COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

TECHNICAL APPENDIX 4

COMMERCIAL PRICE TRENDS

ADDENDUM TO 2022 COST TRENDS REPORT

Table of Contents

1 Summary

This appendix describes the Health Policy Commission's (HPC) approach to the analyses contained in the **Price Chartpack.**

2 Data sources

The HPC used several data sources from the Center for Health Information and Analysis (CHIA) in the compilation of this chartpack. CHIA's Acute Hospital Case Mix Database was used for the exhibit **Proportional composition of inpatient discharges by patient severity of illness, COVID-19 cases excluded, 2013-2021.** The exhibit **Total inpatient spending per commercial discharge and average length of stay for commercial hospital stays, 2013-2020** uses CHIA's Annual Report and CHIA's Total Medical Expenditures data book. For all other exhibits, the HPC used the CHIA Massachusetts All-Payer Claims Database v10.0 (APCD), including data from 2017 to 2020, for the analyses on ambulatory and inpatient prices, as well as the hospital outpatient department (HOPD) price index. The HPC's APCD analytic files contain five of the largest commercial payers in the state: Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Care, Anthem (including Unicare, an Anthem offering), and AllWays (formerly known as Neighborhood Health Plan). These five payers represent approximately 31% of the commercial market and primarily include claims for members enrolled in fully insured plans.[1]

3 Inpatient payment trends

3.1 Composition of inpatient discharges by patient severity

For the exhibit **Proportional composition of inpatient discharges by patient severity of illness, COVID-19 cases excluded, 2013-2021**, the HPC used data from the CHIA Hospital Inpatient Discharge Database (HIDD) from 2013-2021 for an analysis of patient severity of illness from 2013 to 2021 (with COVID-19 cases excluded). Severity groups and typical payment amounts were defined using MassHealth (Medicaid) all-payer refined diagnosis related groups (APR-DRG) and patient severity of illness (SOI) on a four-level severity scale, with 4 being the highest acuity.

The data is comprised of all medical inpatient stays at acute care hospitals for Massachusetts residents, excluding behavioral health stays and extremely long length of stay (5 times the geometric mean by MS DRG severity group) because these cases are usually not paid on a DRG basis. Other exclusions include transfers, patients who died, patients who went to Shriners Hospital for Children (Springfield and Boston), and discharges with some APR coding

[1] This estimate was derived by taking the unique commercial member count from the HPC analysis of the MA APCD (1.2 million members in 2020) and dividing it by the CHIA Enrollment Trend Report number of commercially enrolled members as of 12/15/2020. Available here: https://www.chiamass.gov/enrollment-in-health-insurance/#enrollment-trends-interactive.

restrictions based on discrepancies with CMS major diagnostic categories. COVID-19 cases were defined as any inpatient stay with U071 for the primary or secondary diagnosis code.

3.2 Inpatient spending per commercial discharge and average length of stay

The trend shown in the exhibit **Total inpatient spending per commercial discharge and average length of stay for commercial hospital stays, 2013-2020** is anchored on data reported for 2018 and 2019 in CHIA's 2020 annual report compiling total commercial hospital inpatient expenditures (which includes only facility spending). For these years, the HPC estimates the denominator (total commercial discharges) for state residents from CHIA's Hospital Inpatient Discharge Database. Because total health care spending is sometimes inconsistent across CHIA databooks due to changing reporting requirements or data compilation, the HPC derives 2020 spending per inpatient discharge by combining the 2019 level of spending per discharge with 2019-2020 growth in inpatient hospital spending per commercial enrollee using CHIA's Total Medical Expenditures dataset – which breaks down commercial spending per commercial enrollee using payers reporting full claims data. The 2020 denominator is estimated from the same discharge data source as was the 2018-2019 data. A similar process is then followed to estimate inpatient spending per discharge for years prior to 2018, using the most recent CHIA TME dataset in all cases reporting the change in inpatient spending per commercial member for the relevant two-years in question (e.g. 2017-8 spending growth is taken from the 2020 annual report, though it is also reported, in a preliminary fashion, in the 2019 annual report).

These estimates were confirmed with confidential data reported by payers that include total inpatient spending alongside the number of total discharges in each year.

3.3 Inpatient payments

3.3.1 Inpatient stay analysis

The HPC constructed a dataset of inpatient discharges in the APCD in which all claims for each inpatient discharge were combined. The price of each discharge was defined as the total of allowed amounts for facility and professional claims associated with the discharge. Each discharge had one or more Medicare Severity Diagnosis Related Groups (MS-DRG) associated with it in the claims data.

The payments for all inpatient stays included both the facility and professional payments for services received during the stay. Since each inpatient stay may vary in total services received (e.g., inpatient stays were evaluating spending more broadly than the facility DRG claim and also include any professional components), this analysis refers to inpatient stay *payments* to capture that these are average payments across stays rather than *price* of a specific service.

3.3.2 Analyses

Average inpatient payment growth includes both facility and professional claims for an inpatient stay. Types of inpatient stays were identified by MS-DRG. Only DRGS with at least 20 inpatient

stays and at least $10,000 in 2018 aggregate spending were included in this analysis. Overall average percent payment growth was weighted by 2018 aggregate spending for the DRG.

3.3.3 Change in payments and volume for select high-volume types of inpatient stays

Average payment shown includes both facility and professional claims for an inpatient stay collapsed across severity levels for a DRG stay (e.g., with and without major complexity or comorbidity). To account for changes in payment or volume that may be related to coding within a type of inpatient stay (e.g., more major joint replacements coded as "with complications"), DRGs that differed only by severity classification were grouped together. Vaginal delivery includes MS-DRGs 774 and 775. Major hip and knee joint replacement includes MS-DRG 469 & 470. Cesarean section delivery includes 765 and 766. Sepsis includes MS-DRG 871 and 872, but not 870 (with mechanical ventilation). Obesity procedures includes MS-DRGs 619-621. Cellulitis includes MS-DRGs 602 and 603. Psychoses only includes MS-DRG 885. Digestive disorders include MS-DRGs 391 and 392. Carotid artery stent includes MS-DRG 246-247. Volume is adjusted for total member months in each year.

3.3.4 Cesarean section delivery (without complications) by hospital

Average payment shown includes both facility and professional claims for an inpatient stay. Cesarean section delivery includes only DRG 766 and excludes any stays that had any diagnosis of COVID-19. Hospital inclusion criteria was at least 20 inpatient stays in both 2018 and 2020. Percent change in average payment by hospital between 2018 and 2020 is listed above each payment bar.

3.3.5 Major joint replacement surgery by hospital

Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 470 (major joint replacement without major complication or comorbidity) and without COVID-19. Hospital inclusion criteria was at least 20 inpatient stays in both 2018 and 2020. Percent change in average payment by hospital between 2018 and 2020 is listed above each payment bar.

4 Ambulatory service encounters

4.1 Ambulatory analytic file creation

The HPC's commercial APCD analytic files contain claim line level detail. To evaluate service prices across a range of services in different ambulatory settings (primarily the office and hospital outpatient department), the HPC constructs an encounter-level file that allows for evaluation of prices using a uniform definition of a procedure code encounter across ambulatory settings. In this case, a procedure-encounter is used, defined as claim lines billed for the same person (patient), on the same day (date of service), under the same procedure code (CPT).

To create an ambulatory service encounter file for analysis, the HPC begins with all professional claims billed in ambulatory sites of service (for the purpose of these analyses: Office (11), Hospital Outpatient Department (19, 22), Ambulatory surgical center (24), and Independent Laboratory (81)) and all facility claims. Claim lines missing a procedure code were excluded, as were any claim lines billed by out of state providers.

Claim lines billed indicating emergency department utilization (using either Health Care Cost Institute methodology and/or CPT 99281-99285, 99291, 99292) and inpatient utilization were flagged.[2] Claim lines billed for the same person on the same date as any emergency department/inpatient utilization were excluded along with any emergency department/inpatient utilization to remove any procedures that were performed in an acute and emergent setting and were therefore beyond the scope of these ambulatory analyses.

Professional claims were identified according to site of service. Encounters were defined as mentioned previously by grouping claim lines for the same person (based on a unique person identifier), that occurred on the same day (same date of service) and were billed with the same procedure code (CPT). Importantly, the place of service delivery can determine the billing conventions. For example, services billed in office-based settings typically only bill with professional claims, while the same service billed in a hospital outpatient department often bills facility claims in addition to professional claims for the same service. The total cost of the service in the HOPD setting is the combination of relevant professional and facility (if present) claims.

To compare service prices across care settings, encounters were constructed by collapsing claim lines and summing allowed amounts across multiple claims lines (most often, two distinct claim lines, composed of one facility and one professional claim, if they are present) for each encounter. The above procedure was completed for commercial medical claims for each year of data, 2017 to 2020, the most recent commercial data available to the HPC at the time of publication.

4.2 Trimming and price validation

Claims data can contain data errors or unusual circumstances where amounts paid as indicated on an individual claim line may be unreliable. When computing average prices, HPC excluded values that were more than 10 times the statewide median or less than 20% of the statewide median for a given procedure code.

Separately, with the availability of hospital price transparency data beginning in 2021, HPC analyzed prices for procedures that constitute a HOPD index for a select few hospitals and

[2] For more information on the Health Care Cost Institute's claim type categorization please see: https://healthcostinstitute.org/images/pdfs/HCCI_2018_Methodology_public_v1.pdf.

compared facility portion of APCD-derived mean prices to the prices hospitals reported themselves and found they were highly concordant.

4.3 Analyses

4.3.1 General methodology notes

Unless specified otherwise in text, the unit of analysis for all ambulatory care encounters is the procedure code encounter and therefore includes all payments made for the same procedure code (including relevant facility and professional payments which can often be billed separately). Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average prices because these prices are noted as not reliable by payers.

4.3.2 Percentage increase in aggregate prices by setting

Encounters were divided into mutually exclusive care settings (office and HOPD) and summarized at the appropriate aggregate unit of analysis (CPT for ambulatory services). Average prices were computed for each CPT for each year included in analysis by setting. Yearly summarized files at the aggregate CPT level were merged to retain procedure codes that were billed consistently over time. Overall average prices were weighted according to the aggregate commercial spending for each CPT in each setting to compute a summary measure that reflects the wide variation in aggregate spending across different services and sites of service.

Price growth includes both facility and professional spending and is computed at the level of the procedure code encounter. Encounters are defined as the same person, same date of service, same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. Procedure codes with less than 20 services or less than $1,000 in aggregate spending in 2018 or 2020 were excluded. Overall average percent price growth in office and HOPD settings was weighted by the baseline aggregate spending for the procedure code in the respective setting (e.g., 2018 for 2018-2019 growth).

4.4 Emergency Department (ED), Office, and Hospital Outpatient Department (HOPD) Price Trends

4.4.1 Distribution of emergency department visits by intensity level

Emergency Department (ED) evaluation & management visits (99281-99285) were examined for changes in intensity (e.g., Level 1 “99281” is a lower intensity visit, while Level 5 “99285” is a higher intensity visit) between 2017 and 2020. Each bar represents the total volume of ED evaluation and management visits, and segments of the bar correspond to the share of visits for each level. ED severity was assigned based on ED procedure code 99281-99285 for the patient encounter. If a member had more than one ED evaluation and management code (99281-99285) on the same day, both were included as a separate 'visit'. Providers and billing offices determine the billing level of the visit, and this has large implications for the cost of the visit.

4.4.2 Average prices for common ambulatory services by setting, office or HOPD

Average prices for common services delivered both in the office and HOPD setting are compared in a two-panel figure. Two panels were used because of the relative price difference for different types of services. Services displayed had high aggregate HOPD spending and were high volume service across both settings. Prices reflect encounters (claim lines for the same patient, same date of service, same procedure code) to capture both facility and professional claims billed on the same day in the HOPD setting that is comparable to professional claims being billed in the office setting. CPT codes for services listed include: Lipid test (80061), Evaluation & Management Visit, Level 3 (99213), Therapeutic exercise, 15 min (97110), Echocardiogram (93306), Abdominal CT (74177), Brain MRI (70553), Colonoscopy (45380). Ratios of HOPD/Office prices are shown in brackets above the adjacent office and HOPD bars to demonstrate that the same service delivered in a HOPD is often (but not always) more expensive compared to the price if the service had been delivered in an office.

4.4.3 Average price of a mammography performed in a HOPD by hospital

Facilities listed are limited to those with at least 700 commercial encounters for the service in 2020. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Mammography (CPT 77067, 'Screening mammography, bilateral, including computer-aided detection (CAD) when performed'). Note: CPT 77067 was newly introduced in 2017 to replace a retiring CPT code, G0202.

4.4.4 Average price of a colonoscopy performed in a HOPD by hospital

Facilities listed are limited to those with at least 50 commercial encounters delivered in 2020. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple').

4.4.5 Average price of a surgical pathology service performed in a HOPD by hospital

Data are for surgical pathology (CPT 88305, 'Level IV Surgical pathology, gross and microscopic examination'). Facilities listed are limited to those with at least 400 commercial encounters delivered in 2020. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price.

4.4.6 Average price of a GI endoscopy performed in a HOPD by hospital

Facilities listed are limited to those with at least 50 commercial encounters delivered in 2020. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. GI endoscopy (CPT 43239, 'Esophagogastroduodenoscopy'). Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price.

4.5 Hospital Outpatient Department (HOPD) Commercial Price Index

4.5.1 Defining the index

HPC created a Laspeyres Price Index (i.e., a market basket of HOPD services) for services occurring in HOPDs to readily compare prices across hospitals, across payers, and over time.

Included services
As noted above, encounters are defined as the same person, same date of service, and same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. As such, procedure prices and aggregate allowed amounts includes both facility and professional spending.

For a CPT code to be a candidate code for inclusion in the price index it had to be present with sufficient volume (at least 20 encounters) at outpatient departments of 50 Massachusetts hospitals in 2018. 67 unique procedure codes met the above criteria. The set of services included in the HOPD commercial price index was defined by first only including hospital-procedure code pairs where a hospital had at least 20 encounters for any individual CPT code and HPC then ranked these codes in descending order based on aggregate statewide HOPD spending and then selected the top 50 procedure codes. Sensitivity analyses increasing the size of the code set did not demonstrably change the results. The set of 50 codes was chosen to include a range of typical HOPD services (e.g., visits, procedures, lab services, etc.). The final HOPD price index CPT code list comprised 19.3% of statewide HOPD spending and 37.3% of HOPD volume in 2018.

Service quantities
HPC defined the quantity of each code for use in the index to be the statewide utilization rate of each code per 100 commercially insured members observed in the APCD, as described earlier. Thus, the final market basket represents expected spending per 100 commercially insured members in each year for the services in the index. The quantities are fixed, for all entities and all years, at observed levels in 2018. In accordance with a Laspeyres index, the quantities do not vary by entity, and as a result, the output of the index represents how much it would cost for the identical utilization pattern occurring at hospital A versus hospital B or for payer X versus payer Y.

Service prices

Average prices are computed by averaging the price for each service for the given unit in question (hospital, payer, state, hospital system, etc.). Price trimming as described above in section 4.2 is applied to outlier prices. Because a key focus of the index was prices at hospitals, HPC used our standard method of computing the mean price only where a hospital contained at least 20 instances of the given procedure code in the given year. For hospitals without sufficient volume of these procedures, HPC used two different imputation methods as described below.

4.5.2 Imputation methods for missing procedure codes

Imputation of Incomplete Index Components
In 2018, 26 hospitals had sufficient volume (at least 20 encounters) for all 50 codes. The remainder had at least one procedure code with less than this minimum volume. HPC examined the following two imputation methods to impute average prices in such cases and selected Method 1.

Method 1: Imputation using statewide average prices
The first imputation directly substitutes the statewide average price for a procedure code in which a hospital does not have sufficient volume of that code to calculate its own average price. This method is conservative, biasing a hospital's price toward the statewide average (i.e., high-priced hospitals will appear somewhat lower-priced than they likely would be and vice-versa) but is computationally simple and reduces potential volatility in the index where unusual circumstances may explain why hospitals might have very low volume of a given procedure.

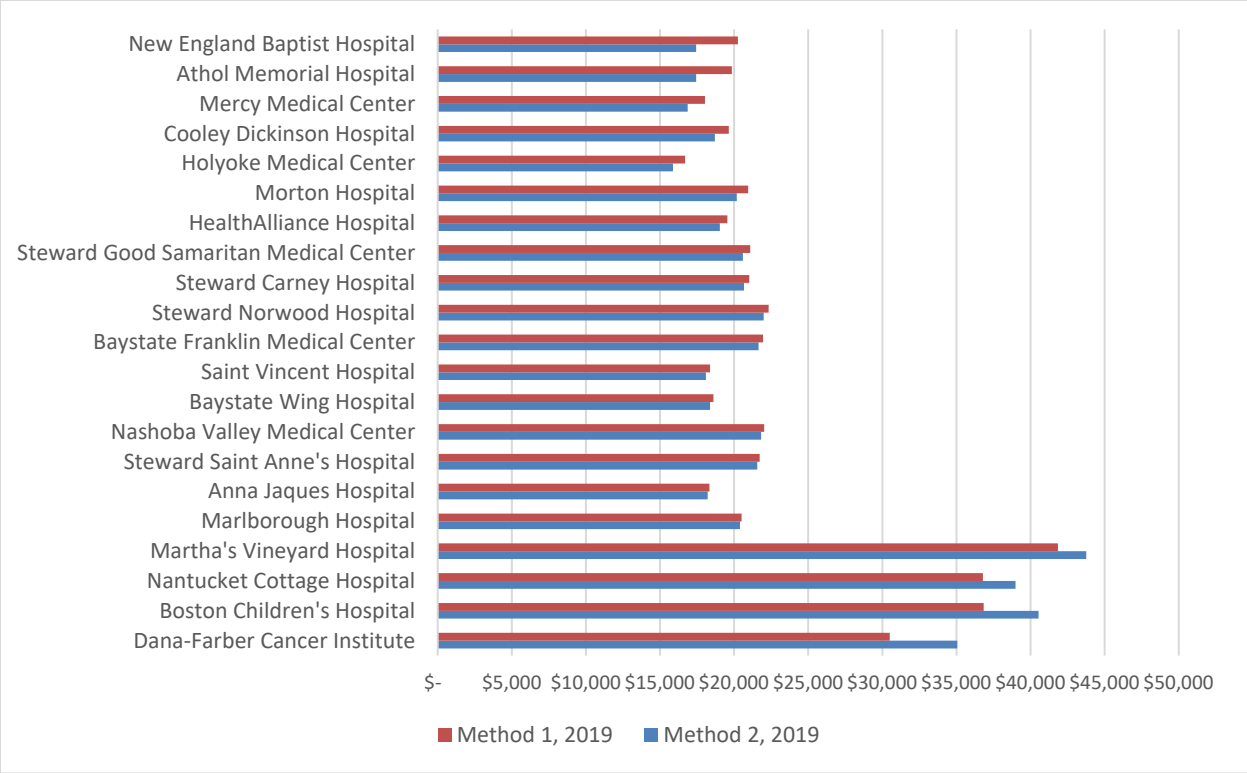
Method 2: Imputation using price ratios for non-missing procedure codes at a given hospital
This method involved the following steps:

1) For each non-missing procedure, HPC calculate the ratio of the hospital's average procedure price and the statewide average price for that procedure code. For example, a hospital with an average price of procedure code X that is 10 percent higher than the statewide average would have a value of 1.1 for this ratio.
2) Calculate the simple average of the ratios from step 1 across all the hospital's non-missing HOPD procedures. For example, if a hospital had two missing codes and ratios of 1.1 and 1.0 for the two codes, this average of ratios would be 1.05.
3) Multiply the statewide average price for the missing procedure by the result from step 2) to impute a missing procedure price.

HPC found that while these ratios vary somewhat by procedure for a given hospital, they tend to be relatively consistent. It is unusual for a hospital to have some prices far above the statewide mean and some far below. For example, it is more typical for a hospital with average prices 20% below the statewide mean to have individual procedure prices that vary between roughly 10% to 30% below the statewide mean.

The following exhibit illustrates the difference between HOPD index in 2019 estimated using each of the two methods described above, showing a selection of hospitals with at least $100 difference in the price index.

Exhibit 1: Comparison of HOPD index levels with different imputation methods, 2019



As noted above, high-priced hospitals have a higher index under Method 2 and lower-priced hospitals have a lower index. HPC examined additional methods such as reducing the threshold for estimating the hospital's empirical procedure price from at least 20 to at least 10 procedures, as well as using a statewide average price in step 1 of method 2 based on only hospitals with complete set of 50 HOPD procedures (rather than all hospitals). These methods yield similar results and were not deemed superior.

4.5.3 Computing the index

The price index was computed for each hospital as well as statewide for each year during 2018-2020 period. The hospital price index therefore is calculated as the weighted sum over all 50 codes of the average hospital-specific price for each code times the statewide fixed quantity of each code. HPC calculated the statewide average HOPD index similarly using statewide average procedure prices. In 2018, the statewide HOPD index total was $22,922. The formula for the calculation of the price index is represented below where j indexes hospitals in Massachusetts, i indexes the 50 procedure codes selected for inclusion in the HOPD index. μ_{i_j}represents the hospital-specific ("j-th") average price for procedure code i, and k_i represents the statewide utilization rate for procedure code i.

$$HOPD\ Price\ Index_j = \sum_{i=50}^{j} \mu_{i_j} * k_i$$

5 Additional data:

HOPD index contents, 2018 and 2020:

			2018		2020		
CPT	Description	Hospitals w/≥ 20 encounters	Mean price ($)	Aggregate HOPD spend ($)	Mean price ($)	Aggregate HOPD spend ($)	Utilization per 100 members per year, 2018
77067	SCREENING MAMMOGRAPHY, BILATERAL, INCLUDING CAD	57	290	29,769,530	306	21,994,490	6.4
45380	COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE	53	1,718	28,381,588	1,906	17,757,678	1.1
45385	COLSC FLX PROX SPLENIC FLXR RMVL LES SNARE TQ	53	1,880	24,110,934	2,036	17,050,132	0.8
88305	LEVEL IV SURG PATHOLOGY GROSS&MICROSCOPIC EXAM	56	303	22,899,980	327	16,695,117	4.8
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	56	184	20,987,216	210	10,961,493	7.8
43239	EDG TRANSORAL BIOPSY SINGLE/MULTIPLE	56	1,474	18,975,394	1,535	14,310,683	0.8
45378	COLONOSCOPY FLX DX W/WO COLLJ SPECIMENS	50	1,576	16,482,558	1,606	9,689,541	0.7
74177	CT ABDOMEN & PELVIS W/CONTRAST MATERIAL	53	1,191	15,543,457	1,315	12,838,323	0.9
93306	ECHO TTHRC R-T 2D W/WOM-MODE COMPL SPEC&COLR D	53	1,135	14,615,646	1,182	10,218,931	0.8
97110	THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	57	139	13,882,467	146	9,582,929	6.3
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	58	117	13,284,039	130	6,631,999	7.2
80061	LIPID PANEL	55	33	8,503,908	33	6,154,366	16.1

84443	ASSAY OF THYROID STIMULATING HORMONE TSH	56	54	8,310,758	56	5,878,433	9.7
71260	CT THORAX W/CONTRAST MATERIAL	52	634	7,076,983	614	5,307,209	0.7
85025	BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	59	28	6,860,677	29	5,416,153	15.4
80050	GENERAL HEALTH PANEL	50	132	6,444,002	152	5,616,582	3.1
82306	25 HYDROXY INCLUDES FRACTIONS IF PERFORMED	53	88	6,093,296	93	2,945,766	4.3
71046	RADIOLOGIC EXAMINATION, CHEST; 2 VIEWS	59	153	6,088,261	169	3,743,662	2.5
80053	COMPREHENSIVE METABOLIC PANEL	58	33	5,997,199	32	4,462,049	12.3
76830	ULTRASOUND TRANSVAGINAL	52	286	5,683,690	287	3,775,125	1.2
76642	US BREAST, UNILATERAL REAL TIME IMGE DOCM	56	251	5,078,207	246	4,408,823	1.3
83036	HEMOGLOBIN GLYCOSYLATED A1C	54	30	4,500,645	31	3,659,815	9.3
93017	CV STRS TST XERS&/OR RX CONT ECG TRCG ONLY	51	496	4,389,268	513	3,200,648	0.6
97140	MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	56	99	4,362,449	98	2,708,672	2.8
77065	DIAGNOSTIC MAMMOGRAPHY, UNILATERAL, INCLUDING CAD	54	279	4,201,273	292	2,849,150	0.9
85027	BLOOD COUNT COMPLETE AUTOMATED	54	21	3,742,062	22	2,612,196	11.0

71250	CT THORAX W/O CONTRAST MATERIAL	52	473	3,695,920	494	2,402,332	0.5
76856	US PELVIC NONOBSTETRIC REAL-TIME IMAGE COMPLETE	52	285	3,385,621	309	2,261,727	0.7
76536	US SOFT TISSUE HEAD & NECK REAL TIME IMGE DOCM	52	308	3,359,969	316	2,456,185	0.7
93005	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	56	86	3,315,225	106	2,680,739	2.4
80048	BASIC METABOLIC PANEL CALCIUM TOTAL	59	26	3,192,045	25	2,133,898	7.9
76700	US ABDOMINAL REAL TIME W/IMAGE DOCUMENTATION	52	355	3,124,828	367	1,937,527	0.6
97161	PHYSICAL THERAPY EVALUATION, LOW COMPLEXITY	54	198	2,764,967	211	1,861,543	0.9
77066	DIAGNOSTIC MAMMOGRAPHY, BILATERAL, INCLUDING CAD\	51	358	2,759,811	364	1,958,376	0.5
77080	DXA BONE DENSITY STUDY 1/> SITES AXIAL SKEL	54	219	2,359,597	238	1,699,804	0.7
82728	ASSAY OF FERRITIN	54	45	2,268,444	47	1,917,272	3.1
73630	RADEX FOOT COMPLETE MINIMUM 3 VIEWS	54	150	2,250,225	166	1,646,487	1.0
82607	CYANOCOBALAMIN VITAMIN B-12	54	46	2,033,919	46	1,536,628	2.8
84153	ASSAY OF PROSTATE SPECIFIC ANTIGEN TOTAL	51	54	1,980,042	57	1,541,578	2.3

86803	HEPATITIS C ANTIBODY	50	43	1,864,754	43	1,290,105	2.8
84439	ASSAY OF FREE THYROXINE	53	31	1,824,306	32	1,394,176	3.7
83970	ASSAY OF PARATHORMONE	50	137	1,623,194	141	1,277,255	0.7
86850	ANTIBODY SCREEN RBC EACH SERUM TECHNIQUE	53	51	1,542,353	79	2,024,858	1.9
80076	HEPATIC FUNCTION PANEL	57	26	1,407,456	24	884,552	3.4
83735	ASSAY OF MAGNESIUM	55	23	1,365,251	25	1,217,700	3.7
73502	RADEX HIP W/WO PELVIS, 2/3 VIEWS	51	172	1,354,884	173	930,570	0.5
73030	RADEX SHOULDER COMPLETE MINIMUM 2 VIEWS	52	145	1,344,150	160	1,019,386	0.6
36415	COLLECTION VENOUS BLOOD VENIPUNCTURE	54	7	1,272,679	7	999,088	11.9
86900	BLOOD TYPING ABO	54	40	1,248,719	111	2,711,378	2.0
72100	RADEX SPINE LUMBOSACRAL 2/3 VIEWS	51	154	1,237,413	197	1,067,319	0.5