CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

CO APCD Allowed Amounts in Support of Out-of-Network House Bill 19-1174

2020 Service Dates, Issued December 2021

Introduction

The purpose of this document is to describe data sets from the Colorado All Payer Claims Database (CO APCD) that were produced to support out-of-network legislation, HB 19-1174.

Colorado HB 19-1174 specifies payment for out-of-network health care services. The bill includes language specifying payments for: a) services delivered by out-of-network providers in in-network facilities, and b) emergency services at an out-of-network facility.

The bill identifies the CO APCD as one of several sources of information for determining payments:

- For services delivered by out-of-network providers, the bill specifies the CO APCD 60th percentile "…in-network rate of reimbursement for the same service in the same geographic area for the prior year based on commercial claims data..."
- For emergency services at an out-of-network facility, the bill specifies the CO APCD "…median in-network rate of reimbursement for the same service provided in a similar facility or setting in the same geographic area for the prior year..."

This document describes several topics that are key to understanding the data sets produced from the CO APCD and how they were created:

- Methodological challenges that had to be resolved before developing data sets of 60th and 50th percentile amounts
- Overview of the CO APCD data sets of allowed amounts
- Steps taken to validate the results
- Key messages about the data sets
- Detailed methodology used to create each data set (Appendix 1)

Methodological Challenges

To calculate the 60th or 50th percentile payment amounts from the CO APCD, several methodological questions and challenges had to be resolved with the release of the initial data sets provided in 2019 and the updated data sets provided in 2020. Here is a list of the issues and their resolution that have been used in annual updates to the files.

Methodological Question or Challenge	Resolution
1. What is the definition of **geographic area**?	Geographic area is defined as the Division of Insurance (DOI) nine rating areas. (See below for more information)
2. What is the definition of **rate of reimbursement**?	Rate of reimbursement is the CO APCD allowed amount, which is the sum of the plan/payer amount and member liability amount.
3. Which claims data should be used to calculate median rate of **reimbursement for emergency services at an out-of-network facility**, since the bill did not specifically reference use of commercial claims?	Commercial claims were used to calculate rate of reimbursement.
4. Commercial claims for targeted services can have very **low volumes**, making it difficult to produce a stable estimate of the 50th or 60th percentile amount.	Findings from an analysis of the distribution (interquartile range) of allowed amounts by claim volume were used to establish a volume threshold of 30 claims for reporting the 50th or 60th percentile allowed amount for facility and provider services.
5. What payment method should be used when the **volume of commercial claims for a targeted service is less than 30** in a DOI region?	Statewide allowed amounts were used for a targeted service when DOI region volumes were less than 30 and statewide volume was 30 or more.
6. Providers can be reimbursed based on CPT-4 procedure and zero, one or two modifiers. How many **CPT-4 procedure modifiers** will be used to calculate the 60th percentile allowed amount?	Ninety-two percent of non-anesthesia CPT-4 procedure codes have zero or one modifier. Therefore, CPT-4 and the first modifier were used to define provider services. Anesthesia services are the exception and require 2 modifiers.
7. Claims for provider **anesthesia services** often have very low volumes and inconsistent definition of time unit values.	CIVHC adopted a method used by the state of Oregon, which is based on a calculated regional conversion factor. Oregon uses the regional conversion factor to create a mechanism for carriers to enter CPT-4 procedure code and modifiers and time units to calculate reimbursement. Calculated regional conversion factors using a "clean" CO APCD data set that excludes allowed amounts and time units that are not valid.

Methodological Question or Challenge	Resolution
8. The **obstetric anesthesia CPT-4 code 01697** (i.e. an epidural) is typically reimbursed per-unit up to a capped rate in complex arrangements that vary by both payer and provider. The allowed amount ceiling on these claims has the potential to artificially deflate the anesthesia conversion factors, which rely heavily on time units.	For the 2020 fee schedules, CIVHC compared the anesthesia conversion factors calculated both with and without CPT-4 01697 included in the data set and determined that including these claims has a negligible effect on the overall results (less than 2% change in all regions). Therefore, the 2020 anesthesia conversion factors do include these claims. CIVHC will continue to monitor the effect of this procedure code on future updates to the anesthesia fee schedules.
9. **In-network emergency services** are often paid to facilities on the basis of a **case rate**, using CPT-4 emergency evaluation and management codes to define several case rate levels. High-cost services are reimbursed separately as carve-outs.	Case rates were defined for five different levels of emergency services and the 50th percentile allowed amount was calculated for each. Similarly, 50th percentile allowed amounts were calculated for six high-cost carve-out services.
10. HB 19-1174 does not address situations where a covered person is seen in the ED and is not able to be transferred to an in-network facility before receiving treatment in an **observation unit, outpatient operating room or inpatient setting.**	CIVHC maintains that a clinical assessment is required to determine whether a patient, receiving emergency services in an out-of-network facility, is stable and able to be transferred to an in-network facility. In cases when the patient requires observation, outpatient operating room or inpatient care and cannot be transferred to an in-network facility, CIVHC calculated 50th percentile allowed amounts to help determine payment for each of these types of services.
11. Commercial claims for in-network **ambulance services** in the CO APCD accounted for only 20% of all commercial claims for ambulance services, making it difficult to use the CO APCD to produce useful estimates of allowed amounts and establish reimbursement rates.	The DOI developed a separate method for calculating the reimbursement rate for out-of-network ambulance services that does not rely on data from the CO APCD.
12. Some procedures in both the professional fee schedule and the emergency facility fee schedule are reimbursed on a **per-unit** basis rather than a flat fee.	CIVHC identified CPT-4 procedure codes that are reimbursed on a per-unit basis and reported the fees as such. To identify procedures reimbursed on a per-unit basis, CIVHC followed the following criteria: **Professional:** • A CPT 4 code definition implying units (not including anesthesia services), OR • Greater than 3% of claims under the fee schedule selection criteria having units > 1 **Emergency Facility:** all nuclear medicine, high-cost drugs, and implants HCPCS codes with a definition implying units

Overview of CO APCD Data Sets of Allowed Amounts

Data sets are provided on the Division of Insurance website in two Excel files specifying:

a. the 60th percentile allowed amount for services delivered by out-of-network providers in in-network facilities,
b. the 50th percentile for emergency services at an out-of-network facility, and

The detailed methodology used to create each of these data sets is presented in Appendix 1.

In the data sets, the DOI region numbers map to the following DOI regions:

DOI Region No.	DOI Region Name
1	Boulder
2	Colorado Springs
3	Denver
4	Ft. Collins
5	Grand Junction
6	Greeley
7	Pueblo
8	East
9	West

For a crosswalk of the DOI regions to zip codes and counties in Colorado, click here.

For each data set, the 60th or 50th percentile allowed amount is displayed for the DOI region when the volume of claims for the DOI region was 30 or more. If the volume of claims for the region was less than 30, the 50th percentile allowed amount for the state is reported.

The "**Statewide Used**" indicator is 0 when the regional allowed amount is used and 1 if the statewide allowed amount is reported.

Importantly, the data set does not include services where the number of claims statewide was less than 30.

The first Excel file, A. CO APCD 60th Percentile Allowed Amounts for Professional Services, includes:

1. **Professional Services, excluding Anesthesia.** These spreadsheets provide the 60th percentile allowed amount for professional services (excluding anesthesia) that can be used to determine payment for services delivered by out-of-network providers in in-network facilities.

   CIVHC produced the three different formats of fee schedules (1a., 1b., and 1c. described below) to allow flexibility for payers to implement them into their systems. The fees associated with the professional codes do not change across the different tabs.

   1a. Professional excl. Anesthesia with Unit Indicator: Lists all professional services with a field that indicates codes for which the fee schedule is the 60th percentile allowed amount **per unit.**

   1b. Professional excl. Anesthesia Flat Fees: Lists only professional services for which the fee schedule is the 60th percentile allowed amount and is a flat fee and **not** summarized per unit.

   1c. Professional excl. Anesthesia Per Unit: Lists **only** professional services for which the fee

schedule is the 60th percentile allowed amount per unit.

Important Notes: CPT-4 and G code modifiers that do not affect reimbursement are not displayed in the data set, however, they were used in the calculation of 60th percentile allowed amounts. Payment for CPT-4 or G code with such modifiers should be based on the allowed amount for the code without a modifier.

2. **Anesthesia Conversion Factors**. This spreadsheet lists the anesthesia conversion factor for each of the nine DOI regions. The conversion factors will be used to calculate reimbursement for claims for anesthesia services.

   Claims for anesthesia services include the CPT-4 procedure code, modifiers and time units, which are used to assign base units, physical status units, time units and Q modifier adjustment. These values and the conversion factor for the DOI region are entered in the formula shown in this spreadsheet to calculate reimbursement.

   Important Notes: Claims for anesthesia services with invalid time units were excluded from the calculation of conversion factors. More detail is provided in the methodology section in Appendix 1.

The second Excel file, B. CO APCD 50th Percentile Allowed Amount for Emergency Services, includes data sets that address five different types of services: Emergency room case rates and carve-outs from case rates for high-cost services (e.g., advanced imaging, high cost drugs). In addition, since patients seen in the emergency room might also receive emergent treatment in an observation unit, outpatient operating room or inpatient facility, data sets were created for services in each of these locations. **Like emergency room case rates, observation and outpatient operating room case rates have the same carve-outs for high-cost services.**

1. **Emergency Room Case Rates.** This spreadsheet provides the 50th percentile for outpatient emergency room case rates for five different levels. Each level is defined by CPT-4 emergency evaluation and management code:

   - Level 1 – 99281
   - Level 2 – 99282
   - Level 3 – 99283
   - Level 4 – 99284
   - Level 5 – 99285 or 99291 or 99292

   The case rate 50th percentile allowed amounts are calculated after excluding high-cost services, such as implants and advanced imaging, observation stays and operating room procedures. These services are addressed separately as either carve-outs or case rates (see below).

   If a patient was seen in the observation unit or received a surgical procedure, use the Observation or Outpatient OR Procedures data set, respectively.

2. **Emergency Services Carve-Outs for:**
   - Implants
   - Advanced Imaging
   - Nuclear Medicine

- Cardiac Catheterization
- High Cost Drugs
- Trauma Activation

A data set is provided for each carve-out service, identified as claim lines within emergency services claims. For implants, nuclear medicine, cardiac catheterization and high-cost drugs, the carve-out services are selected using revenue codes, but reported as the 50th percentile allowed amount by CPT-4 procedure code. For implants, nuclear medicine, and high-cost drugs, the 50th percentile allowed amount is reported per unit.

For advanced imaging, services are selected and grouped by type of imaging test (e.g., CT, MRI) using revenue codes. The 50th percentile allowed amounts are displayed for each type of test.

Finally, for trauma activation, the data set displays the 50th percentile for each revenue code designating a trauma activation level.

3. **Observation Case Rates.** This spreadsheet provides the 50th percentile allowed amount for observation stays for five different levels. Each level is defined by CPT-4 emergency evaluation and management code:

   - Level 1 – 99281
   - Level 2 – 99282
   - Level 3 – 99283
   - Level 4 – 99284
   - Level 5 – 99285 or 99291 or 99292

   Observation stays are identified by revenue code. Claims for observation services must also include a revenue code for emergency room services. The case rate 50th percentile allowed amounts are calculated after excluding high-cost services, such as implants and advanced imaging and surgical procedures. These services are addressed separately as either carve-outs or case rates. If a patient received a surgical procedure, use the Outpatient OR Procedures data set.

4. **Outpatient OR Procedures.** This spreadsheet provides 50th percentile allowed amount for outpatient operating room cases, by surgical CPT-4 procedure code.

   Outpatient operating room visits are identified using OR revenue codes. Claims for outpatient OR services must also include a revenue code for emergency room services. The case rate 50th percentile allowed amounts are calculated after excluding high-cost services, such as implants and advanced imaging. These services are addressed separately as carve-outs.

5. **Hospital Admissions from the ER.** This spreadsheet provides the 50th percentile allowed amount that can be used to determine payment for direct admissions from the emergency room at an out-of-network facility.

Validation of Data Sets

Prior to preparing the initial data sets to support HB 19-1174 in 2019, CIVHC spent several months evaluating and analyzing CO APCD in- and out-of-network services, particularly provider services. This work contributed to improvements in the data needed to identify the network status of providers in

claims submitted to the CO APCD and to the development of a knowledge base at CIVHC about payments for in- and out-of- network services.

In addition, when preparing the data sets, CIVHC analyzed CO APCD data to identify potential methodological nuances in calculating the 50th and 60th percentile allowed amounts. In response to these methodological concerns, CIVHC proposed solutions and sought input from the DOI and from payer and provider stakeholders.

The creation of the data sets described in this document are the result of an extensive process of data discovery, problem identification and resolution, and testing. Each of the resulting data sets was evaluated and validated.

The following is a description of the validation steps CIVHC takes with the production of annual updates to the datasets. If problems are identified, the programming code used to produce results is modified and re-tested.

- 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 for an additional layer of quality control.
- Assessment of percentile allowed amounts based on review of results for component claims for randomly selected provider and emergency services.
- Review of output to identify unexpected results. Investigation and documentation of findings.
- For calculation of anesthesia conversion factors, comparison of results produced by two different analysts.
- Comparison of results to the previously issued fee schedules, where applicable. Investigation and documentation of findings related to any fees that increased or decreased significantly.

Key Considerations about Data Sets

- Data sets with calculated 50th or 60th percentile allowed amounts were created empirically, based on the data submitted to the CO APCD.

  Routine data validation is conducted on a monthly basis as payers submit data to the CO APCD to ensure an acceptable level of data quality upon intake. However, not all payers consistently capture and submit unit values for procedures. This is particularly challenging for determining payments for anesthesia claims which are based on time units, professional services reimbursed on a unit basis, and emergency carve-outs (i.e. high-costs drugs, nuclear medicine, implants, etc.) that are reimbursed per unit. Several of the large payers are now correctly submitting unit values for medical claims, however claims from payers with consistently invalid unit values and no supplemental unit information have been removed before calculating unit-based payments. Excluded payers are mostly smaller payers that represent a very small percentage of overall claims in the CO APCD.

- The 50th or 60th percentile allowed amounts reported for some services, particularly emergency service carve-outs, may differ significantly by DOI region. In many instances, the 50th or 60th percentile allowed amount was based on services with a claim volume that well-exceeded the threshold of 30, but were still influenced by claims with either very low or very

high allowed amounts. These data were reviewed and investigated and were determined to be valid.

- As noted above, the provider and emergency services contained in the data sets include only those services with a statewide claim volume of 30 or more. Some services for which a reimbursement rate must be determined were not included.

Appendix 1 – Detailed Methodology

Services Delivered by Out-of-Network Providers in In-Network Facilities (Excluding Anesthesia Services)

Payment Methodology	Data Selection Criteria and Output
For CPT-4 or HCPCS codes that either have a definition implying units (e.g. "per hour") or are submitted with units > 1 on at least 3% of claims that are used to calculate fees report: • The 60th percentile in-network allowed amount **per unit** for CPT-4 or G code procedure + 1 modifier in the same geographic (DOI) region • **If the volume is below the threshold of 30 claims,** use the 60th percentile statewide in-network allowed amount **per unit**. **For all other professional procedure codes, report:** • The 60th percentile in-network allowed amount for CPT-4 or G code procedure + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 60th percentile statewide in-network allowed amount.	Select professional claims that satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Allowed amount > $0 • Network status is in-network • CPT-4 or HCPCS G code + 1 modifier; include only modifiers that affect reimbursement. Modifiers that affect reimbursement and were also resident in the CO APCD professional claims: 22, 26, 50, 52, 53, 54, 55, 56, 59, 62, 73, 76, 78, 80, 81, 82, AA, AD, AS, CT, GC, P1, P2, P3, P4, P5, P6, QK, QS, QX, QY, QZ, TC • Place of service in a facility (based on CMS definition): 19 (off-campus, outpatient hospital), 21 (inpatient hospital), 22 (on-campus, outpatient hospital), 23 (ER, hospital), 24 (ambulatory surgical center), 26 (military treatment facility), 31 (SNF), 34 (hospice), 41 (ambulance – land) , 42 (ambulance air or water), 51 (independent psychiatric facility), 52 (psychiatric facility, partial hospitalization), 53 (community mental health facility), 56 (psychiatric residential treatment center), 61 (comprehensive inpatient rehabilitation facility) For procedure codes that are reported per-unit, exclude claims from payers who submit invalid, hard-coded unit values of "1" and did not provide corrected units information. Calculate and report volume and 60th percentile allowed amount for CPT-4 or HCPCS G code + 1 modifier, by DOI region and statewide. Note: CPT-4 and G code modifiers that do not affect reimbursement are displayed in the data set. However, the 60th percentile allowed amount shown was calculated for the CPT-4 or G code as if the modifier was not present.

Anesthesia Services Delivered by Out-of-Network Providers in In-Network Facilities

Payment Methodology	Data Selection Criteria and Output
If the CO APCD cannot be used to report 60th percentile allowed amount because of small volumes and inconsistent units: Use the method adopted by the state of Oregon, which creates a mechanism for carriers to enter CPT-4 procedure code and modifiers and time units to calculate reimbursement. Oregon uses the Medicare formula, but with a local calculation of the conversion factor and recommendations from the American Association of Anesthesiologists for base units. This formula for calculating reimbursement is: [(base units + time units + physical status units (if any)) x Q modifier adjustment (if applicable)] x conversion factor]	1. Select professional claims that satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • CPT-4 anesthesia procedure codes, 00100 – 01999 • Place of service in a facility (based on CMS definition) 2. Modify time unit values for payers that report actual minutes, not 15-minute time increments. Identification of time units for modification was based on a comparison of reported units to CMS benchmarks in addition to the new Unit of Measure field implemented in 2020. More specifically: • Units with a Unit of Measure of 'minutes' and unit value greater than or equal to 15 were divided by 15 • Units with a Unit of Measure of 'minutes' and unit value less than 15 were converted to '1' • Units with a Unit of Measure of 'fifteen minutes' were kept as is • Units with a Unit of Measure other than 'minutes' or 'fifteen minutes', (unit value/CMS unit benchmark) ratio greater than 4*, and unit value greater than 15 were divided by 15 • Units with a Unit of Measure other than 'minutes' or 'fifteen minutes', (unit value/CMS unit benchmark) ratio greater than 4*, and unit value less than 15 were converted to '1' • Units with a Unit of Measure other than 'minutes' or 'fifteen minutes' and a (unit value/CMS unit benchmark) ratio less than or equal to 4* were kept as is * A ratio of 4 was found to be the highest 99th percentile between values that had a Unit of Measure of 'minutes' or 'fifteen minutes' and therefore is used as a cutoff for the other Units of Measure indicators.

	3. Exclude data for payers that consistently reported time unit values of "1" across anesthesia procedures and did not provide updated units information. 4. Exclude claim lines with 0 units or with $0 allowed amount 5. Exclude claims with outlier 60th percentile allowed amounts per time unit. 6. Report 60th percentile allowed amount and average number of units by CPT procedure code and 2 modifiers for each DOI region 7. Calculate a conversion factor for each CPT-4 procedure code + 2 modifiers using the following formula: 60th percentile allowed amount ÷ [(base units + average time units + physical status units (if any)) x Q modifier adjustment (if any)] (Use American Association of Anesthesiologists base units for 2020; Physical Status Codes: P3=1 unit, P4=2, P5=3; 50% adjustment for modifier QK, QX or QY) 8. Calculate the weighted average conversion factor across all CPT-4 procedure codes for each DOI region Report conversion factor by DOI region that carriers can use to enter CPT-4 procedure code and modifiers and time units to calculate reimbursement.

Emergency Services in Out-of-Network Facilities – Emergency Room Case Rates

Payment Methodology	Data Selection Criteria
For emergency room case rates, calculate the 50th percentile allowed amount by DOI region. **If the volume is below the threshold of 30 claims**, use the 50th percentile allowed amount for statewide for each emergency room case rate level.	Select claims for emergency room visits that are outpatient services, with specified revenue codes (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&M) codes, CPT-4 99281-99285, 99291 or 99292. Select ER visits that satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Excludes claim lines with revenue codes: 252, 274, 275, 278, 340-343, 350, 351, 352, 359, 401-404, 481, 490, 540, 549, 610-615, 619, 636, 681-684, 689, 710. (These are revenue codes for carve-out services and ambulance) • Excludes claims with revenue codes 360, 361, 369 or 762 (These are claims for ER visits that included observation and/or outpatient OR procedures) Stratify ER claims by level, based on CPT-4 evaluation and management or critical care code: Level 1 – 99281 Level 2 – 99282 Level 3 – 99283 Level 4 – 99284 Level 5 – 99285 or 99291 or 99292 Calculate and report 50th percentile allowed amount for the entire claim, by level and by DOI region and statewide.

Emergency Services in Out-of-Network Facilities – High-Cost Carve-Out Services

Payment Methodology	Data Selection Criteria
For each high cost service, calculate the 50th percentile allowed by DOI region. **If the volume is below the threshold of 30,** use the 50th percentile statewide for each high-cost service.	Select claims for emergency room visits that are outpatient services, with specified revenue codes (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&M) codes, CPT-4 99281-99285, 99291 or 99292. Claims for ER visits must also satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network Calculate and report 50th percentile allowed amount for claim lines that satisfy the following criteria: • Implants - Identified by revenue code (274, 275 or 278) and reported by CPT-4 code. Include only claim lines where allowed amount > $0. Report allowed amount per unit. • Advanced Imaging - Identified by revenue code for each of these categories: CT (350- 352, 359), Mammography (401, 403), Ultrasound (402), PET (404), MRI (610-615, 619). Include claim lines where allowed amount > $0. • Nuclear Medicine - Identified by revenue code (340-343) and reported by CPT-4 procedure code. Include claim lines where allowed amount > $0. Report allowed amount per unit. • Cardiac Catheterization - Identified by revenue code (481) and reported by CPT-4 procedure code. Include claim lines where allowed amount > $0. • High Cost Drug – Identified by revenue code (636, 252) and reported by CPT-4 procedure code. Include claim lines where allowed amount > $0. Report allowed amount per unit. • Trauma Activation – Identified by revenue code, each describing an activation level (681-684, 689) and include claim lines where allowed amount > $0. For Implants, Nuclear Medicine, and High Cost Drugs, exclude claims from payers who submit invalid, hard-coded unit values of “1” and did not provide corrected units information.

Emergency Services in Out-of-Network Facilities – Observation Stay from ER

Payment Methodology	Data Selection Criteria
For observation stay case rates, calculate the 50th percentile allowed amount by DOI region. **If the volume is below the threshold of 30 claims,** use the 50th percentile statewide allowed amount for each observation stay case.	Select claims for hospital outpatients that have a revenue code of 762. The claim must also have an ER revenue code (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&M) codes, CPT-4 99281-99285, 99291 or 99292. Claims for observation stays must also satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Excludes claim lines revenue codes: 252, 274, 275, 278, 340-343, 350, 351,352, 359, 401-404, 481, 490, 540, 549, 610-615, 619, 636, 681-684, 689, 710. (These are revenue codes for carve-out services and ambulance) • Excludes claims with revenue codes 360, 361, 369 (These are claims for ER visits that included an outpatient OR procedure) • Allowed amount > $0 Stratify observation claims by level, based on CPT-4 evaluation and management or critical care code: Level 1 – 99281 Level 2 – 99282 Level 3 – 99283 Level 4 – 99284 Level 5 – 99285 or 99291 or 99292 Calculate and report 50th percentile allowed amount for the entire claim, by level and by DOI region and statewide.

Emergency Services in Out-of-Network Facilities – Outpatient OR Procedure from ER

Payment Methodology	Data Selection Criteria
For outpatient OR case rates, calculate the 50th percentile allowed amount by DOI region. **If the volume is below the threshold of 30 claims,** use the 50th percentile statewide allowed amount for each outpatient OR case.	Select claims for hospital outpatients with an OR revenue code (360 or 361 or 369). The claim must also have an ER revenue code (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&M) codes, CPT-4 99281-99285, 99291 or 99292. Claims for outpatient OR procedures must also satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Excludes claim lines with revenue codes: 252, 274, 275, 278, 340-343, 350, 351, 352, 359, 401-404, 481, 540, 549, 610-615, 619, 636, 681-684, 689. (These are revenue codes for carve-out services and ambulance) • Allowed amount > $0 Calculate and report 50th percentile allowed amount for the entire claim, by surgical CPT-4 procedure code and by DOI region and statewide.

Emergency Services in Out-of-Network Facilities - Admissions from ER

Payment Methodology	Data Selection Criteria
For MS-DRGs for direct admissions from an ER to an in-network facility to determine payment for admissions from an out-of-network ER, calculate the 50th percentile allowed amount by DOI region. **If the volume is below the threshold of 30 claims,** use the 50th percentile statewide allowed amount for each MS-DRG.	Select inpatient facility claims that satisfy these criteria: • Commercial claims • Service date in calendar year 2020 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Discharge from acute care hospital following direct admission from the ER Report volume and 50th percentile allowed amount for acute care hospital discharges for each MS-DRG, by DOI region and statewide.