CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

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

COVID-19 Fee Schedule

Jan 2020 – Jun 2021 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 addresses out-of-network COVID-related services that apply to the 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..."

A separate fee schedule with COVID-19 specific claims was added in light of the COVID-19 pandemic.

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 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 50th percentile payment amounts from the CO APCD for COVID-related services, several methodological questions and challenges had to be resolved with the release of the data sets provided. Here is a list of the issues and their resolution that have been used in the COVID-19 data files.

Methodological Question or Challenge	Resolution
1. Because **COVID-19** related fees are covered under an emergency order, should the fee schedules be integrated with the standard fee schedules?	CIVHC determined that it was most appropriate to release the COVID-19 fees as a separate schedule because of several elements in the Emergency Regulation that differ from the typical HB 19-1174 Out-of-Network legislation, and therefore impact the methodology. Primarily, the applicable timeframe is different. The regular out-of-network fee schedules that CIVHC produces on an annual basis apply to reimbursement for services incurred during the following calendar year. In contrast, the COVID fee schedules are meant to apply retroactively to reimbursement for services incurred during the COVID-19 emergency. Additionally, some of the COVID-related services that required CIVHC to produce a fee schedule do not apply to the typical methodology. For example, some COVID services require reimbursement to facilities in non-emergent scenarios. Non-emergent reimbursement to out-of-network facilities is not covered under the HB 19-1174 bill. These methodological distinctions led CIVHC to separate the COVID-related services from the regular updates of the fee schedule.
2. What timeframe should be used?	CIVHC used COVID-related claims that were submitted to the CO APCD during calendar year 2020 through June 2021 to obtain at least a full twelve months of data during the emergency regulation. This provided a higher volume of claims, allowing for more accurate region-specific reimbursement amounts to be established. **This differs from the methodology included in the regular updates of the out-of-network fee schedules, which requires only the prior calendar year of data to be included in the selection criteria.**

3. The emergency regulation concerning the **COVID-19** pandemic considers services associated with **COVID as an emergency service**.	CIVHC calculated all COVID-related claims as the 50th percentile rate of reimbursement rather than the 60th percentile rate of reimbursement due to the designation of "emergency" in the regulation. The HB 19-1174 bill requires that emergency services be reimbursed at the 50th percentile rate of reimbursement.

4. What considerations should be taken when determining the **COVID-19** treatment and testing methodology?	After collecting sufficient runout of COVID-19 claims in the CO APCD, CIVHC reviewed the data and determined that COVID treatment and testing should be separated into different fee schedules. See the appendix for more specific methodology.
	
	• **Testing** is split between professional testing and outpatient facility testing.
	  • ***Professional testing*** includes any COVID test billed on a professional claim. CIVHC did not find substantial differences on professional claims for reimbursement rates in facility settings vs non-facility settings, so all commercial professional COVID testing claims were included in the selection criteria.
	  • ***Facility testing*** includes any COVID test billed on a non-emergent facility claim. Emergency facility claims are excluded, as the testing is already included in the emergency fee schedules.
	• **Treatment** is split between outpatient treatment and inpatient treatment associated with COVID-19. Treatment billed on a professional claim is already incorporated into the professional fee schedule that is produced on an annual basis.
	  • ***Outpatient treatment*** includes non-emergent outpatient facility claims associated with COVID treatment (principal diagnosis code of U071). Emergency outpatient claims are excluded, as the treatment is already included in the emergency fee schedules.
	  • ***Inpatient treatment*** includes non-emergent inpatient facility claims associated COVID treatment (principal diagnosis code of U071) with MS-DRG codes that are regularly billed for COVID treatment in inpatient settings. Inpatient claims that originated in the emergency room are excluded, as the treatment is already included in the emergency fee schedules.

Overview of CO APCD Data Sets of Allowed Amounts

Data sets for COVID services are provided on the Division of Insurance website in an Excel file specifying the 50th percentile for COVID testing and treatment.

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 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 Excel file, C. 2020-2021 CO APCD 50th Percentile Allowed Amount for COVID Services, includes data sets that address four different types of services:

- COVID testing on a professional claim,
- COVID testing on a facility claim,
- COVID treatment billed by an outpatient facility, and
- COVID treatment billed by an inpatient facility.

Validation of Data Sets

Prior to preparing the COVID-19 data sets to support HB 19-1174, CIVHC spent several months evaluating and analyzing CO APCD in- and out-of-network services, particularly provider services.

CIVHC analyzed CO APCD data to identify potential methodological nuances in calculating the 50th 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 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.
- Feedback from both the payer and provider community was incorporated into the methodology when appropriate. CIVHC distributed several methodological documents to stakeholders to seek input on approaches to the fee schedule, to ensure the established fee schedules would be both appropriate and feasible to incorporate into carrier systems.

Key Considerations about Data Sets

- Data sets with calculated 50th 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.
- The 50th percentile allowed amounts reported for some services may differ significantly by DOI region. In many instances, the 50th 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.
- Note that the underlying data used to produce the COVID-related fee schedules is inclusive of testing and treatment billed on a commercial, in-network claim adjudicated and submitted by current CO APCD submitters. CIVHC recognizes that some COVID testing and treatment in Colorado was not billed through health insurance during the COVID emergency.
- 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 were therefore not included due to lack of sufficient statewide claim volume.

Appendix 1 – Detailed Methodology

COVID-19 Facility Testing

Payment Methodology	Data Selection Criteria
For COVID-19 facility testing 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 50th percentile in-network allowed amount **per unit** for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile in-network statewide allowed amount **per unit**. **For all other COVID-19 testing facility procedure codes, report:** • The 50th percentile in-network allowed amount for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile in-network statewide allowed amounts	Select COVID-19 testing facility claims that satisfy these criteria: • Commercial claims • Service date in January 2020 – June 2021 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Non-emergent Report 50th percentile allowed amount by region and procedure code + 1 modifier. Report statewide amount when regional volume falls below the 30 claims threshold.

COVID-19 Professional Testing

Payment Methodology	Data Selection Criteria
For COVID-19 professional testing 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 50th percentile in-network allowed amount **per unit** for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile in-network statewide allowed amounts **per unit**. **For all other COVID-19 testing professional procedure codes, report:** • The 50th percentile in-network allowed amount for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile in-network statewide allowed amount.	Select COVID-19 testing professional claims that satisfy these criteria: • Commercial claims • Service date in January 2020 – June 2021 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Non-emergent Report 50th percentile allowed amount by region and procedure code + 1 modifier. Report statewide amount when regional volume falls below the 30 claims threshold.

COVID-19 Outpatient Treatment

Payment Methodology	Data Selection Criteria
For COVID-19 outpatient treatment 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 50th percentile in-network allowed amount **per unit** for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile statewide in-network allowed amount **per unit**. **For all other COVID-19 outpatient treatment procedure codes, report:** • The 50th percentile in-network allowed amount for procedure code + 1 modifier in the same geographic (DOI) region. • **If the volume is below the threshold of 30 claims,** use the 50th percentile statewide in-network allowed amount.	Select COVID-19 outpatient treatment claims that satisfy these criteria: • Commercial claims • Service date in January 2020 – June 2021 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • Non-emergent • Principal diagnosis code of COVID-19 Report 50th percentile allowed amount by region and procedure code + 1 modifier. Report statewide amount when regional volume falls below the 30 claims threshold.

COVID-19 Inpatient Treatment

Payment Methodology	Data Selection Criteria
For MS-DRGs for COVID-related treatment in an inpatient setting, calculate the 50th percentile allowed amount by DOI region. **If the volume of claims by MS-DRG in the same geographic region is below the 30 claims threshold,** use the statewide 50th percentile.	Select inpatient facility claims that satisfy these criteria: • Commercial claims • Service date in January 2020 – June 2021 • Claims where carrier was primary payer • Fee-for-service claims, not capitation encounters with fee-for-service equivalent amounts • Network status is in-network • MS DRG is related to COVID-treatment (177, 178, 179, 207, 208) Report 50th percentile allowed amount by region and MS-DRG. Report statewide amount when regional volume falls below the 30 claims threshold.