

HB 19-1174 Out-of-Network Bill
Colorado All Payer Claims Database Frequently Asked Questions
Last Updated: December 2020



Background

During the 2019 Colorado legislative session, [House Bill 19-1174](#) was passed to help protect patients from surprise out-of-network bills. The bill identifies provider reimbursement requirements for out-of-network emergency and non-emergency visits. The Colorado All Payer Claims Database (CO APCD) is identified in the bill as a data source to provide statewide and geographic commercial allowed (paid) amounts. During the summer and fall of 2019, Center for Improving Value in Health Care (CIVHC) worked collaboratively with the Division of Insurance (DOI), providers, and payers to determine how to most accurately analyze and provide information from the CO APCD to support implementation of the bill. The first dataset was provided publicly in January 2020 and will be updated on an annual basis.

The following list of Frequently Asked Questions (FAQs) provides more information related to the allowed amount datasets available from the CO APCD. Please direct any additional data-related questions to ColoradoAPCD@civhc.org.

For more information regarding the bill, visit the DOI Out-of-Network webpage:
<https://www.colorado.gov/pacific/dora/out-network-health-care-provider-reimbursement>

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General Questions

How does the bill specify *Non-Emergency Out-of-Network* provider reimbursements?

If the OON provider submits a bill **within 180 days of service** for non-emergency services, they will receive the **greater of**:

- 1) 110% of the health insurance carrier in-network median for that same geographic area, OR
- 2) 100% of the 60th percentile of the in-network allowed amount in the same geographic area for the prior year based on commercial claims in the CO APCD

If the OON provider submits a bill **after 180 days of service** for non-emergency services, they will receive:

- 125% of the Medicare Reimbursement rate for the same geographic area

How does the bill specify *Emergency Out-of-Network* provider reimbursements?

If the OON provider (*with the exception of Denver Health and Hospital Authority*) submits a bill **within 180 days of service** for emergency services, they will receive the **greater of**:

- 1) 105% of the health insurance carrier in-network median for that same geographic area, OR
- 2) 100% of the in-network median (50th percentile) allowed amount in the same geographic area for the prior year based on commercial claims in the CO APCD

If the OON provider is **Denver Health and Hospital Authority** and they submit a bill **within 180 days of service** for emergency services, they will get paid the **greater of**:

- 1) Denver Health's median commercial payment, or
- 2) 250% of Medicare reimbursement rate, or
- 3) The median in-network rate for the same service provided in a similar facility in the same geographic area for the prior year based on commercial claims in the CO APCD

If the OON provider or Denver Health and Hospital Authority submits a bill **after 180 days of service**, for non-emergent services, they will receive:

- 125% of the Medicare Reimbursement rate for the same geographic area

CO APCD Data-related Questions

What data has CIVHC provided for HB 19-1174 and where can we find it?

In December of every calendar year, CIVHC provides an allowed amount analysis based on the previous year's CO APCD commercial claims data. The data is available at the statewide and Division of Insurance geographic rating region.

To access the allowed amount data sets directly, visit the DOI Out-of-Network webpage:
<https://www.colorado.gov/pacific/dora/out-network-health-care-provider-reimbursement>

Does the data available from the CO APCD include paid amounts from self-insured employer plans?

Yes. CIVHC utilized all available commercial claims, including the data for non-ERISA and ERISA self-insured plans in the CO APCD. CIVHC estimates that approximately 25% of all self-insured plans, primarily non-ERISA, are included in the database currently.

What methods were used to calculate the regional and statewide allowed amounts?

For detailed information on how the allowed amounts were calculated, please refer to the **“Cover Page” tab on the Excel data sets available above** as well as the [Overview and Methods](#) document which provides additional methodology information.

If you have additional questions about methodology, please contact ColoradoAPCD@civhc.org.

I'm not seeing all codes listed in the allowed amount CO APCD dataset. Why weren't some CPT-4 and HCPCS codes included, and what should we do if there is a code we use that isn't listed?

Not all CPT-4 and HCPCS codes had enough volume (minimum 30 claims statewide for each code in the analysis year identified was required) to be included in the allowed amount datasets. If you do not see a code that you use, the Division of Insurance is advising payers and providers to operate as they did prior to implementation of HB 19-1174. For more information, contact the DOI directly at:

DORA_INS_RulesandRecords@state.co.us

Is there a zip code crosswalk linking to each of the 9 DOI geographical regions so I can determine which region to use for my allowed amounts?

Yes. For HB 19-1174, CIVHC assigned claims by location of service using zip codes that were matched to one of the 9 Division of Insurance geographical regions in Colorado. To search regions by zip code, download the [DOI Zip Code Crosswalk](#).

How were the allowed amounts validated in the CO APCD?

CIVHC follows a rigorous validation process for all analyses as outlined below. If problems were identified at any step in the process, the programming code used to produce results was modified and re-tested.

1. Analyst quality check of programming code to determine if it satisfied specifications for extracting data from the CO APCD, calculating percentile allowed amounts and producing the required data output. Note that the analyst who conducted the quality check is different from the analyst who wrote the programming code.

2. Assessment of percentile allowed amounts based on review of results for component claims for randomly selected provider and emergency services.
3. Review of output to identify unexpected results. Investigation and documentation of findings.
4. For calculation of anesthesia conversion factors, comparison of results produced by two different analysts.

Can we talk to CIVHC if we have specific concerns over allowed amounts for specific CPT-4 and HCPS codes for certain regions?

Yes. The CIVHC data analyst team would be happy to investigate specific codes for specific regions that may be of particular interest or concern. Please contact ColoradoAPCD@civhc.org and we will connect with you to discuss further.

Can we request additional data from the CO APCD related to this bill that is not already available publicly?

Yes. CIVHC has a data request process that may suit your needs. For example, we can provide data specific to your practice or practice groups that can provide additional insights into your current allowed amounts in comparison with the state and corresponding DOI region.

The first step to request a custom analysis is defining a project purpose, which includes how the analysis contributes to at least one of the three Triple Aim objectives, and how it will benefit Colorado. To learn more refer to our application and data request process resources:

1. [CO APCD data request application](#) and [instructions](#)
2. [Data request process visualization](#)

How much would it cost to receive a custom analysis outside the currently available datasets?

To access data from the CO APCD, outside of the fee schedule generated for the HB 19-1174 and the related documents already shared, there is a data licensing fee. The data licensing fees allow us to maintain and operate the CO APCD and cover expenses to conduct the analysis. Prices are determined based on the complexity of the request and start at \$5,000 for a standard offering.

Please contact ColoradoAPCD@civhc.org to discuss your custom data needs.