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CO APCD Calculated Allowed Amounts to Support Implementation of House Bill 19-1174 October 2020 Update

The purpose of this document is to describe data sets from the Colorado APCD that were produced to support out-of-network legislation, HB 19-1174. **This document has been revised to describe the impact of re-issuing a portion of procedure codes to reflect per-unit allowed amounts.**

A portion (17%) of professional CPT-4 procedure codes (not including those for anesthesia services) are paid based on time units or number of services. In the out-of-network fee schedules, CIVHC provided a 60th percentile payment for these services when they occur in-network, but not the 60th percentile payment per unit. This also affects a small number of emergency facility HCPCS codes. As a consequence, the fee schedule for these services and resulting payments, when they occur out-of-network, will be different than the initial fee schedule CIVHC issued to support the surprise billing legislation for calendar year 2020. Depending on the procedure code and the units billed for the service, the resulting total amount paid will be either higher or lower than what was originally reflected in the fee schedule. Based on CIVHC's estimates, most procedure code changes will result in lower payments to providers when the updated fee schedule is used to calculate these reimbursements.

Introduction

Colorado HB 19-1174 specifies payment for out-of-network health care services. The bill includes language about payment 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 Colorado All Payer Claims Database (CO APCD) as one of several sources of information for determining payment:

- 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 2)

Methodological Challenges

To calculate the 60th or 50th percentile payment amounts from the CO APCD, several methodological questions and challenges had to be resolved. Here is a list of the issues and their resolution.

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.
2. What is the definition of **rate of reimbursement**?	Rate of reimbursement equals CO APCD allowed amount, which is the combination of the amount the plan/payer and member pays.
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 will be 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?	Use statewide allowed amount, when the statewide claim volume is 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 provider CPT-4 procedure codes, excluding anesthesia CPT-4 codes, have zero or one modifier. As a consequence, CPT-4 + the first modifier is used to define provider services, with the exception of anesthesia services, which require 2 modifiers.
7. Claims for provider **anesthesia services** often have very low volumes and inconsistent definition of time unit values.	Adopt 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. Calculate 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. 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 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.
9. 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.
10. 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 will develop a separate method for calculating the reimbursement rate for out-of-network ambulance services that will not rely on data from the CO APCD.

Overview of CO APCD Data Sets of Allowed Amounts

Data sets specifying: a) the 60th percentile allowed amount for services delivered by out-of-network providers in in-network facilities and b) the 50th percentile for emergency services at an out-of-network facility are provided in the two attached Excel files. The detailed methodology used to create each of these data sets is presented in Appendix 2.

Please note that, in the data sets, the DOI region number maps 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

Also, 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 is less than 30.

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

1. Professional Services, excl. 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 the changes 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 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 2.

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 and also 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 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 is displayed for each type of imaging 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 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. 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 50th and 60th percentile allowed amounts and both proposed

solutions and sought input from the DOI and from payer and provider stakeholders.

The creation of the data sets described in this document was 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.

A portion (17%) of professional CPT-4 procedure codes (not including those for anesthesia services) are paid based on time units or number of services. In the out-of-network fee schedules, CIVHC provided a 60th percentile payment for these services when they occur in-network, but not the 60th percentile payment per unit. This also affects a small number of emergency facility HCPCS codes. CIVHC is re-issuing all data sets to reflect the per unit fees for affected codes.

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.

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

Key Messages about Data Sets

- The re-issued per-unit data sets are based on paid claims through June 2020; the original data flat fee sets were based on paid claims through August 2019. The updated data in the CO APCD would have had some, but not a large impact on claims for services incurred in 2018, which are used to calculate the fee schedules for out-of-network services.
- The data sets with calculated 50th or 60th percentile allowed amounts were created empirically, based on the data resident in the CO APCD.

  Routine data validation is conducted each time payers submit data to ensure a level of data quality in the CO APCD. However, there were three instances where the data validation process did not uncover problems – problems that produced unexpected results in a few datasets.

  One instance involved anesthesia claims, which were submitted by some payers with consistently recorded time unit values of 1, regardless of the procedure. These data were considered invalid and were removed from the data before calculating anesthesia conversion factors.

  Another instance involved professional services that are reimbursed per unit. Again, some payers consistently reported unit values of 1 regardless of the procedure. Claims for these payers were removed from the data before calculating 60th percentile allowed amounts for these services.

  The last instance involved emergency services carve-outs for high-cost drugs, nuclear medicine, implants. Again, some payers consistently reported unit values of 1, which produced some outlier allowed amount values. Claims for high-cost drugs, nuclear medicine, and implants for these payers were removed from the data before calculating 50th percentile allowed amounts for these services.

- The 50th or 60th percentile allowed amounts reported for some services, particularly emergency services 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 could not be attributed to invalid data.
- As noted above, the provider and emergency services included 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 will not be included.

Appendix 1 – Summary of Changes in CO APCD Out-of-Network Fee Schedules Following Re-Issue of Per Unit Fees

The following table summarizes the impact of changes in out-of-network fee schedules that were produced from the CO APCD after re-issuing fees for several procedures to reflect per-unit costs. Claims from payers that submit invalid, hard-coded unit values of "1" are excluded from the re-issued fees. In addition to methodological changes for the affected codes, the new data sets are now based on CO APCD data that includes ten additional months of claims runout for services incurred in 2018.

For most procedures that have been updated to reflect per-unit costs, the per-unit fee will be less than the flat fee reported in the previous fee schedule. For a small number of the re-issued procedure codes the fee increased due to the additional runout and payer exclusions described above.

Data Set / Fee Schedule	Scope of Change	Changes in Suppression	Loss of Services Due to Drop in Volume to < 30
Professional (Excluding Anesthesia Services)	323 CPT-4 + modifier combinations re-issued to reflect per-unit allowed amounts (17% of total professional procedure codes from previously-issued fee schedule)	Fees for 56 CPT-4 + modifier + DOI region combinations were suppressed and were replaced with fees for CPT- 4 + modifier + state	4 CPT-4 + modifier combinations no longer have enough statewide volume to report
Professional - Anesthesia	N/A	N/A	N/A

Data Set / Fee Schedule	Scope of Change	Changes in Suppression	Loss of Services Due to Drop in Volume to < 30
ER Case Rates	N/A	N/A	N/A
ER Carve-Out: Implants	N/A	N/A	N/A
ER Carve-Out: Advanced Imaging	N/A	N/A	N/A
ER Carve-Out: Nuclear Medicine	All procedure codes re-issued to reflect per-unit allowed amounts, resulting in fee decreases for 4 out of 7 codes	None	None
ER Carve-Out: Cardiac Catheterization	N/A	N/A	N/A
ER Carve-Out: High Cost Drugs	N/A	N/A	N/A
ER Carve-Out: Trauma Activation	N/A	N/A	N/A
Observation Case Rates	N/A	N/A	N/A
OR Case Rates	N/A	N/A	N/A
Admits from the ED	N/A	N/A	N/A

Appendix 2 – 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 HCPC 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: a. 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 b. The 60th percentile of in-network allowed amounts **per unit** for the state. For all other professional procedure codes, report: c. 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 d. The 60th percentile of in-network allowed amounts for the state.	Select professional claims that satisfy these criteria: • Commercial claims • Service date in calendar year 2018 • 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." 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
Cannot use CO APCD to report 60th 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. 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 2018 • 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. 3. Exclude data for payers that consistently reported time unit values of "1" across anesthesia procedures 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 2018; 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
a. The 50th percentile allowed amount for each emergency room case rate level, by DOI region. If the volume is below the threshold of 30 claims, use b. The 50th percentile allowed amount for each emergency room case rate level for the state.	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 2018 • 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
a. 50th percentile allowed amount for each high-cost service, by DOI region. If the volume is below the threshold of 30, use b. The 50th percentile for each high-cost service for the state.	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 2018 • 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.

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

Payment Methodology	Data Selection Criteria
a. The 50th percentile allowed amount for each observation stay case rate level, by DOI region. If the volume is below the threshold of 30 claims, use b. The 50th percentile allowed amount for each observation stay case rate level for the state.	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 2018 • 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
a. The 50th percentile allowed amount for each outpatient OR case, by DOI region. If the volume is below the threshold of 30 claims, use b. The 50th percentile allowed amount for each outpatient OR case for the state.	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 2018 • 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
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 b. The 50th percentile for the state.	Select inpatient facility claims that satisfy these criteria: • Commercial claims • Service date in calendar year 2018 • 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.