



# CO APCD Allowed Amounts Methodology & Details

## Out-of-Network House Bill 19-1174

*2021 Service Dates, Issued December 2022*

### Introduction

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

Colorado HB 19-1174 specifies payments for out-of-network health care services. The bill includes language regarding payment parameters 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 60<sup>th</sup> 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 the methodology and details surrounding the production of the data sets.

### Table of Contents

---

Introduction .....	1
Methodology Frequently Asked Questions.....	2
Overview of CO APCD Data Sets of Allowed Amounts.....	4
Validation of Data Sets.....	7
Key Considerations.....	7
Appendix 1 – Detailed Methodology .....	9

## Methodology Frequently Asked Questions

To calculate the 60<sup>th</sup> or 50<sup>th</sup> percentile payment amounts from the CO APCD, several methodological questions and challenges had to be answered and resolved. Here is a list of the questions and determinations that were agreed upon through the process that CIVHC and DOI undertook with feedback from payers and providers.

Methodology Question	Answer
1. What is the definition of <b>geographic area</b> ?	The geographic area is defined as the Division of Insurance (DOI) nine rate setting areas. (see above for more details)
2. What is the definition of <b>rate of reimbursement</b> ?	Rate of reimbursement is the CO APCD allowed amount, which is the sum of the plan/payer amount and member liability amount.
3. <b>What payer type</b> in the CO APCD is used to calculate reimbursement for emergency services, since the legislation does not specifically reference use of commercial claims?	Commercial claims are used to calculate rate of reimbursement.
4. What <b>minimum claim volume</b> was used to ensure valid estimates of the 50 <sup>th</sup> or 60 <sup>th</sup> percentile amounts are produced?	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 50 <sup>th</sup> or 60 <sup>th</sup> percentile allowed amount for facility and provider services.
5. What payment method is used when the volume of commercial claims for a targeted service is <b>less than 30 in a DOI region</b> ?	Statewide allowed amounts are 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 the CPT-4 code for the procedure and up to two modifiers. How many <b>CPT-4 procedure modifiers</b> are used to calculate the 60 <sup>th</sup> percentile allowed amount?	For non-anesthesia CPT-4 procedure codes, the code and the first modifier (which includes 33 distinct modifiers) are used to calculate the 60 <sup>th</sup> percentile allowed amount. In addition, CPT-4 codes and the first modifier are used to define provider services. Anesthesia services are the exception and require two modifiers.
7. How were <b>payments for anesthesia services</b> determined since they often have very low volumes, and claims are often submitted with inconsistent definitions of time unit values (i.e. actual minutes vs. individual units equaling 15-minute increments).	CIVHC adopted a method used by the state of Oregon, which is based on a calculated regional conversion factor that payers use to enter the CPT-4 procedure code, modifiers, and time units to calculate reimbursement.

Methodological Question	Answer
<p>8. The <b>obstetric anesthesia CPT-4 code 01697</b> (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. How is this accounted for in the data?</p>	<p>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. Therefore, the 2021 anesthesia conversion factors also do include these claims. CIVHC will continue to monitor the effect of this procedure code on future updates to the anesthesia fee schedules.</p>
<p>9. In-network emergency services are often paid to facilities on the basis of a <b>case rate</b>, using CPT-4 emergency evaluation and management codes to define several case rate levels. <b>High-cost services are reimbursed separately as carve-outs</b>. How is this accounted for in the data?</p>	<p>Case rates were defined for five different levels of emergency services and the 50<sup>th</sup> percentile allowed amount was calculated for each. Similarly, 50<sup>th</sup> percentile allowed amounts were calculated for six high-cost carve-out services.</p>
<p>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 <b>observation unit, outpatient operating room or inpatient setting</b>. How is this accounted for in the data?</p>	<p>In cases when the patient requires observation, outpatient operating room or inpatient care and cannot be transferred to an in-network facility, CIVHC calculated 50<sup>th</sup> percentile allowed amounts to help determine payment for each of these types of services.</p>
<p>11. Why aren't payments for in-network <b>ambulance services</b> provided?</p>	<p>Commercial claims for ambulance services in the CO APCD account for approximately 20% of all ambulance services provided due to fact that the majority of services are NOT a covered benefit and paid for by commercial payers. With a low representative sample, it was decided not to use the CO APCD to produce allowed amounts and establish reimbursement rates. The DOI develop a separate method for calculating the reimbursement rate for out-of-network ambulance services in <a href="#">Regulation 4-2-66</a>.</p>
<p>12. How does the data account for professional and emergency facility services that are reimbursed on a <b>per-unit basis rather than a flat fee</b>?</p>	<p>CPT-4 procedure codes that are reimbursed on a per-unit basis are reported as per-unit payments. To identify procedures reimbursed on a per-unit basis, CIVHC followed the following criteria:</p> <p><b>Professional Services:</b></p> <ul style="list-style-type: none"> <li>• A CPT 4 code definition implying units (not including anesthesia services), OR</li> <li>• Greater than 3% of claims under the fee schedule selection criteria having units &gt; 1</li> </ul> <p><b>Emergency Facility Services:</b> all nuclear medicine, high-cost drugs, and implants HCPCS codes with a definition implying units</p>

## Overview of CO APCD Data Sets of Allowed Amounts

The CO APCD data sets contain information specifying:

- **Excel File A:** The 60<sup>th</sup> percentile allowed amount for services delivered by out-of-network providers in in-network facilities, and
- **Excel File B:** The 50<sup>th</sup> percentile for emergency services at an out-of-network facility

Please note that the DOI region number in the data sets map to the following Division of Insurance geographical rate setting areas:

DOI Region	DOI Region Name	DOI Region County/Counties
1	Boulder	Boulder
2	Colorado Springs	El Paso, Teller
3	Denver	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
4	Ft. Collins	Larimer
5	Grand Junction	Mesa
6	Greeley	Weld
7	Pueblo	Pueblo
8	East	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
9	West	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat

### Volume Considerations

For each data set, the 60<sup>th</sup> or 50<sup>th</sup> percentile allowed amount is displayed for the DOI region when the volume of claims for the DOI region is 30 or more. If the volume of claims for the region is less than 30, the 50<sup>th</sup> percentile allowed amount for the state is reported. The “Statewide Used” indicator is displayed as “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.

### Excel file A: CO APCD 60<sup>th</sup> Percentile Allowed Amounts for Professional Services

In the Professional Services excel file, data is available for provider payments on a number of tabs.

1. **Professional Services, excl. Anesthesia.** These tabs provide the 60<sup>th</sup> 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 60<sup>th</sup> 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 60<sup>th</sup> 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 should 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 on this tab to calculate reimbursement.

**Important Note:** 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.

### Excel file, B. CO APCD 50<sup>th</sup> Percentile Allowed Amount for Emergency Services

The excel file for Emergency Services includes data sets that address different types of emergency services, carve outs and setting types.

- Emergency room case rates and **carve-outs from case rates for high-cost services** (e.g., advanced imaging, high cost drugs).
- Emergency services performed in an **observation unit, outpatient operating room or inpatient facility**. 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 tab provides the 50<sup>th</sup> 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 50<sup>th</sup> 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:**
  - a. Implants
  - b. Advanced Imaging

- c. Nuclear Medicine
- d. Cardiac Catheterization
- e. High Cost Drugs
- f. 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 50<sup>th</sup> percentile allowed amount by CPT-4 procedure code. For implants, nuclear medicine, and high-cost drugs, the 50<sup>th</sup> 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 50<sup>th</sup> percentile allowed amounts are displayed for each type of test.

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

3. **Observation Case Rates.** This tab provides the 50<sup>th</sup> 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 50<sup>th</sup> 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 Operating Room (OR) Procedures** data set.

4. **Outpatient Operating Room (OR) Procedures.** This tab provides 50<sup>th</sup> percentile allowed amounts 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 50<sup>th</sup> 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 tab provides the 50<sup>th</sup> 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 data sets to support HB 19-1174, CIVHC spent several months evaluating and analyzing CO APCD in- and out-of-network services, particularly for 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 problems in calculating the 50<sup>th</sup> and 60<sup>th</sup> percentile allowed amounts. In response to these methodological problems, 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 product of a long 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. If problems were identified, the programming code used to produce results was 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(s) who conducted the quality check are different from the analyst who wrote the programming code.
- 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. Investigation and documentation of findings related to fees that have increased or decreased significantly.

## Key Considerations

- The data sets with calculated 50<sup>th</sup> or 60<sup>th</sup> percentile allowed amounts were created empirically, based on the data submitted by payers to the CO APCD.

Routine data validation is conducted each time payers submit data to ensure an acceptable level of data quality in the CO APCD. However, there are still instances where payers submit data inconsistently or their submissions may be considered invalid. For example, some payers consistently record unit values of 1, regardless of the procedure or duration. These data present a methodological obstacle for anesthesia claims, which are based on time units; professional services that are reimbursed per unit; and emergency carve-outs (i.e. high-cost drugs, nuclear medicine, implants) that are reimbursed per unit.

Claims from payers with consistently invalid unit values and no supplemental unit information are removed before calculating the anesthesia, per-unit professional, and per-unit emergency carve-out fee schedules. The excluded payers are mostly small organizations and comprise of a small percentage of claims in the CO APCD.

- The 50<sup>th</sup> or 60<sup>th</sup> percentile allowed amounts reported for some services, particularly emergency service carve-outs, may differ significantly by DOI region. In many instances, the 50<sup>th</sup> or 60<sup>th</sup> 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 could not be attributed to invalid data.
- 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
<p>For CPT-4 or HCPCS codes that either have a definition implying units (e.g. “per hour”) or are submitted with units &gt; 1 on at least 3% of claims that are used to calculate fees report:</p> <p>a. The 60<sup>th</sup> percentile in-network allowed amount <b>per unit</b> 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</p> <p>b. The 60<sup>th</sup> percentile of in-network allowed amounts <b>per unit</b> for the state.</p> <p>For all other professional procedure codes, report:</p> <p>c. The 60<sup>th</sup> 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</p> <p>d. The 60<sup>th</sup> percentile of in-network allowed amounts for the state.</p>	<p>Select professional claims that satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Allowed amount &gt; \$0</li> <li>• Network status is in-network</li> <li>• 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</li> <li>• 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)</li> </ul> <p>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.</p> <p>Calculate and report volume and 60<sup>th</sup> percentile allowed amount for CPT-4 or HCPCS G code + 1 modifier, by DOI region and statewide.</p> <p>Note: CPT-4 and G code modifiers that do not affect reimbursement are displayed in the data set. However, the 60<sup>th</sup> percentile allowed amount shown was calculated for the CPT-4 or G code as if the modifier was not present.</p>

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

Payment Methodology	Data Selection Criteria and Output
<p>Cannot use CO APCD to report 60<sup>th</sup> percentile allowed amount because of small volumes and inconsistent units. Instead, 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.</p> <p>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:</p> <p>[(base units + time units + physical status units (if any)) x Q modifier adjustment (if applicable)] x conversion factor]</p>	<ol style="list-style-type: none"> <li>1. Select professional claims that satisfy these criteria: <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> <li>• CPT-4 anesthesia procedure codes, 00100 – 01999</li> <li>• Place of service in a facility (based on CMS definition)</li> </ul> </li> <li>2. Modify time unit values for payers that report actual minutes or other units, not 15-minute time increments. Identification of time units for medication was based on a comparison of the newly implemented Units of Measure field in 2020. <ul style="list-style-type: none"> <li>• Unit of measure of ‘fifteen-minute increments’ were left as is.</li> <li>• Unit of measure of ‘minutes’ <ul style="list-style-type: none"> <li>○ If the unit value is greater than or equal to 15, then divide by 15</li> <li>○ If the unit value is less than 15, then set as 1</li> </ul> </li> <li>• All other units of measure <ul style="list-style-type: none"> <li>• If the unit value is greater than or equal to 15 AND greater than the 95<sup>th</sup> percentile of unit values of matching CPT code on claims in 2021 with a unit of measure of ‘fifteen minutes’ then divide by 15</li> <li>• If the unit value is less than 15 AND greater than the 95<sup>th</sup> percentile of unit values of matching CPT code on claims in 2021 with a unit of measure of ‘fifteen minutes’ then set as 1</li> <li>• If the unit value equals 1 AND is also less than or equal to the 95<sup>th</sup> percentile of unit values of matching CPT code on claims in 2021 with a unit of measure of ‘fifteen minutes’ then assign the 50<sup>th</sup> percentile of unit values of matching CPT code claims in 2021 with a unit of measure of ‘fifteen minutes’</li> </ul> </li> </ul> </li> </ol>

	<ul style="list-style-type: none"> <li>• If the unit value is greater than 1 AND less than or equal to the 95<sup>th</sup> percentile of unit values of matching CPT code on claims in 2021 with a unit of measure of 'fifteen minutes' then leave as is</li> </ul> <ol style="list-style-type: none"> <li>3. Exclude claim lines with 0 units or with \$0 allowed amount</li> <li>4. Calculate a cost per total units for each claim line using the following formula:        Allowed amount ÷ [(base units + modified time units + physical status units (if any)) x Q modifier adjustment (if any)]       <ul style="list-style-type: none"> <li>• Use American Association of Anesthesiologists base units for 2018</li> <li>• Physical Status Codes: P3=1 unit, P4=2, P5=3</li> <li>• 50% adjustment for modifier QK, QX, QY, or AD)</li> </ul> </li> <li>5. Calculate the regional conversion factor across all claims within each DOI region by taking the 60<sup>th</sup> percentile of the cost per total units</li> </ol> <p>Report conversion factor by DOI region that payers can use to enter CPT-4 procedure code and modifiers and time units to calculate reimbursement.</p>
--	--

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

Payment Methodology	Data Selection Criteria
<p>a. The 50<sup>th</sup> percentile allowed amount for each emergency room case rate level, by DOI region. If the volume is below the threshold of 30 claims, use</p> <p>b. The 50<sup>th</sup> percentile allowed amount for each emergency room case rate level for the state.</p>	<p>Select claims for emergency room visits that are <u>outpatient</u> services, with specified revenue codes (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&amp;M) codes, CPT-4 99281-99285, 99291 or 99292.</p> <p>Select ER visits that satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> <li>• 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)</li> <li>• Excludes claims with revenue codes 360, 361, 369 or 762 (These are claims for ER visits that included observation and/or outpatient OR procedures)</li> </ul> <p>Stratify ER claims by level, based on CPT-4 evaluation and management or critical care code:</p> <p>Level 1 – 99281            Level 2 – 99282            Level 3 – 99283            Level 4 – 99284            Level 5 – 99285 or 99291 or 99292</p> <p>Calculate and report 50<sup>th</sup> percentile allowed amount for the entire claim, by level and by DOI region and statewide.</p>

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

Payment Methodology	Data Selection Criteria
<p>a. 50<sup>th</sup> percentile allowed amount for each high-cost service, by DOI region. If the volume is below the threshold of 30, use</p> <p>b. The 50<sup>th</sup> percentile for each high-cost service for the state.</p>	<p>Select claims for emergency room visits that are <u>outpatient</u> services, with specified revenue codes (450, 451, 452 or 459) and CPT-4 emergency services evaluation and management (E&amp;M) codes, CPT-4 99281-99285, 99291 or 99292.</p> <p>Claims for ER visits must also satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> </ul> <p>Calculate and report 50<sup>th</sup> percentile allowed amount for claim lines that satisfy the following criteria:</p> <ul style="list-style-type: none"> <li>• Implants - Identified by revenue code (274, 275 or 278) and reported by CPT-4 code. Include only claim lines where allowed amount &gt; \$0. Report allowed amount per unit.</li> <li>• 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 &gt; \$0.</li> <li>• Nuclear Medicine - Identified by revenue code (340-343) and reported by CPT-4 procedure code. Include claim lines where allowed amount &gt; \$0. Report allowed amount per unit.</li> <li>• Cardiac Catheterization - Identified by revenue code (481) and reported by CPT-4 procedure code. Include claim lines where allowed amount &gt; \$0.</li> <li>• High Cost Drug – Identified by revenue code (636, 252) and reported by CPT-4 procedure code. Include claim lines where allowed amount &gt; \$0. Report allowed amount per unit.</li> <li>• Trauma Activation – Identified by revenue code, each describing an activation level (681-684, 689) and include claim lines where allowed amount &gt; \$0.</li> </ul> <p>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.</p>

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

Payment Methodology	Data Selection Criteria
<p>a. The 50<sup>th</sup> percentile allowed amount for each observation stay case rate level, by DOI region. If the volume is below the threshold of 30 claims, use</p> <p>b. The 50<sup>th</sup> percentile allowed amount for each observation stay case rate level for the state.</p>	<p>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&amp;M) codes, CPT-4 99281-99285, 99291 or 99292.</p> <p>Claims for observation stays must also satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> <li>• 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)</li> <li>• Excludes claims with revenue codes 360, 361, 369 (These are claims for ER visits that included an outpatient OR procedure)</li> <li>• Allowed amount &gt; \$0</li> </ul> <p>Stratify observation claims by level, based on CPT-4 evaluation and management or critical care code:</p> <p>Level 1 – 99281            Level 2 – 99282            Level 3 – 99283            Level 4 – 99284            Level 5 – 99285 or 99291 or 99292</p> <p>Calculate and report 50<sup>th</sup> percentile allowed amount for the entire claim, by level and by DOI region and statewide.</p>

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

Payment Methodology	Data Selection Criteria
<p>a. The 50<sup>th</sup> percentile allowed amount for each outpatient OR case, by DOI region. If the volume is below the threshold of 30 claims, use</p> <p>b. The 50<sup>th</sup> percentile allowed amount for each outpatient OR case for the state.</p>	<p>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&amp;M) codes, CPT-4 99281-99285, 99291 or 99292.</p> <p>Claims for outpatient OR procedures must also satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> <li>• 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)</li> <li>• Allowed amount &gt; \$0</li> </ul> <p>Calculate and report 50<sup>th</sup> percentile allowed amount for the entire claim, by surgical CPT-4 procedure code and by DOI region and statewide.</p>

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

Payment Methodology	Data Selection Criteria
<p>a. 50th percentile of allowed amount by MS-DRG in the same DOI region for direct admissions from an ER to an in-network facility to determine payment for admissions from an out-of-network ER. If the volume of claims by MS-DRG in the same geographic region below the threshold, use</p> <p>b. The 50th percentile for the state.</p>	<p>Select inpatient facility claims that satisfy these criteria:</p> <ul style="list-style-type: none"> <li>• Commercial claims</li> <li>• Service date in calendar year 2021</li> <li>• Claims where carrier was primary payer</li> <li>• Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts</li> <li>• Network status is in-network</li> <li>• Discharge from acute care hospital following direct admission from the ER</li> </ul> <p>Report volume and 50<sup>th</sup> percentile allowed amount for acute care hospital discharges for each MS-DRG, by DOI region and statewide.</p>