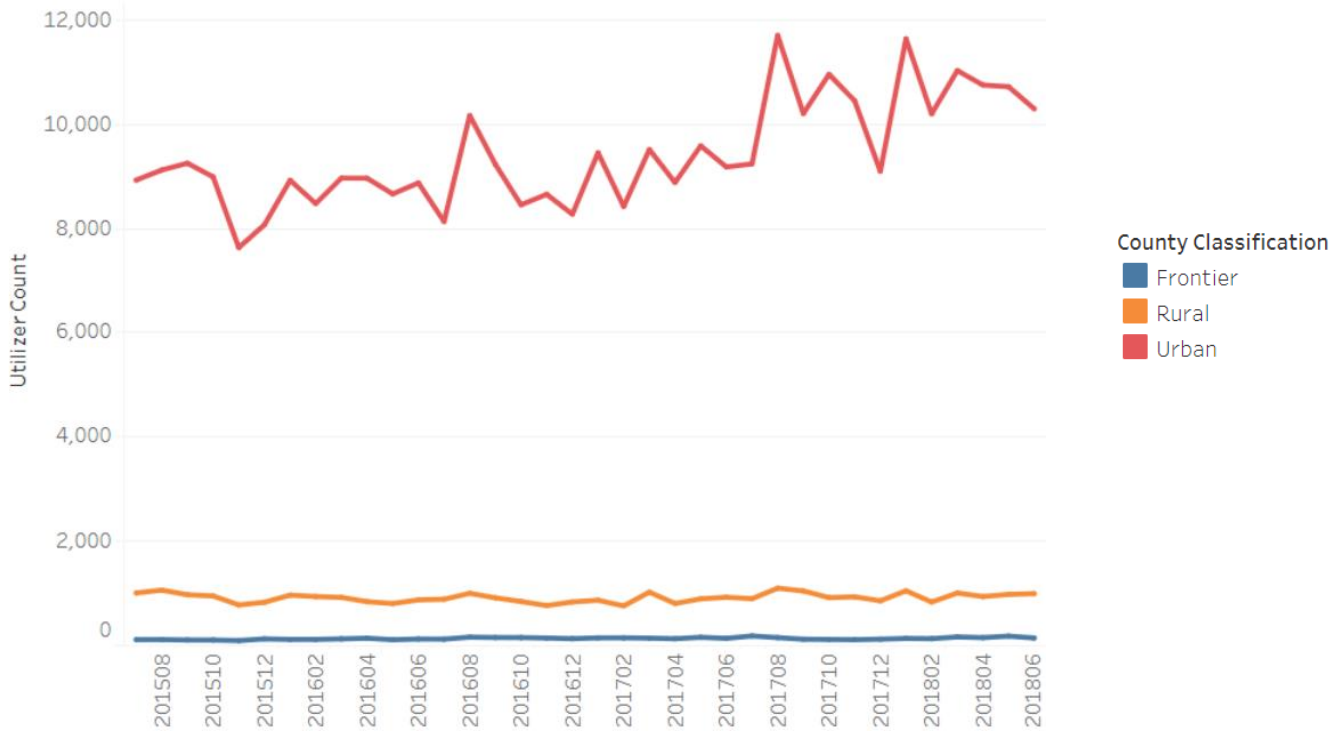
Fee-for-Service Behavioral Health Services

Top 10 Procedure Codes by Total Paid

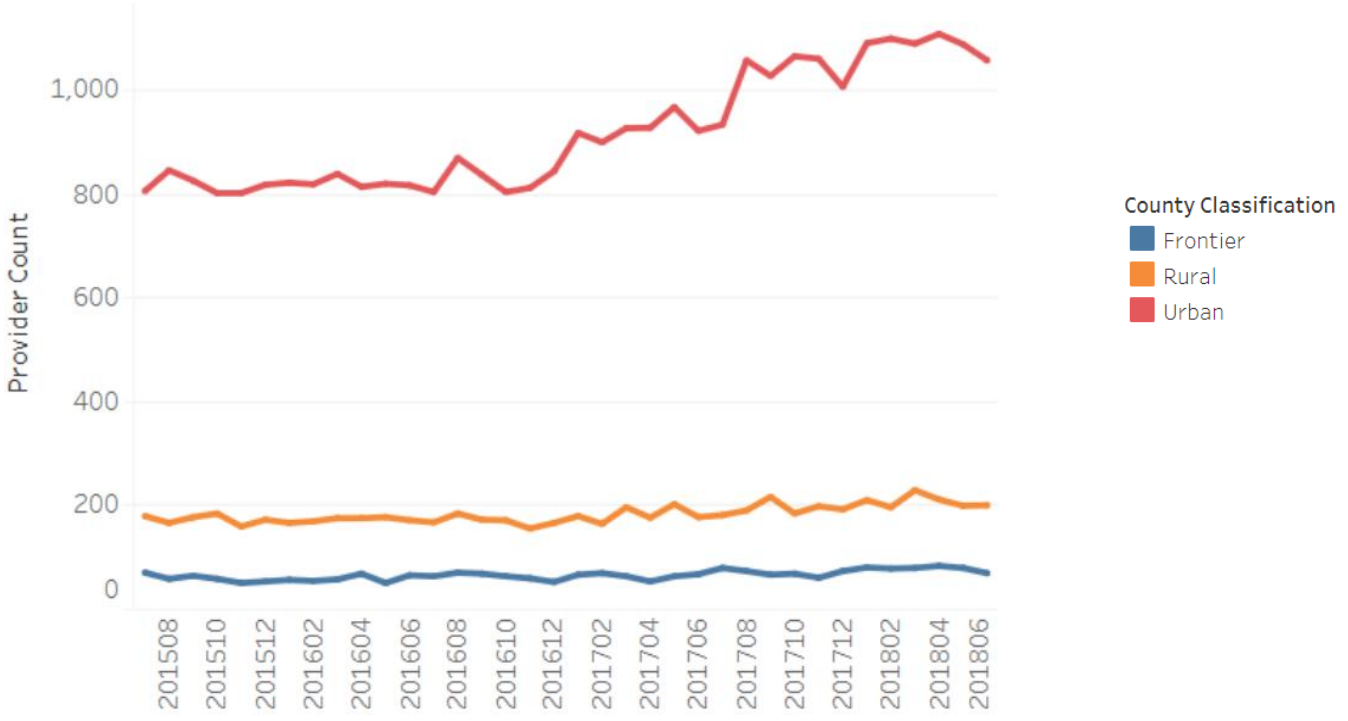
FFS Behavioral Health Top 10 Procedure Codes						
Procedure Code	**Description**	**Paid Amount**	**Benchmark Source**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
96118	NEUROPSYCH TST BY PSYCH/PHYS	$1,880,686	Medicare PFS	$120.56	$134.53	89.61%
96110	DEVELOPMENTAL SCREEN W/SCORE	$1,824,386	Other States	$17.85	$14.97	119.27%
T1019	PERSONAL CARE SER PER 15 MIN	$1,191,272	Other States	$4.87	$4.98	97.89%
90837	PSYTX W PT 60 MINUTES	$778,460	Medicare PFS	$103.23	$137.56	75.04%
96101	PSYCHO TESTING BY PSYCH/PHYS	$644,945	Medicare PFS	$62.01	$48.46	127.97%
90791	PSYCH DIAGNOSTIC EVALUATION	$296,868	Medicare PFS	$108.62	$140.86	77.11%
H0005	ALCOHOL AND/OR DRUG SERVICES	$178,747	Other States	$30.16	$13.04	231.23%
90792	PSYCH DIAG EVAL W/MED SRVCS	$151,824	Medicare PFS	$132.03	$145.15	90.96%
96111	DEVELOPMENTAL TEST EXTEND	$151,568	Medicare PFS	$103.76	$138.97	74.66%
96110	DEVELOPMENTAL SCREEN W/SCORE	$98,657	Other States	$18.21	$14.97	121.68%

*Adjusted for claims incurred but not reported

Distinct Utilizers Over Time by Month



Active Providers Over Time by Month



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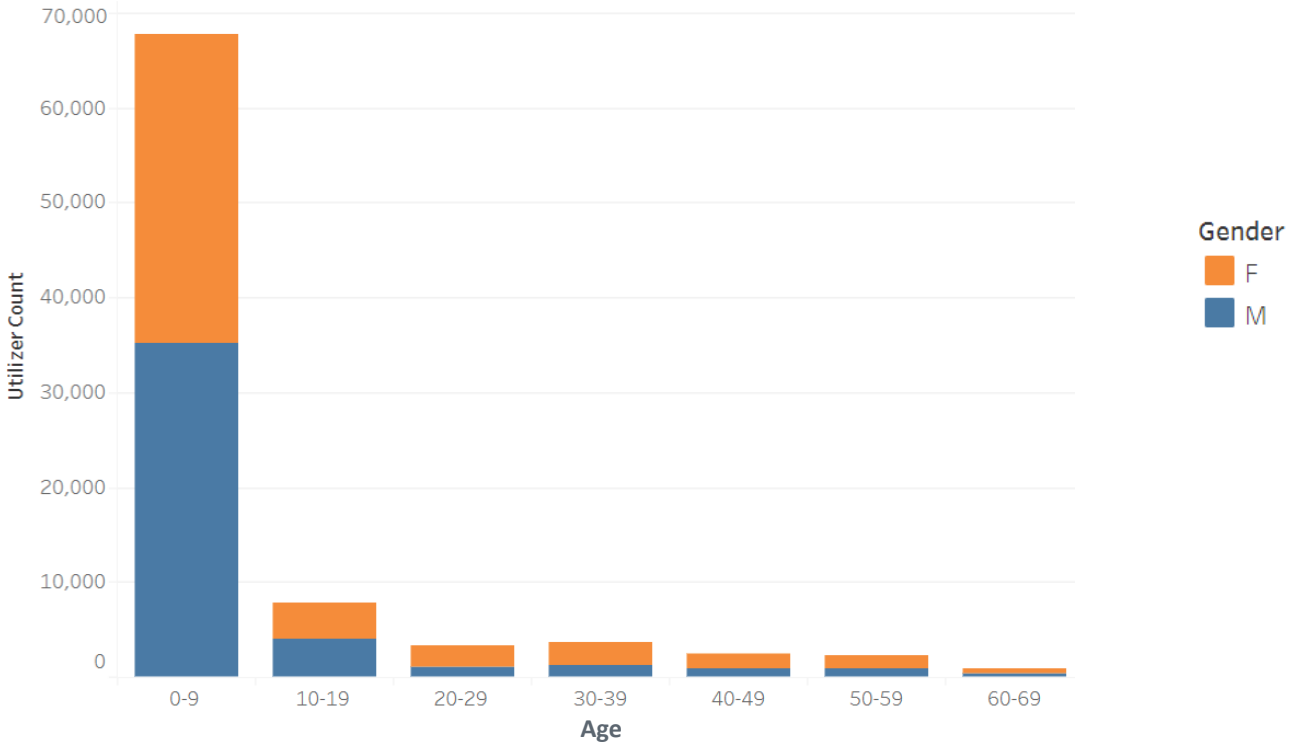
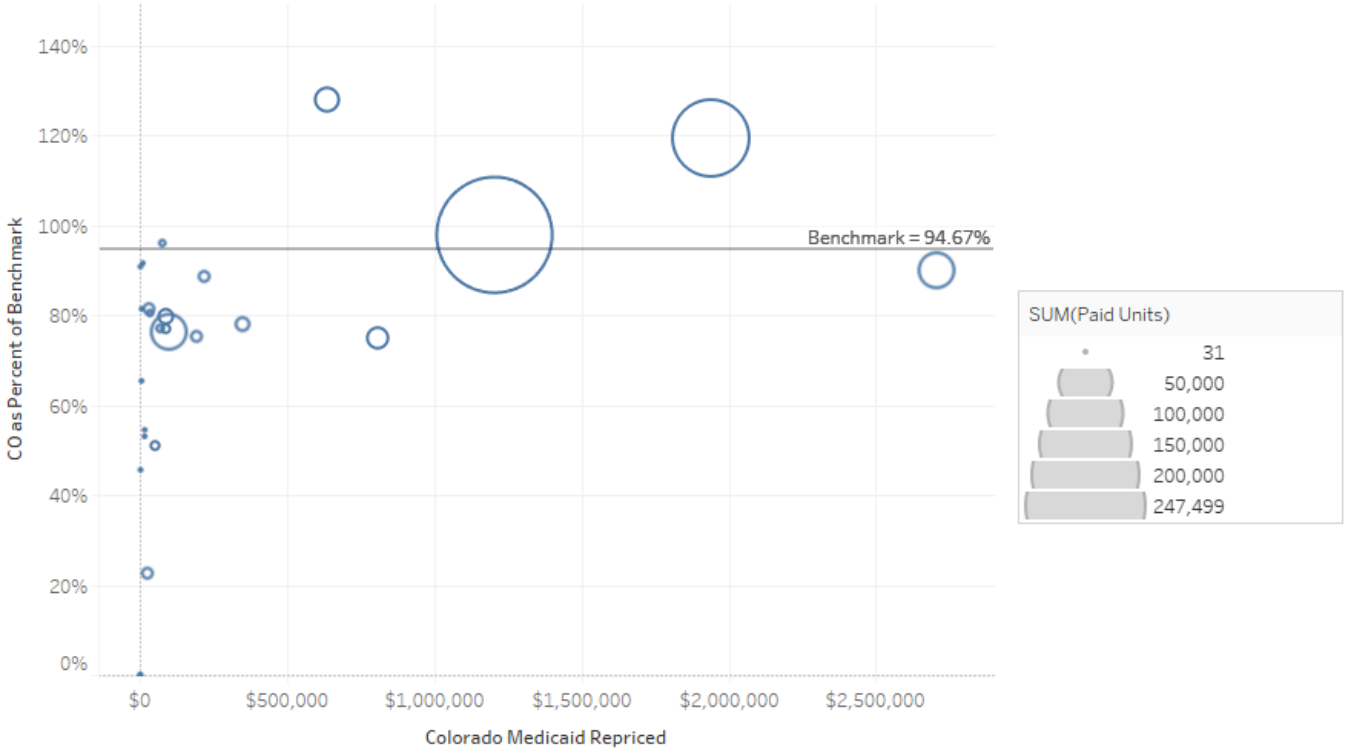
Population Age and Gender



Rate Comparison by Total Paid Units and Dollars



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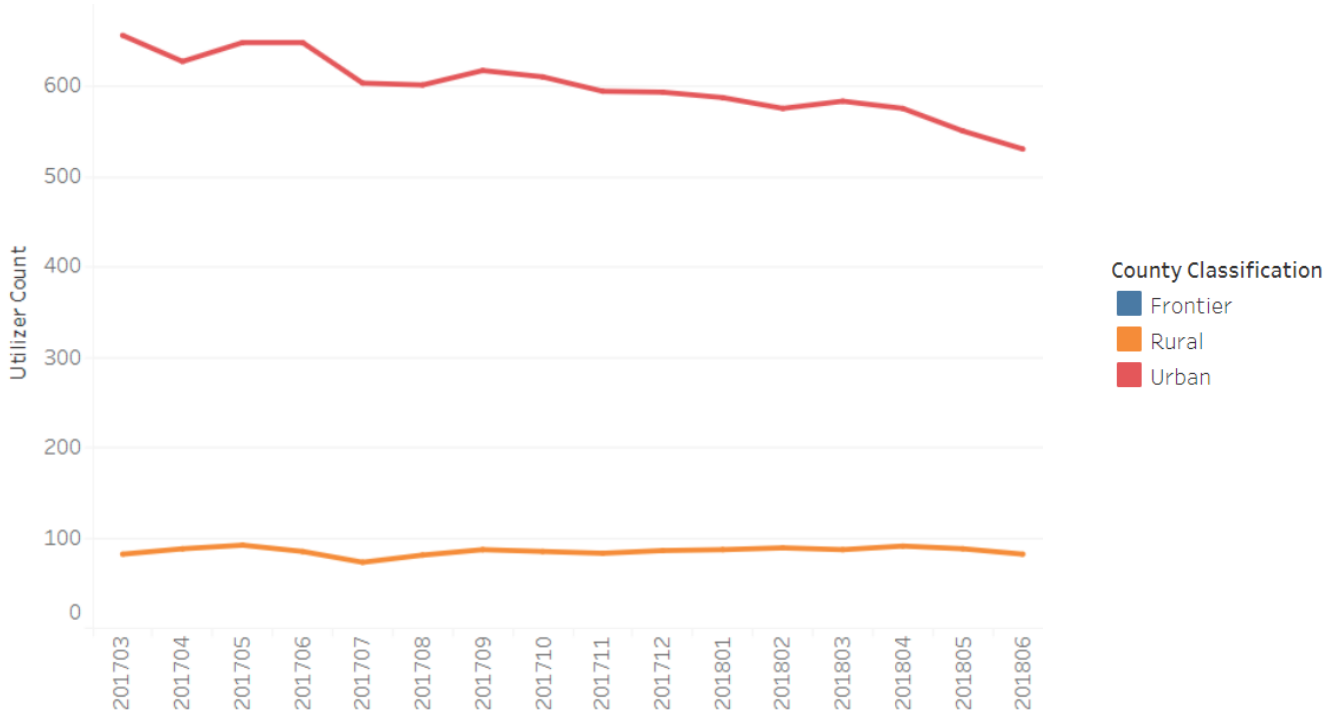
Residential Child Care Facilities

Top 10 Procedure Codes by Total Paid

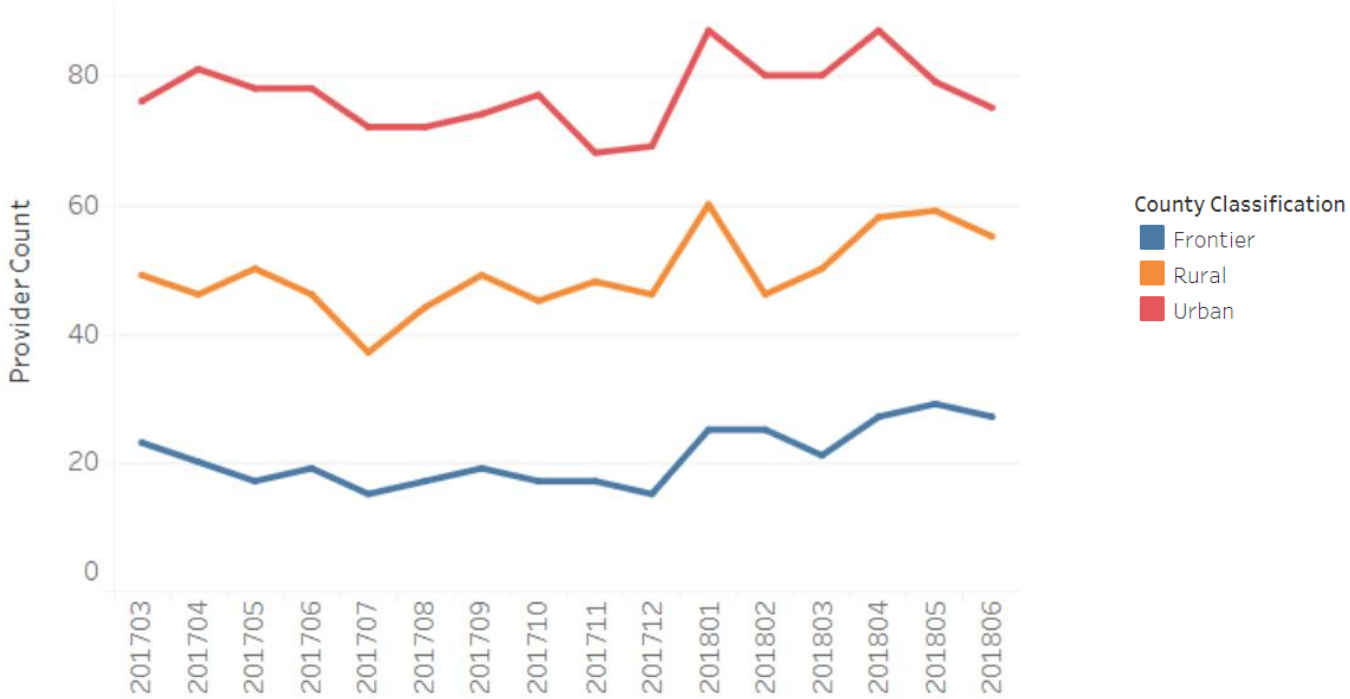
RCCF Top 10 Procedure Codes						
Procedure Code	**Description**	**Paid Amount***	**Benchmark Source**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
90837	PSYTX W PT 60 MINUTES	$2,654,404	Other States	$103.23	$107.41	96.11%
90853	GROUP PSYCHOTHERAPY	$1,780,570	Other States	$12.12	$25.79	47.00%
90832	PSYTX W PT 30 MINUTES	$722,518	Other States	$54.80	$54.54	100.47%
90834	PSYTX W PT 45 MINUTES	$709,289	Other States	$70.54	$77.52	91.00%
90847	FAMILY PSYTX W/PT 50 MIN	$586,422	Other States	$61.44	$95.18	64.55%
90791	PSYCH DIAGNOSTIC EVALUATION	$96,465	Other States	$108.62	$122.25	88.85%
90863	PHARMACOLOGIC MGMT W/PSYTX	$77,229	Other States	$33.20	$40.68	81.62%
90846	FAMILY PSYTX W/O PT 50 MIN	$62,966	Other States	$58.57	$82.89	70.66%
90792	PSYCH DIAG EVAL W/MED SRVCS	$54,258	Other States	$132.03	$132.90	99.35%
90832	PSYTX W PT 30 MINUTES	$39,171	Other States	$54.80	$52.79	103.81%

*Adjusted for claims incurred but not reported

Distinct Utilizers Over Time by Month



Active Providers Over Time by Month



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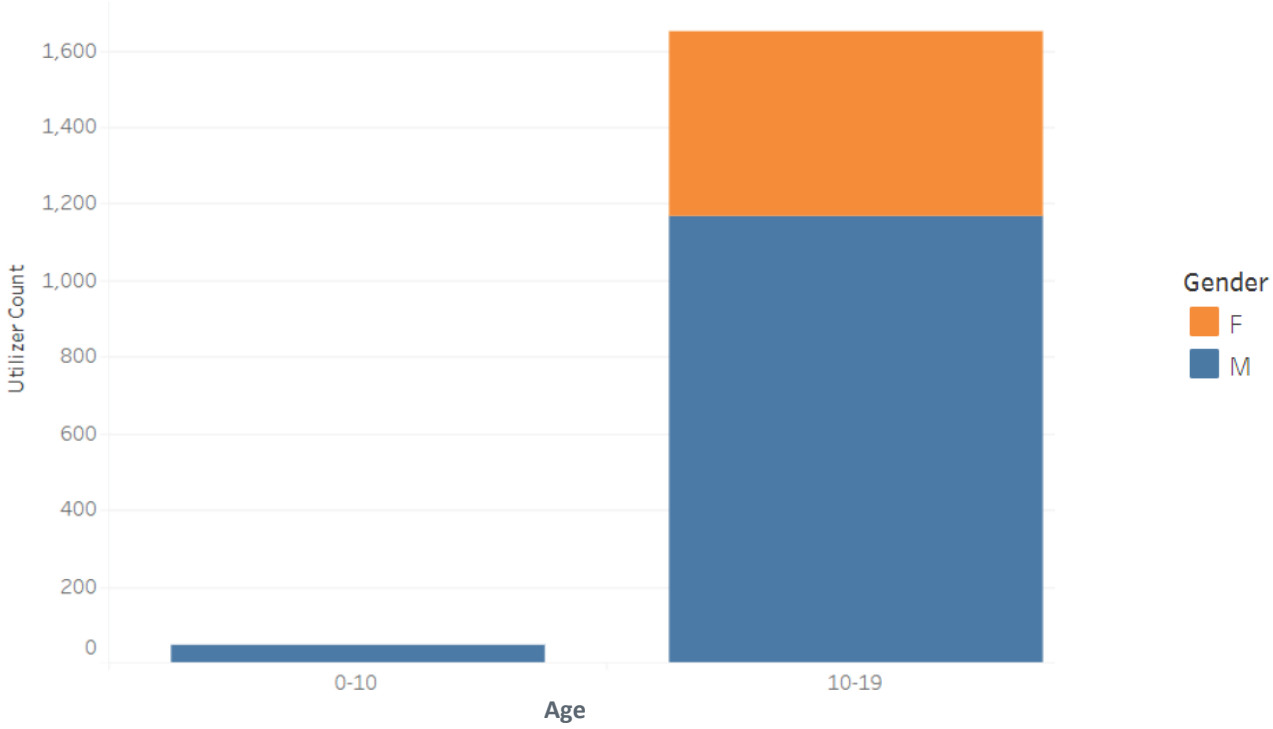
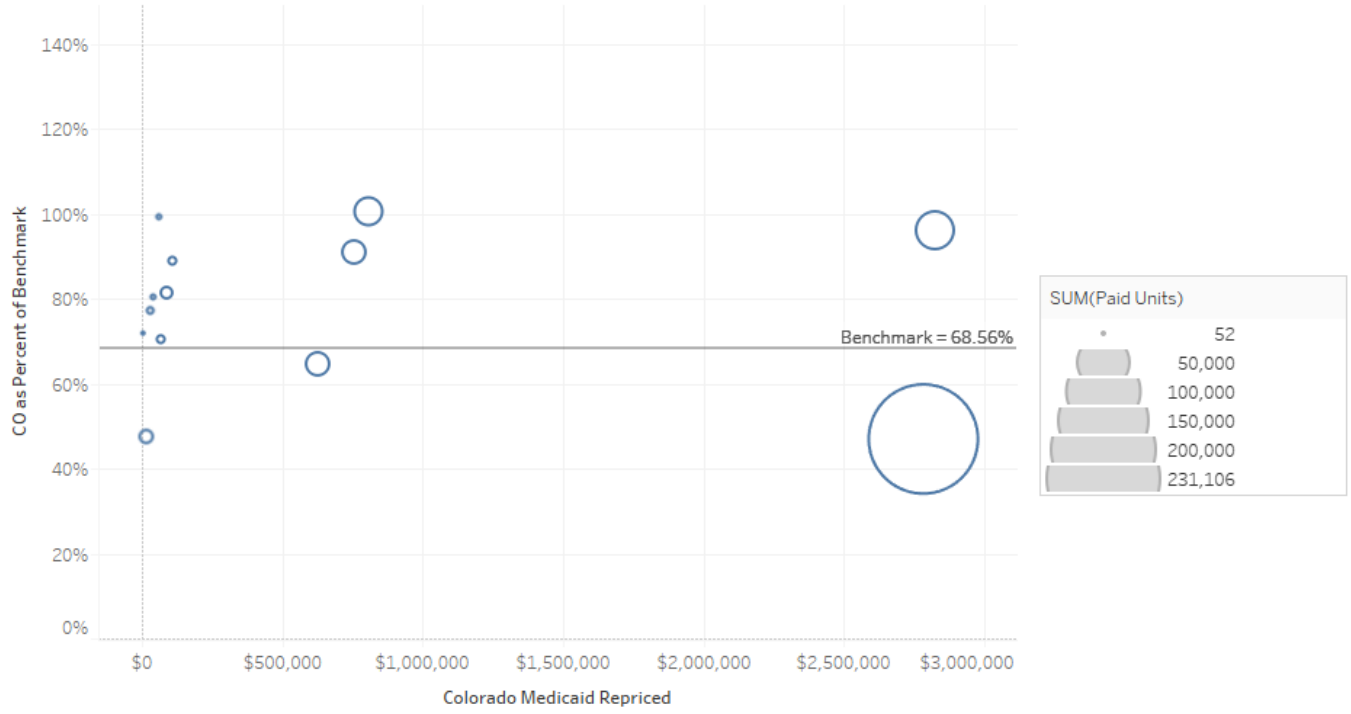
Population Age and Gender



Rate Comparison by Total Paid Units and Dollars



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Special Connections

Top Procedure Codes

Special Connections Procedure Codes						
Procedure Code	**Modifiers** [101]	**Service Description**	**Unit**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
H0004	HD	Behavioral health counseling and therapy	15 Minutes	$14.04	$28.31	**49.59%**
H0004	HD, HQ	Behavioral health counseling and therapy	15 Minutes	$7.50	$28.31	**26.51%**
H1000	HD	Prenatal care, at-risk assessment	Per Assessment	$105.39	$16.71	**630.72%**
H1002	HD	Prenatal care, at-risk enhanced service; care coordination	Per Encounter	$8.79	$48.79	**18.01%**
H1003	HD	Prenatal at-risk education	Per Encounter	$3.62	$36.96	**9.78%**
H2036	HD	A/d tx program	Per Day	$192.10	$167.72	**114.54%**

[101] Other states did not tend to use the same modifiers as Colorado, so the Department applied the same comparison rate for H0004-HD and H0004-HQ.

Dialysis and End-Stage Renal Disease Services

Top Revenue and Procedure Codes by Total Paid

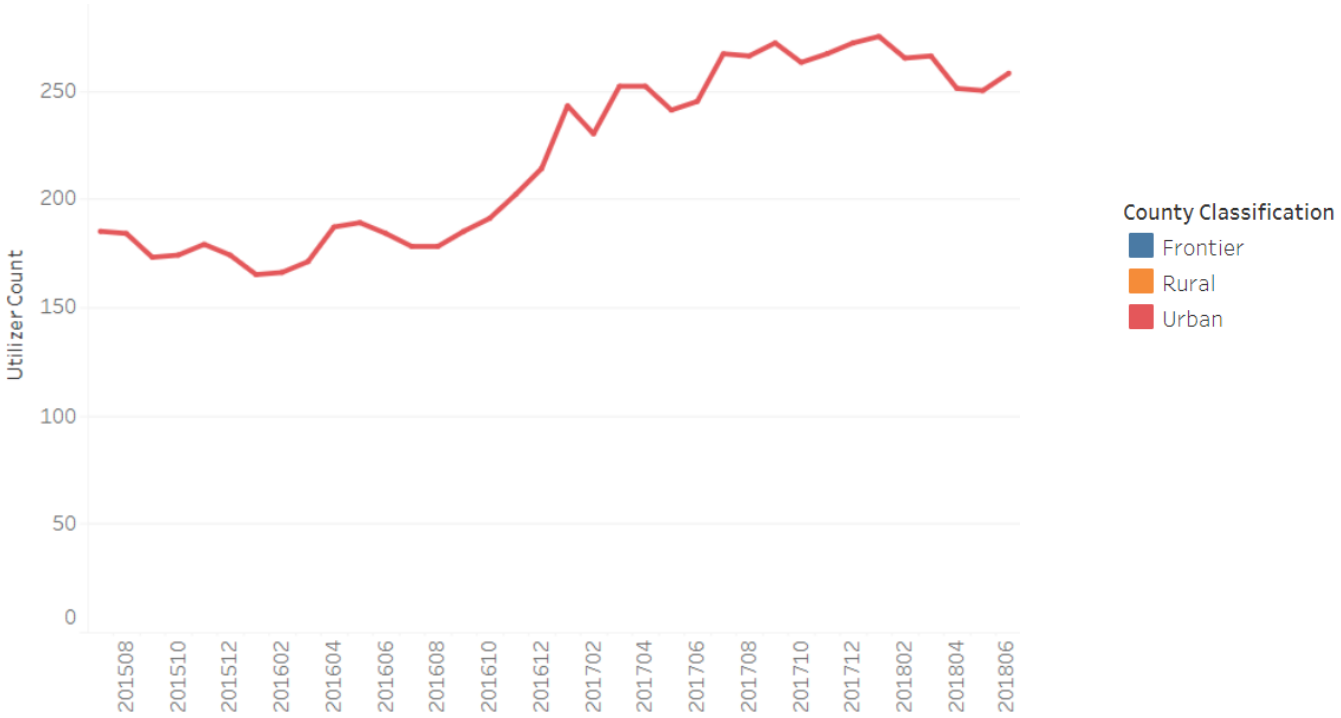
Dialysis and ESRD Top 10 Revenue Codes - Facility							
Wage Index Region	**Revenue Code**	**Condition Code**	**Age Band**	**Paid Amount***	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
Denver, Aurora, Lakewood	821		45 - 59	$1,825,640	$203.23	$254.49	79.86%
Denver, Aurora, Lakewood	821		18 - 44	$1,486,348	$203.23	$299.52	67.85%
Denver, Aurora, Lakewood	821		60 - 69	$939,323	$203.23	$254.96	79.71%
Denver, Aurora, Lakewood	851	74	18 - 44	$287,672	$203.23	$128.37	158.32%
Colorado Springs, CO	821		45 - 59	$280,484	$188.54	$245.22	76.89%
Denver, Aurora, Lakewood	851	74	45 - 59	$259,705	$203.23	$109.07	186.34%
Rural Colorado	821		45 - 59	$211,113	$196.01	$253.56	77.30%
Denver, Aurora, Lakewood	851	74	60 - 69	$194,931	$203.23	$109.27	185.99%
Colorado Springs, CO	821		18 - 44	$163,129	$188.54	$288.62	65.32%
Greeley, CO	821		45 - 59	$158,703	$192.30	$238.89	80.50%

*Adjusted for claims incurred but not reported

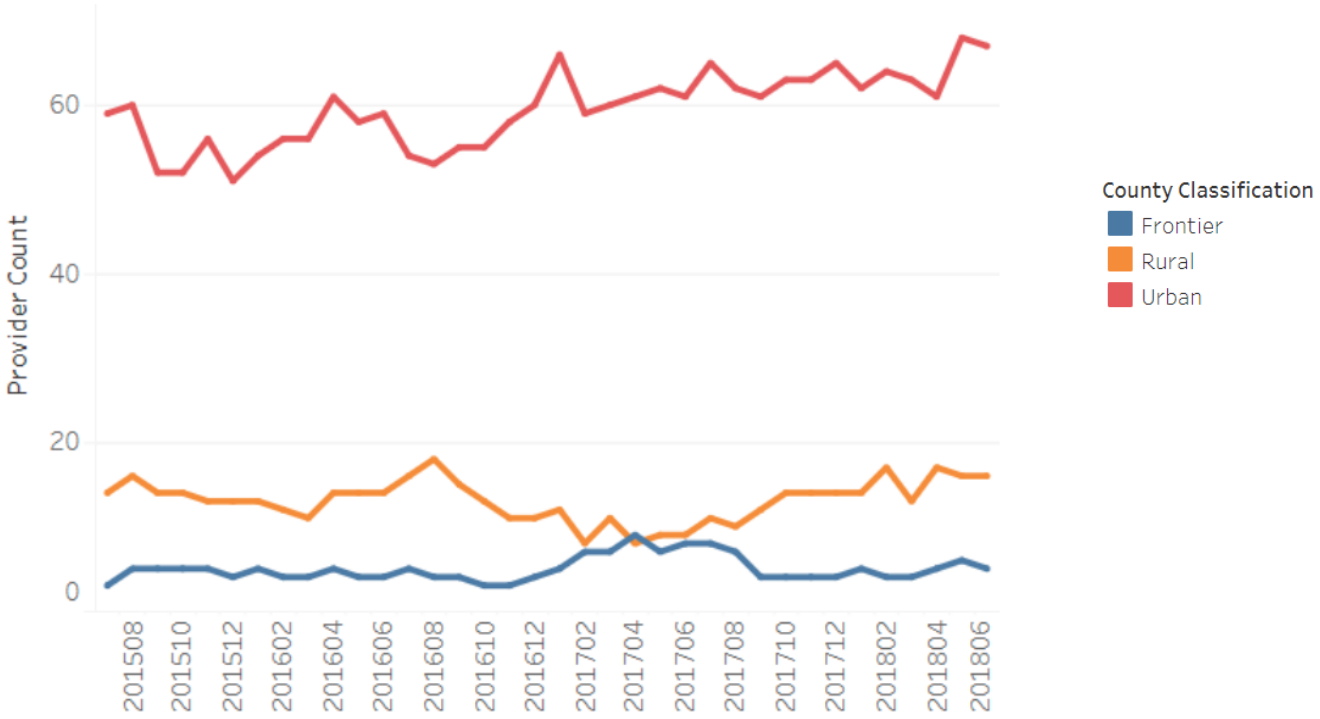
Dialysis and ESRD Top Procedure Codes – Professional						
Procedure Code	**Description**	**Paid Amount***	**Benchmark Source**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
90966	ESRD HOME PT SERV P MO 20+	$37,659	Medicare PFS	$166.78	$243.99	68.36%
90937	HEMODIALYSIS REPEATED EVAL	$7,767	Medicare PFS	$102.29	$106.96	95.63%
90989	DIALYSIS TRAINING COMPLETE	PHI	Other States	$500.05	$457.30	109.35%
90963	ESRD HOME PT SERV P MO <2YRS	PHI	Medicare PFS	$403.01	$559.79	71.99%

*Adjusted for claims incurred but not reported

Distinct Utilizers Over Time by Month



Active Providers Over Time by Month



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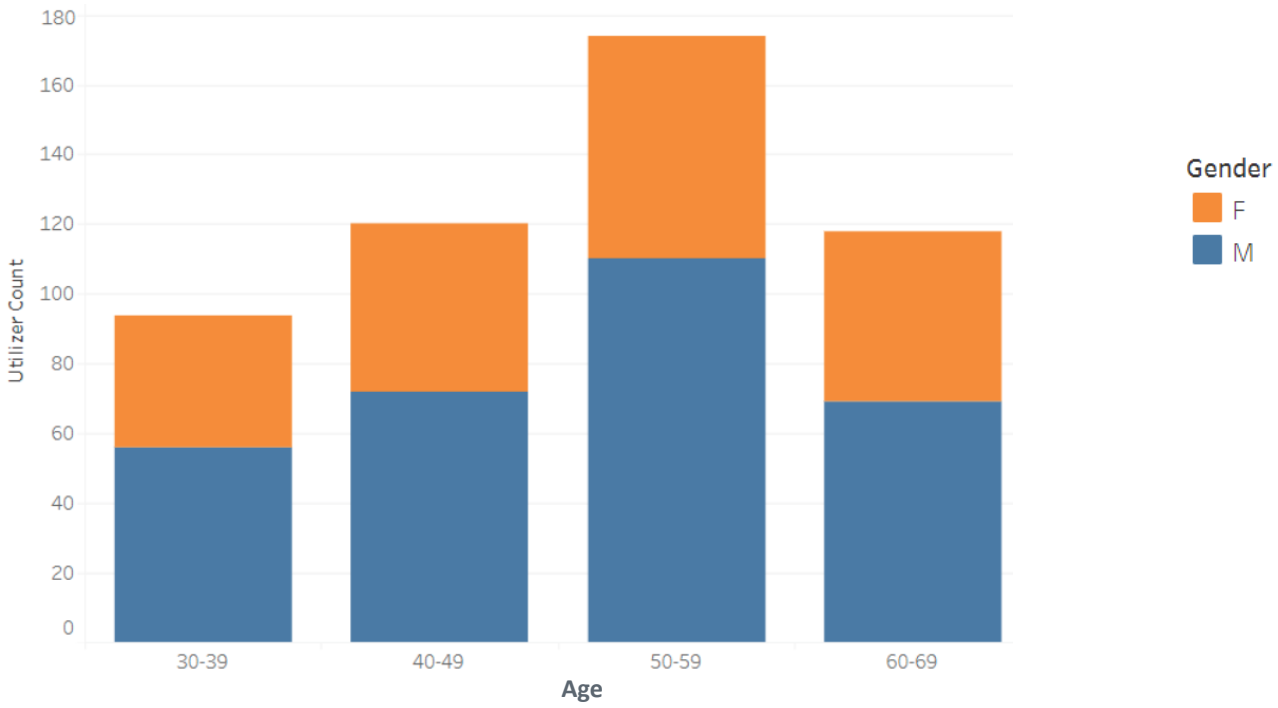
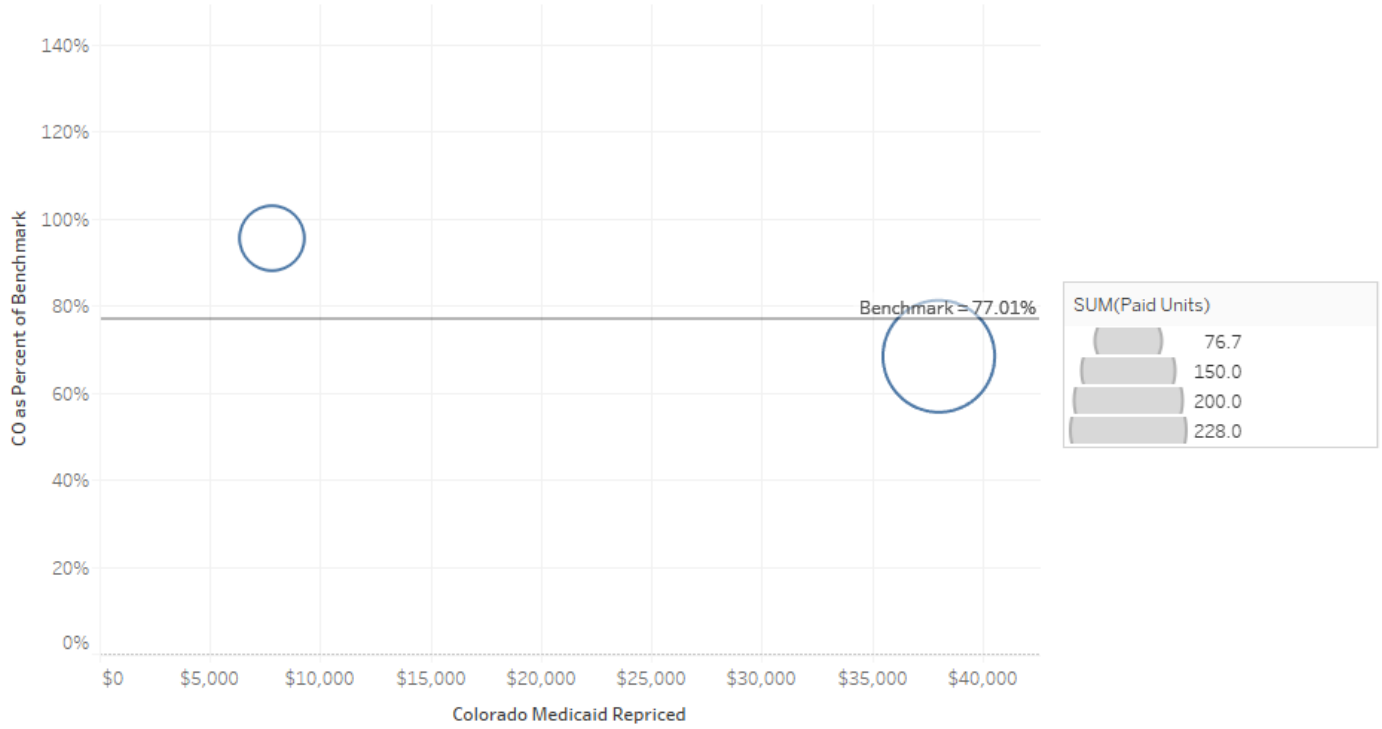
Population Age and Gender



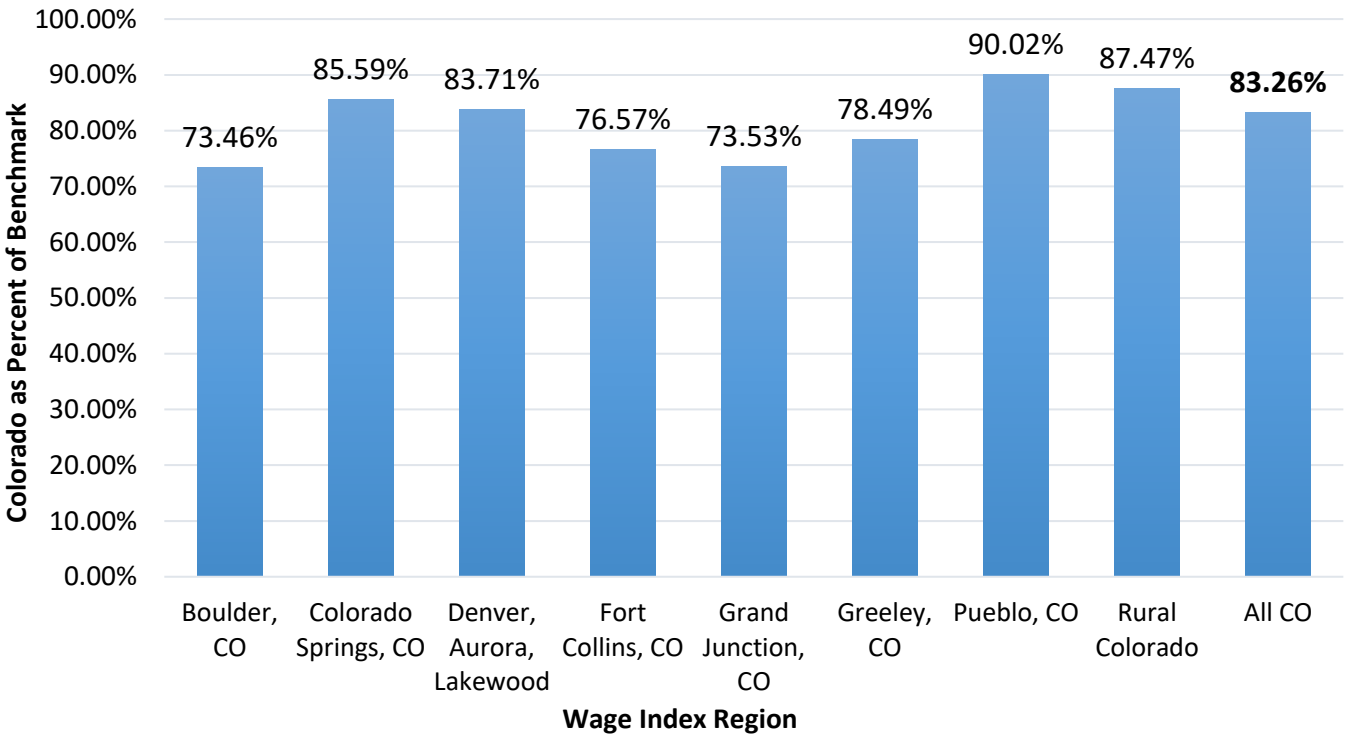
Rate Comparison by Total Paid Units and Dollars - Facility[102]

[102] For the dialysis and ESRD facility scatterplot, circles represent Total Paid Units for each Wage Index Region.

Rate Comparison by Total Paid Units and Dollars – Professional



Rate Comparison by Wage Index Region



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Durable Medical Equipment

Top 10 Procedure Codes by Total Paid

DME Top 10 Procedure Codes – Medicare Upper Payment Limit (UPL)							
Procedure Code	**Procedure Description**	**Paid Amount***	**UPL Status**	**Benchmark Fee Schedule**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
E1390	OXYGEN CONCENTRATOR	$7,405,338	UPL	Medicare CBA Denver	$73.88	$73.88	100.00%
E1390	OXYGEN CONCENTRATOR	$4,499,180	UPL	Medicare DMEPOS	$73.80	$73.80	100.00%
E0466	HOME VENT NON-INVASIVE INTER	$4,417,282	UPL	Medicare DMEPOS	$934.17	$934.17	100.00%
E1390	OXYGEN CONCENTRATOR	$4,267,260	UPL	Medicare DMEPOS	$134.71	$134.71	100.00%
E1390	OXYGEN CONCENTRATOR	$3,406,858	UPL	Medicare CBA CO Springs	$75.31	$75.31	100.00%
E0465	HOME VENT INVASIVE INTERFACE	$2,582,769	UPL	Medicare DMEPOS	$934.17	$934.17	100.00%
E0748	ELEC OSTEOGEN STIM SPINAL	$1,635,732	UPL	Medicare DMEPOS	$4,479.68	$4,479.68	100.00%
E0784	EXT AMB INFUSN PUMP INSULIN	$1,354,893	UPL	CO DME UPL	$4,370.50	$4,370.50	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	$1,188,688	UPL	Medicare DMEPOS	$51.30	$51.30	100.00%
E0441	STATIONARY O2 CONTENTS, GAS	$1,149,562	UPL	Medicare CBA Denver	$50.81	$50.81	100.00%

*Adjusted for claims incurred but not reported

DME Top 10 Procedure Codes – Medicare Non-UPL							
Procedure Code	**Procedure Description**	**Paid Amount***	**UPL Status**	**Benchmark Fee Schedule**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
K0606	AED GARMENT W ELEC ANALYSIS	$429,414	Non-UPL	Medicare DMEPOS	$1,591.43	$2,899.50	54.89%
E0562	HUMIDIFIER HEATED USED W PAP	$372,157	Non-UPL	Medicare CBA Denver	$239.70	$136.56	175.53%
E0562	HUMIDIFIER HEATED USED W PAP	$266,024	Non-UPL	Medicare DMEPOS	$239.70	$133.55	179.48%
E0562	HUMIDIFIER HEATED USED W PAP	$139,309	Non-UPL	Medicare DMEPOS	$239.70	$223.90	107.06%
E0973	W/CH ACCESS	$109,517	Non-UPL	Medicare CBA	$128.12	$47.97	267.08%

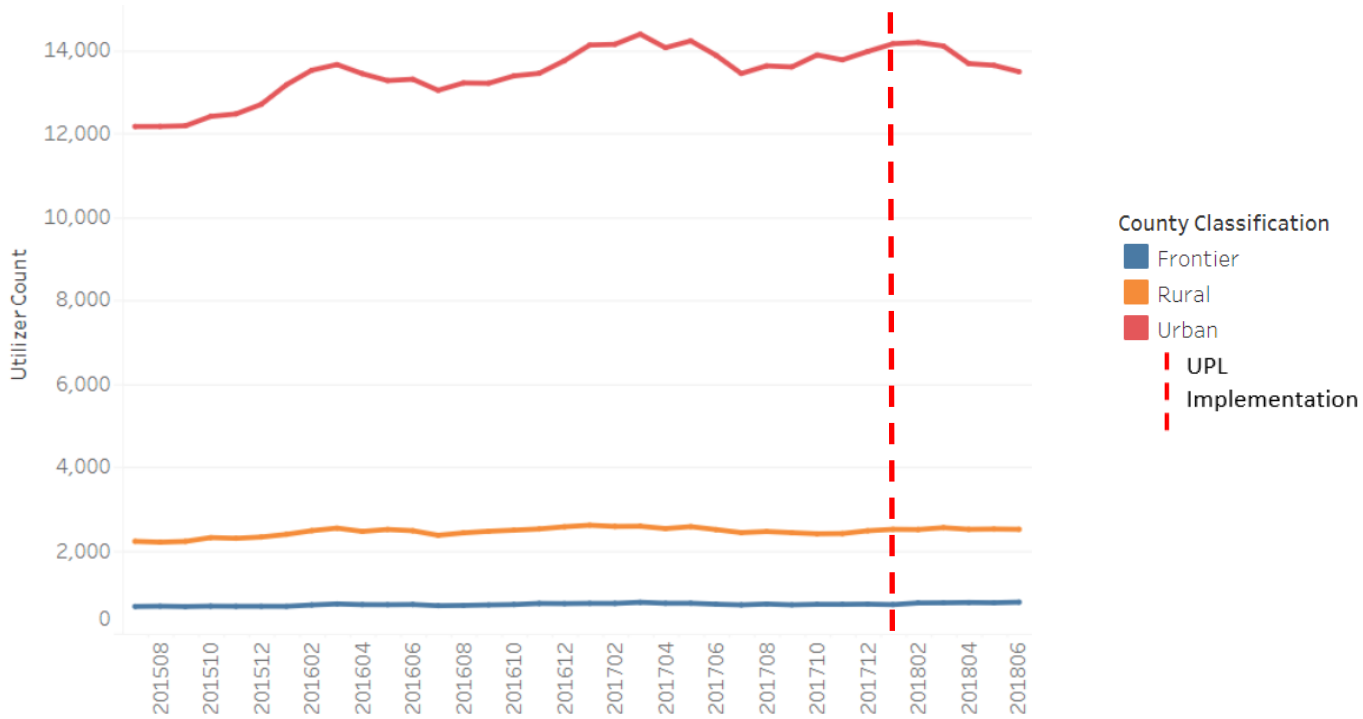
	DET ADJ ARMREST			Denver			
E0562	HUMIDIFIER HEATED USED W PAP	$108,282	Non-UPL	Medicare CBA CO Springs	$239.70	$137.95	173.76%
E2622	ADJ SKIN PRO W/C CUS WD<22IN	$49,623	Non-UPL	Medicare DMEPOS	$365.40	$303.58	120.36%
E2620	WC PLANAR BACK CUSH WD <22IN	$48,767	Non-UPL	Medicare CBA Denver	$605.11	$389.90	155.20%
E0667	SEG PNEUMATIC APPL FULL LEG	$47,277	Non-UPL	Medicare DMEPOS	$281.43	$316.86	88.82%
E2607	SKIN PRO/POS WC CUS WD <22IN	$42,427	Non-UPL	Medicare CBA Denver	$334.52	$210.13	159.20%

*Adjusted for claims incurred but not reported

DME Top 10 Procedure Codes – Other States Non-UPL							
Procedure Code	**Procedure Description**	**Paid Amount***	**UPL Status**	**Benchmark Fee Schedule**	**Colorado Rate**	**Benchmark Rate**	**Rate Ratio**
E1007	PWR SEAT COMBO W/SHEAR	$617,822	Non-UPL	Other States	$8,323.83	$8,394.56	99.16%
E0445	OXIMETER NON-INVASIVE	$484,167	Non-UPL	Other States	$367.17	$455.44	80.62%
K0739	REPAIR/SVC DME NON-OXYGEN EQ	$373,737	Non-UPL	Other States	$26.57	$13.77	192.98%
E1028	W/C MANUAL SWINGAWAY	$344,512	Non-UPL	Other States	$228.19	$182.46	125.06%
E1002	PWR SEAT TILT	$261,392	Non-UPL	Other States	$4,298.60	$3,913.48	109.84%
E0986	MAN W/C PUSH-RIM POWR SYSTEM	$225,511	Non-UPL	Other States	$5,374.10	$4,568.07	117.64%
E2311	ELECTRO CONNECT BTW 2 SYS	$198,049	Non-UPL	Other States	$2,034.90	$2,275.23	89.44%
E0218	WATER CIRC COLD PAD W PUMP	$168,634	Non-UPL	Other States	$354.75	$431.30	82.25%
E0202	PHOTOTHERAPY LIGHT W/ PHOTOM	$142,801	Non-UPL	Other States	$51.99	$112.35	46.28%
E1012	CTR MOUNT PWR ELEV LEG REST	$85,087	Non-UPL	Other States	$1,089.16	$1,054.70	103.27%

*Adjusted for claims incurred but not reported

Distinct Utilizers Over Time by Month



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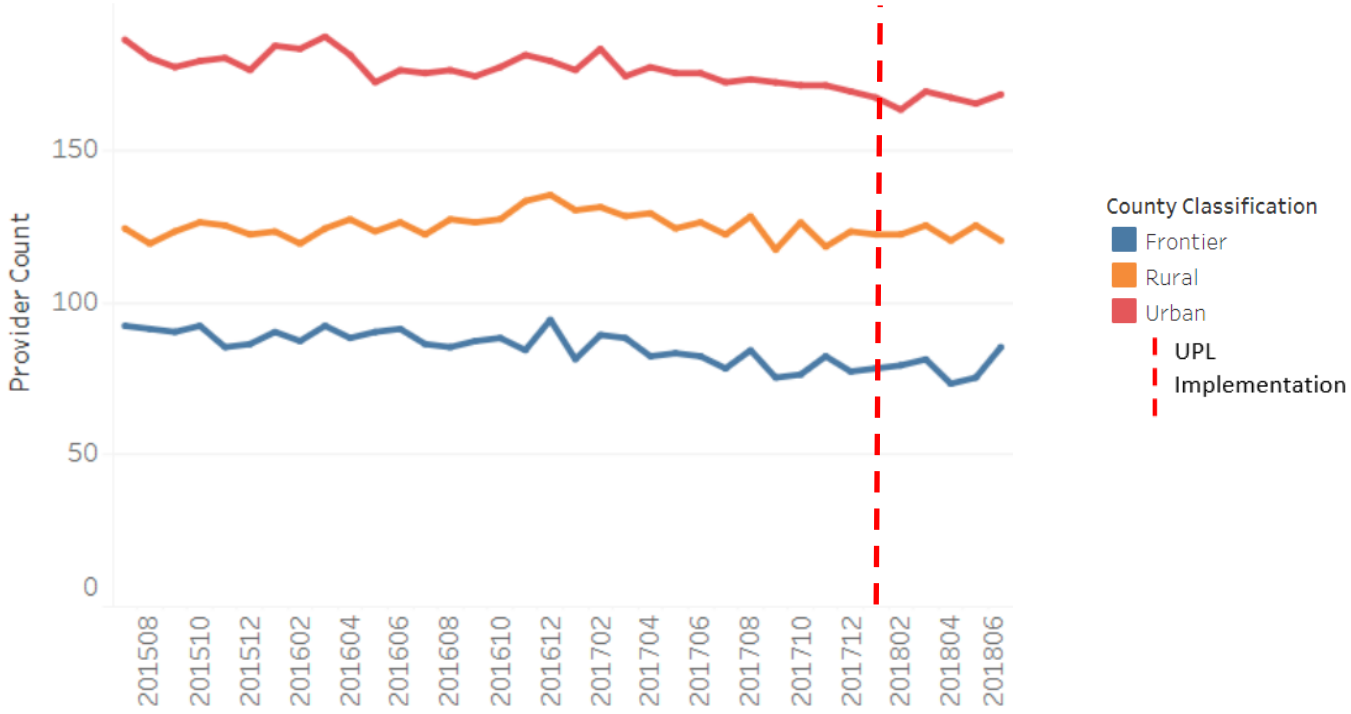
Active Providers Over Time by Month



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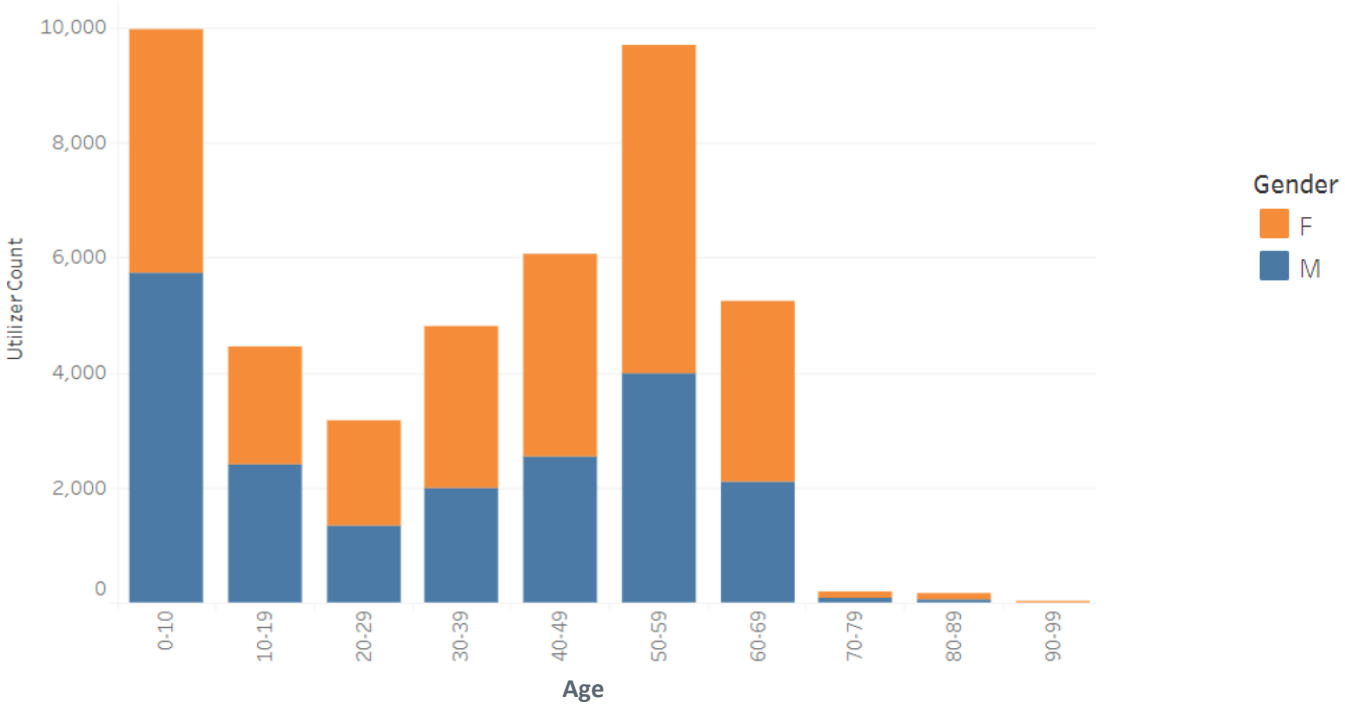
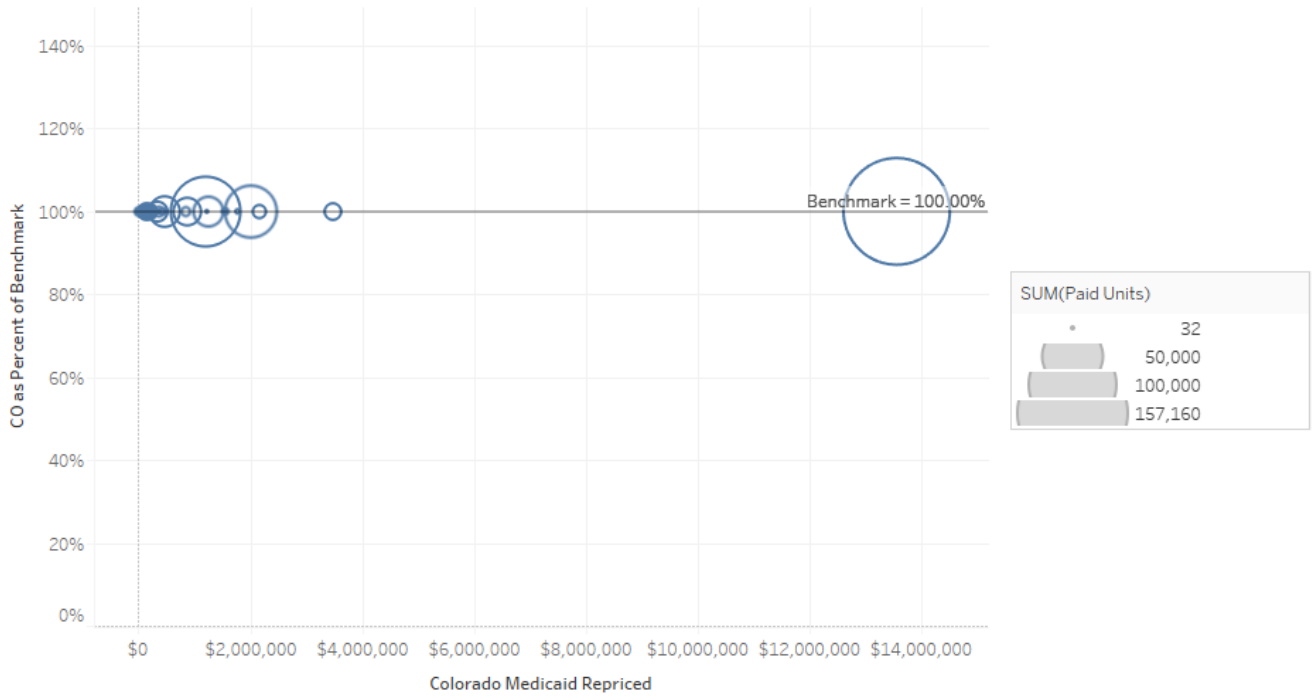
Population Age and Gender



Rate Comparison by Total Paid Units and Dollars – Medicare UPL



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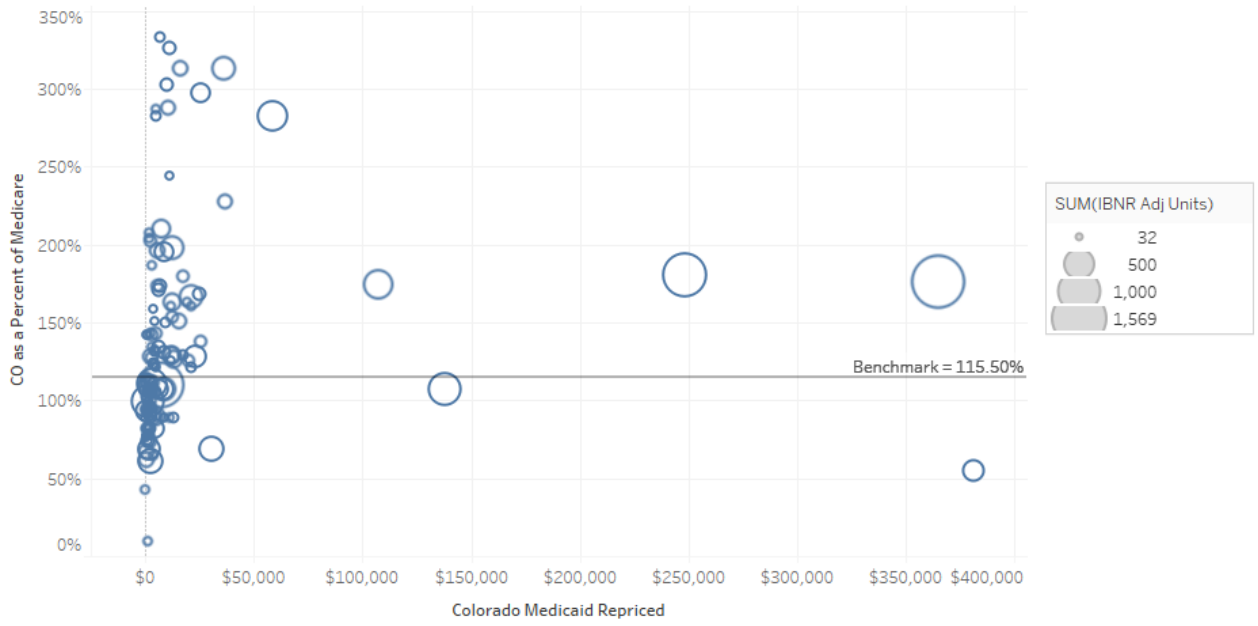
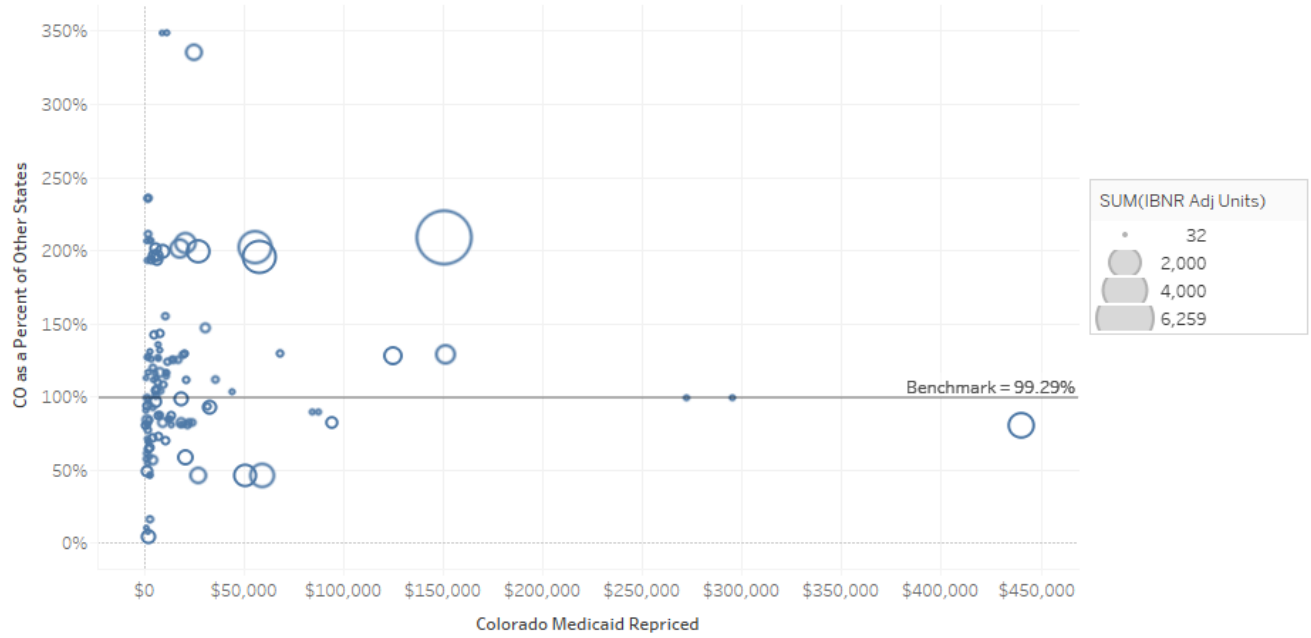
Rate Comparison by Total Paid Units and Dollars – Medicare Non-UPL[103]



Rate Comparison by Total Paid Units and Dollars – Other States Non-UPL



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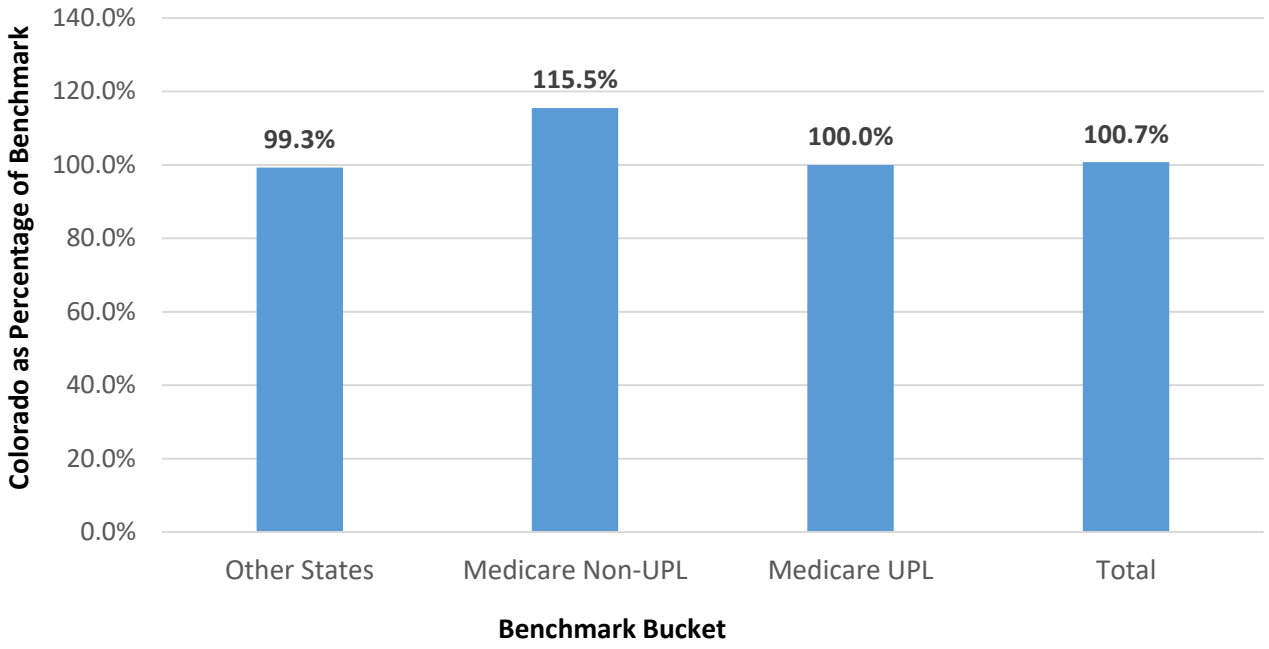
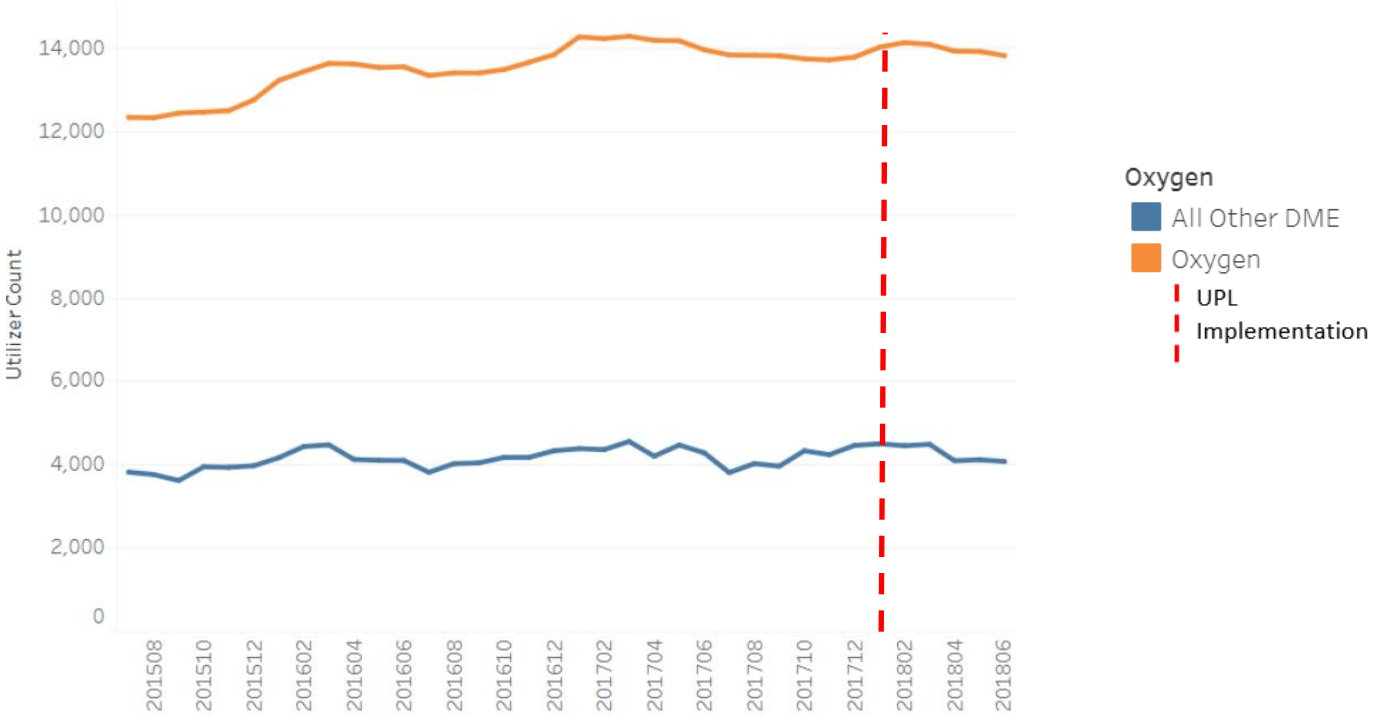
Rate Comparison by Benchmark Bucket

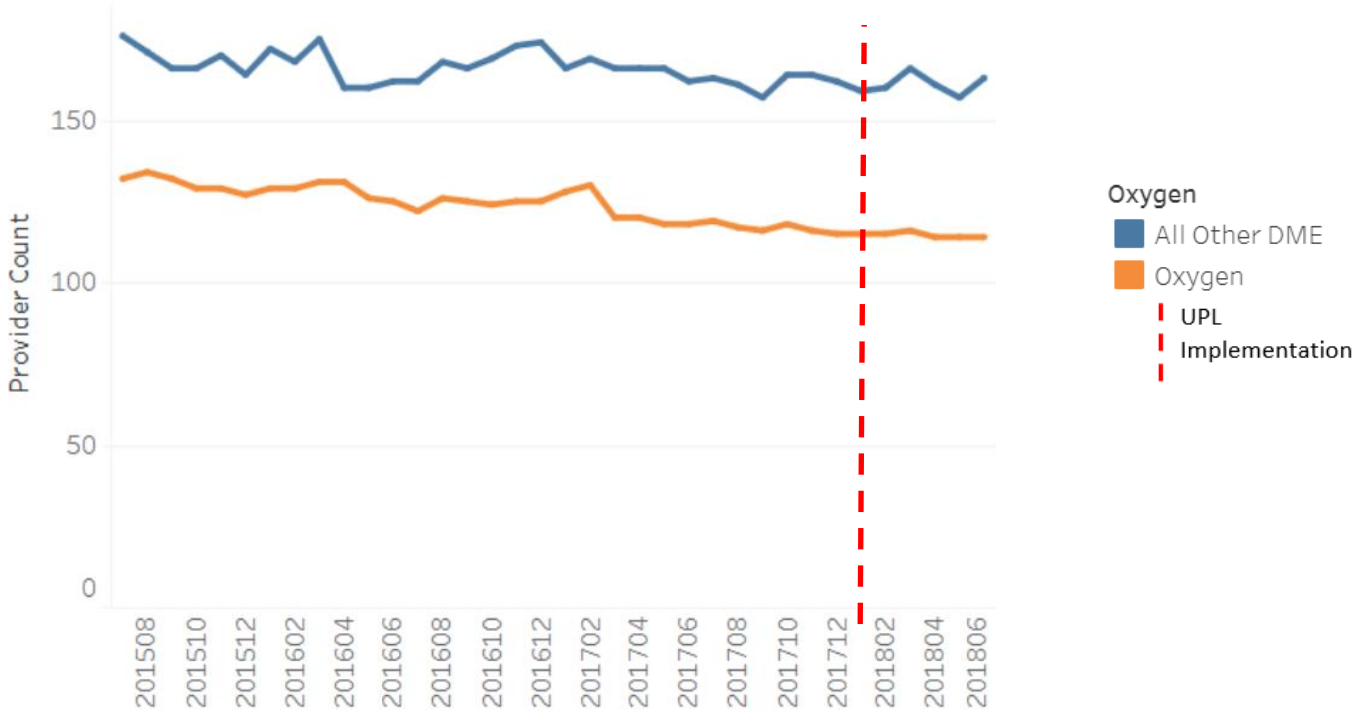


[103] On average, Colorado Medicaid payments for DME not subject to the UPL are 104.83% of the benchmark for both Medicare and other states' comparisons. Please see page 46 of the 2019 Analysis Report for the weighted average benchmark comparison.

Oxygen Services – Utilizers Over Time by Month



Oxygen Services – Active Providers Over Time by Month



Oxygen Services – Utilizers per Provider (Panel Size)

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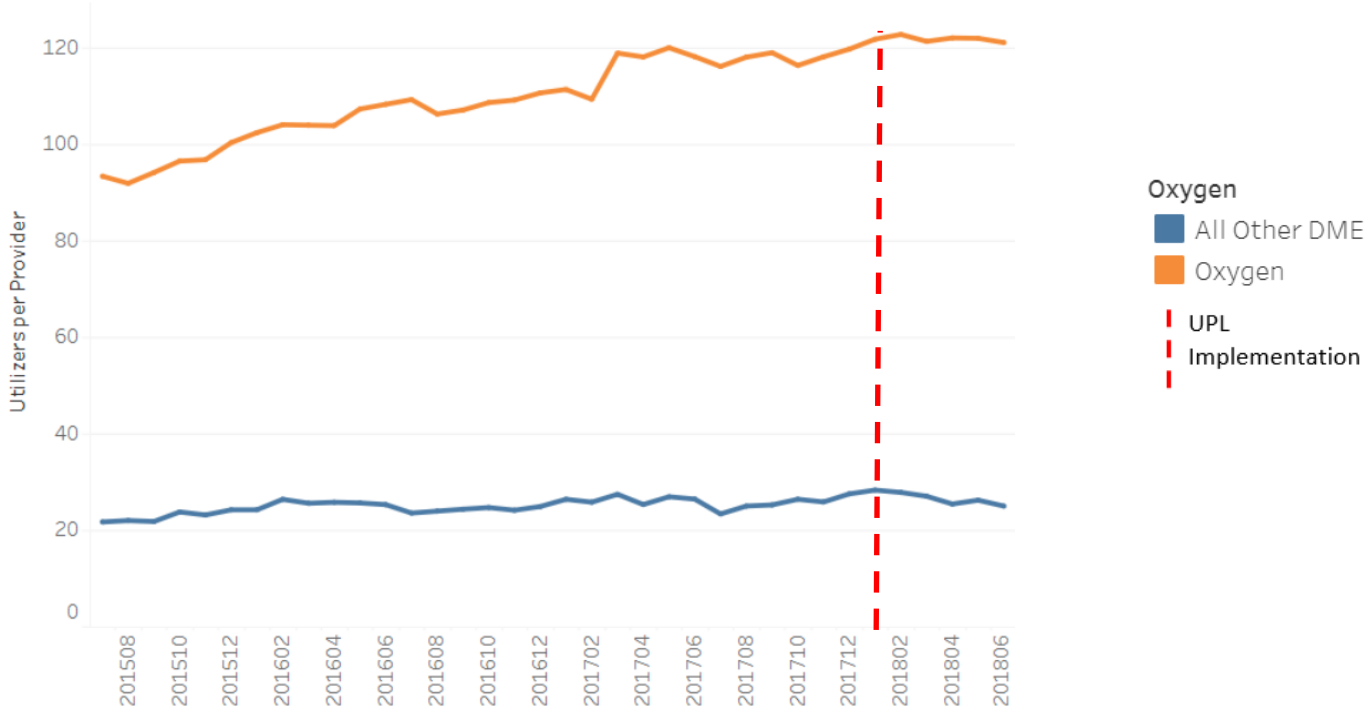
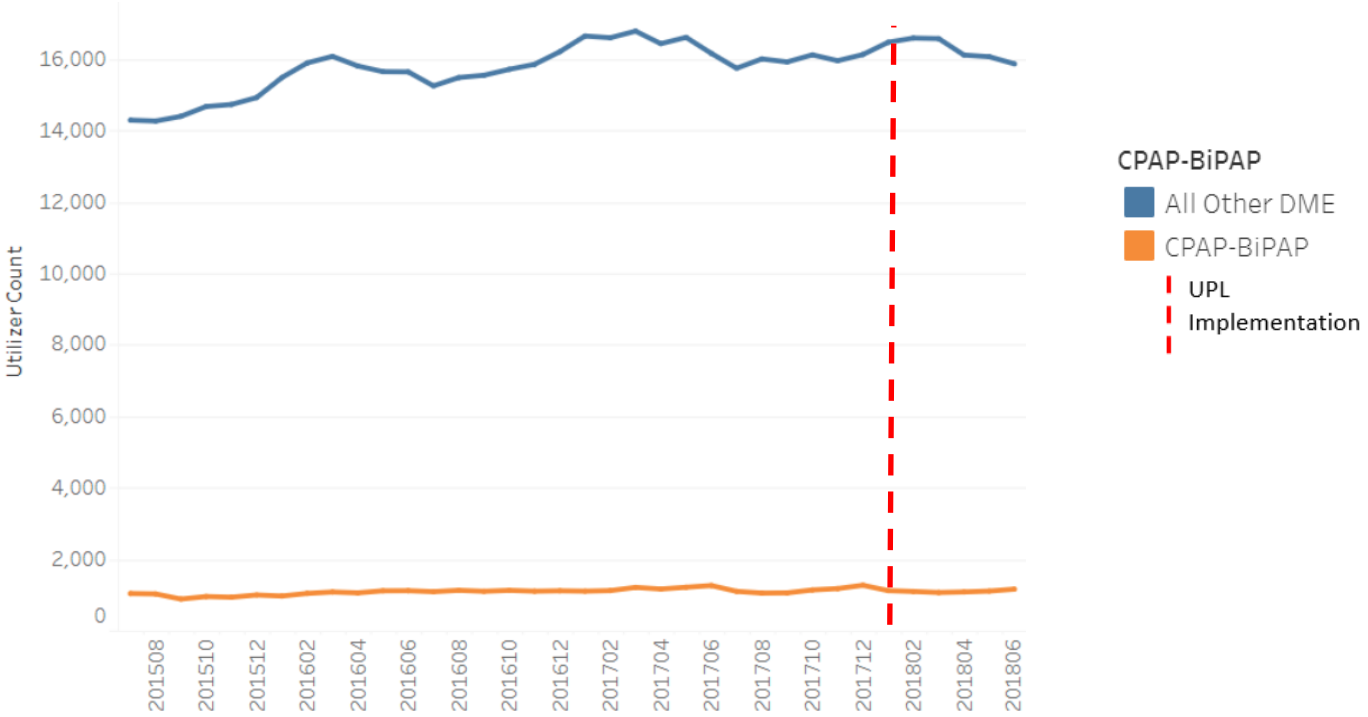


CPAP/BiPAP Services – Distinct Utilizers Over Time by Month



CPAP/BiPAP Services – Active Providers Over Time by Month

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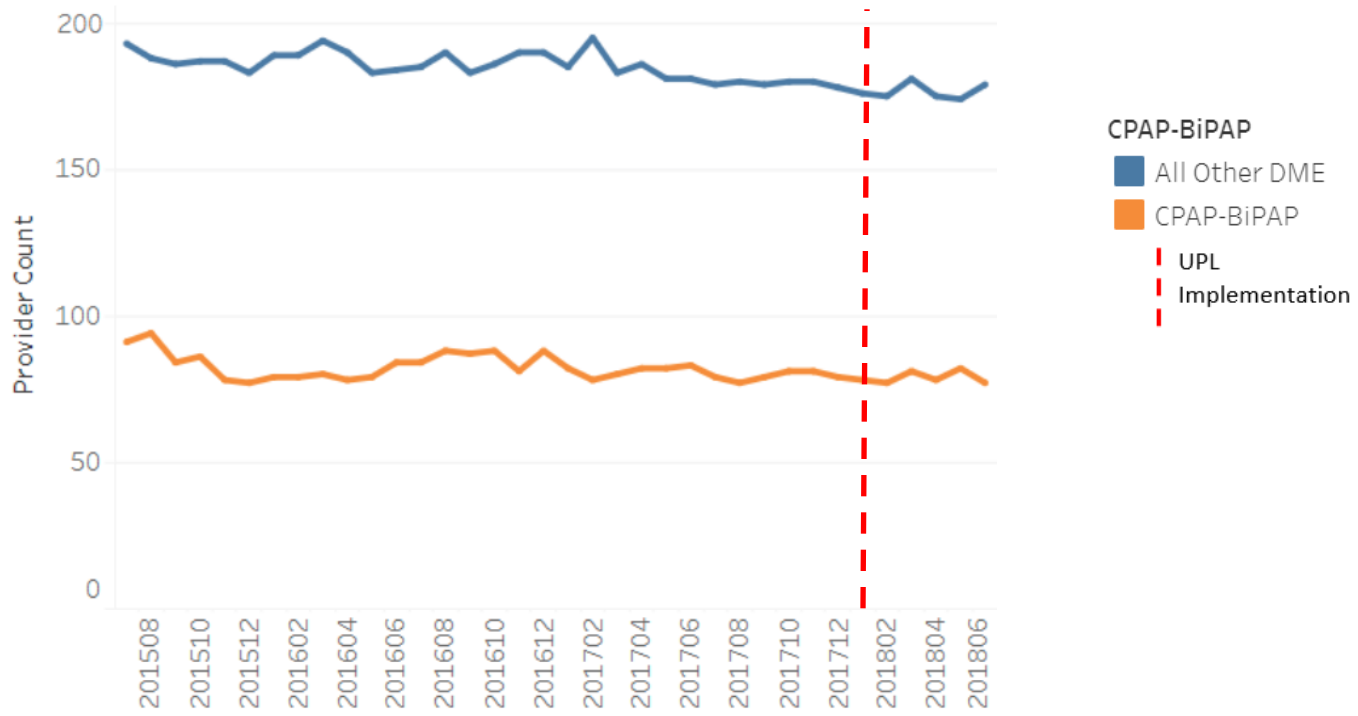
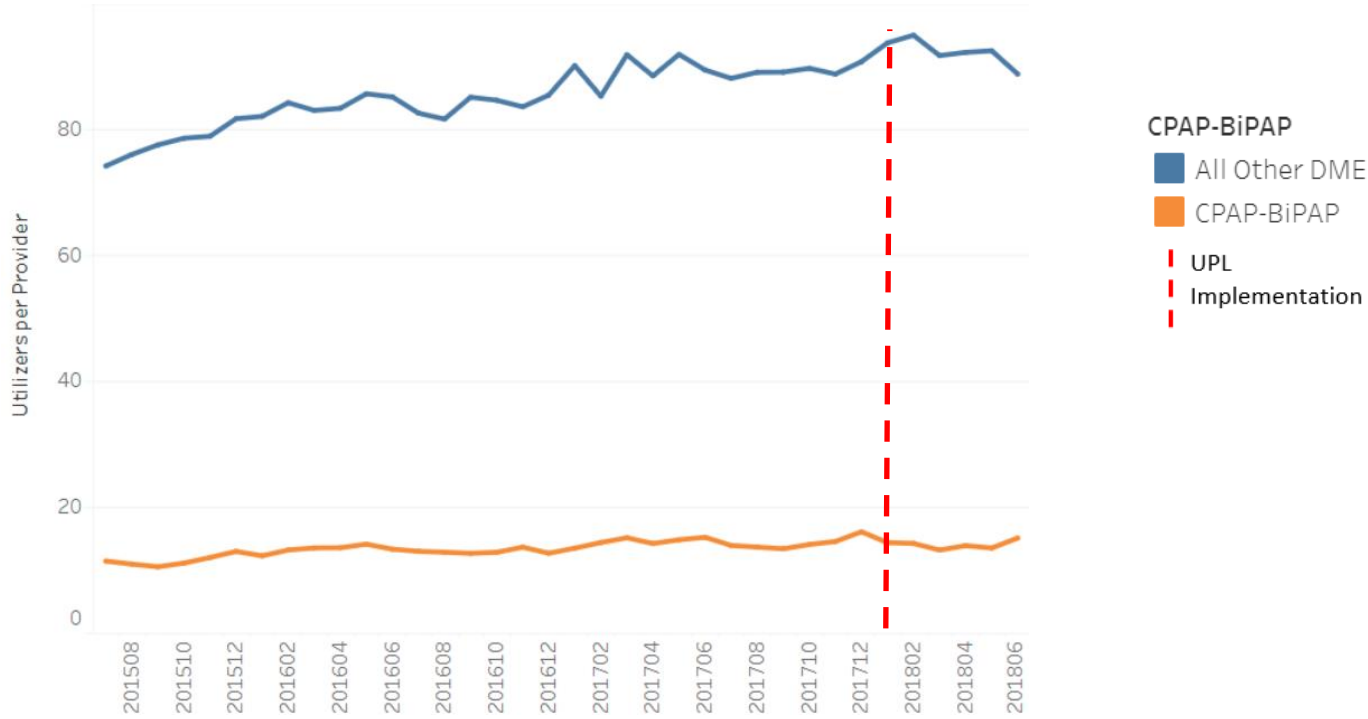


CPAP/BiPAP Services – Utilizers per Provider (Panel Size)



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