

Institutional Relations

# Claims Pricing Manual

for Institutional Providers



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## Reimbursement Information

Blue Cross and Blue Shield of Kansas (BCBSKS) provides policy documents that include both inpatient and outpatient Maximum Allowable Payment (MAP) schedules to the hospital CEO and CFO in July as part of the upcoming year's contract. Contact your hospital CEO or CFO if you do not have access to these documents.

In all reimbursement methods, the contracting provider is required to write-off all charges in excess of MAPs for covered services. Members will be responsible for any deductible, coinsurance and shared payment. All payments shall be made based on the allowance in effect as of the date the services were provided, not based on when the Contracting Provider billed for the services.

Charges for services that are determined to be not medically necessary (NMN) or experimental/investigational (E/I) will be deducted from the total charge before making final payment. These charges will be denied as provider write-off, unless a Limited Patient Waiver (LPW) signed by the member is obtained before services being provided to the BCBSKS member. Charges for services that are excluded from coverage in the member contract are considered member responsibility.

Providers are advised to refer to their individual provider contract and payment attachment to determine the specific guidelines and MAP applicable under their provider contract.

## Quality-Based Reimbursement Program

The Quality-Based Reimbursement Program (QBRP) offers providers an opportunity to earn increased reimbursement incentives. QBRP incentives are applied to both inpatient and outpatient MAP allowable excluding pharmacy or when billed charge is less than the MAP. Refer to the QBRP Brochure for complete details.

**IMPORTANT NOTE:** For training purposes, the QBRP incentives calculated for the claim examples in this document are presented as a lump sum. BCBSKS claims processing system applies each individual incentive earned separately to each qualifying claim line. The QBRP information enclosed illustrates how the QBRP percentage/payment is accurately determined by BCBSKS for each claim.

## BCBSKS Inpatient Claims

### Pricing an Inpatient BCBSKS Claim

The MS-DRG assigned to a claim is noted on the provider's paid Remittance Advice (RA).

### Additional Information on Inpatient Claims

Inpatient claims must reflect charges incurred from admission through discharge. Reimbursement will be based on the MS-DRG assigned to the complete stay.

An interim bill may be submitted to BCBSKS for an inpatient stay exceeding 30 days and at 30-day intervals thereafter. Interim payments will be estimated with final payment based on

the MS-DRG assigned for the entire admission. Final adjudication will be based on the appropriate MS-DRG for the entire admission. Final bill submission should include statement period from date of admission to date of discharge and with Type of Bill (TOB) XX4.

## Inpatient MS-DRG MAP Listing

*EXAMPLE ONLY*

DRG Code	DRG Description	2017 Map	Low Trim Days	High Trim Days
0003	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	\$111,595.88	1	29
0004	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	\$63,315.26	1	29
0020	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	\$55,083.86	1	9
0021	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	\$41,743.28	1	13
0022	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	\$32,179.45	1	9
0023	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPLANT	\$30,883.20	1	9
0024	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	\$21,853.75	1	6
0025	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	\$26,917.66	1	9
0026	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	\$17,507.62	1	10
0027	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	\$13,314.90	1	3
0028	SPINAL PROCEDURES W MCC	\$31,483.49	1	6
0029	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	\$18,888.24	1	7
0030	SPINAL PROCEDURES W/O CC/MCC	\$11,735.61	1	3
0031	VENTRICULAR SHUNT PROCEDURES W MCC	\$24,205.90	1	9
0032	VENTRICULAR SHUNT PROCEDURES W CC	\$11,857.06	1	9
0033	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	\$9,101.79	1	9
0034	CAROTID ARTERY STENT PROCEDURE W MCC	\$21,589.48	1	6
0035	CAROTID ARTERY STENT PROCEDURE W CC	\$12,897.80	1	6
0036	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	\$10,099.94	1	4
0037	EXTRACRANIAL PROCEDURES W MCC	\$18,352.34	1	6
0038	EXTRACRANIAL PROCEDURES W CC	\$9,673.55	1	6
0039	EXTRACRANIAL PROCEDURES W/O CC/MCC	\$8,434.65	1	6
0040	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	\$22,144.85	1	5
0041	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	\$12,406.60	1	5
0042	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	\$10,842.57	1	5
0052	SPINAL DISORDERS & INJURIES W CC/MCC	\$10,461.15	1	7
0053	SPINAL DISORDERS & INJURIES W/O CC/MCC	\$7,923.36	1	6

## Inpatient Claim Examples

### Inpatient Admission – CAP

Admission/Discharge Date:	6/4/23 – 6/7/23 (3 days)
Contract Type:	CAP
MS-DRG Assigned:	0036
MS-DRG MAP:	\$10,099.94
Total Charge:	\$11,500.00
QBRP:	3.75%
Incentive Rate (if applicable):	21.00%
High Trim Days:	4
Per Diem Add-on for Days Above High Trim:	Not Applicable

The calculation is as follows:

#### Step 1 – Calculate QBRP Rate

• MS-DRG MAP	\$10,099.94
• QBRP (3.75 percent plus 1 to include the MS-DRG MAP)	<u>x 1.0375</u>
• QBRP Rate	\$10,478.69

#### Step 2 – Calculate Inpatient Incentive

• Claim's Total Charge	\$11,500.00
• QBRP Rate	<u>-\$10,478.69</u>
	\$1,021.31
• Inpatient Incentive (21%)	<u>x .21</u>
• Total Inpatient Incentive	\$214.48

#### Step 3 – Calculate Contractual Discount

No CAP contractual discount since the MS-DRG is MAP'd

#### Step 4 – Calculate CAP MAP

• QBRP Rate	\$10,478.69
• Total Inpatient Incentive	<u>+ \$214.48</u>
• New MS-DRG Allowable	<b>\$10,693.17</b>

**Inpatient Admission – CAP – Length of Stay Exceeds High Trim Days**

Admission/Discharge Date:	6/4/23 – 6/14/23 (10 days)
Contract Type:	CAP
MS-DRG Assigned:	0036
MS-DRG MAP:	\$10,099.94
Total Charge:	\$55,500.00
QBRP:	3.75%
Incentive Rate (if applicable):	21.00%
High Trim Days:	4
Per Diem Add-on for Days Above High Trim:	
• Days of Admission	10
• High trim days	<u>-4</u>
• Days above high trim	6

To determine the per diem add-on, divide the MS-DRG by the number of high trim days assigned to this MS-DRG. In this example:

Step 1 – Determine daily per diem rate

• MS-DRG MAP	\$10,099.94
• High trim days	<u>÷ 4.00</u>
• This is the daily per diem add-on.	\$2,524.99

Step 2 – The total per diem add-on

• Number of days above high trim	<u>x 6.00</u>
• Total Per Diem Add-on	\$15,149.94

Step 3 – Determine New MS-DRG MAP

• MS-DRG MAP	\$10,099.94
• Per Diem Add-on	<u>+ \$15,149.94</u>
• New MS-DRG MAP	\$25,249.88

Step 4 – Calculate QBRP

• New MS-DRG MAP	\$25,249.88
• QBRP (3.75%)	<u>+ \$946.87</u>
• QBRP Rate	\$26,198.75

Step 5 – Calculate Inpatient Incentive

• Claim's Total Charge	\$55,500.00
• QBRP Rate	<u>- \$26,198.75</u>
• Inpatient Incentive Figure	\$29,301.25
• Inpatient Incentive (21.00%)	<u>x .21</u>
• Total Inpatient Incentive	\$6,153.26

Step 6 – Calculate Contractual Discount

No CAP contractual discount since the MS-DRG is MAP'd

Step 7 – Calculate Final MS-DRG MAP

• New MS-DRG MAP plus QBRP incentive	26,198.75
• Total Inpatient Incentive	<u>+ \$6,153.26</u>
• New MS-DRG allowable	<b>\$32,352.01</b>

## Inpatient Admission – Blue Choice

Admission/Discharge Date:	6/4/23 – 6/7/23 (3 days)
Contract Type:	Blue Choice (BC)
MS-DRG Assigned:	0036
MS-DRG MAP:	\$10,099.94
Total Charge:	\$11,500.00
QBRP:	3.75%
Incentive Rate (if applicable):	21.00%
High Trim Days:	4
Per Diem Add-on for Days Above High Trim:	Not Applicable

The calculation is as follows:

### Step 1 – Calculate QBRP Incentive

• MS-DRG MAP	\$10,099.94
• QBRP (3.75%)	<u>x 0.0375</u>
• Total QBRP Rate	\$378.75

### Step 2 – Calculate New MS-DRG MAP

• Total MS-DRG MAP	\$10,099.94
• Total QBRP Rate	<u>+ \$378.75</u>
• New MS-DRG MAP	\$10,478.69

### Step 3 – Calculate Inpatient Incentive

• MS-DRG MAP plus QBRP incentive	\$10,478.69
• Inpatient Incentive (21.00%)	<u>x .21</u>
• Total Inpatient Incentive	\$2,200.52

### Step 4 – Calculate Contractual Discount

• MS-DRG MAP plus QBRP Incentive	\$10,478.69
• Blue Choice Discount (5.00%)	<u>x .05</u>
• Total Blue Choice Discount	\$523.93

### Step 5 – Calculate MS-DRG minus Blue Choice Discount

• MS-DRG MAP plus QBRP Incentive	\$10,478.69
• Total Blue Choice Discount	<u>\$523.93</u>
• MS-DRG MAP plus QBRP Incentive minus Discount	\$9,954.76

### Step 6 – Calculate New Blue Choice MAP

• MS-DRG MAP plus QBRP Incentive minus Discount	\$9,954.76
• Total Inpatient Incentive	<u>+ 2,200.52</u>
• New MS-DRG allowable	<b>\$12,155.28</b>

### Inpatient Admission – Blue Choice – Length of Stay Exceeds High Trim Days

Admission/Discharge Date:	6/4/23 – 6/14/23 (10 days)
Contract Type:	CAP
MS-DRG Assigned:	0036
MS-DRG MAP:	\$10,099.94
Total Charge:	\$55,500.00
QBRP:	3.75%
Incentive Rate (if applicable):	21.00%
High Trim Days:	4
Per Diem Add-on for Days Above High Trim:	
• Days of Admission	10
• High trim days	<u>-4</u>
• Days above high trim	6

To determine the per diem add-on, divide the MS-DRG by the number of high trim days assigned to this MS-DRG. In this example:

Step 1 – Determine daily per diem rate

• MS-DRG MAP	\$10,099.94
• High trim days	<u>÷ 4.00</u>
• This is the daily per diem add-on.	\$2,524.99

Step 2 -

• The total per diem add-on	\$2,524.99
• Number of days above high trim	<u>x 6.00</u>
• Total Per Diem Add-on	\$15,149.94

Step 2 – Determine New MS-DRG MAP

• MS-DRG MAP	\$10,099.94
• Per Diem Add-on	<u>+\$15,149.94</u>
• New MS-DRG MAP	\$25,249.88

Step 3 – Calculate QBRP

• New MS-DRG MAP	\$25,249.88
• QBRP (3.75%)	<u>+ \$946.87</u>
• New MS-DRG MAP plus QBRP incentive	\$26,198.75

Step 4 – Calculate Inpatient Incentive

• Claim's Total Charge	\$55,500.00
• QBRP Rate	<u>-\$26,198.75</u>
• Inpatient Incentive Figure	\$29,301.25
• Inpatient Incentive (21.00%)	<u>x .21</u>
• Total Inpatient Incentive	\$6,153.26

Step 5 – Calculate Contractual Discount	
• MS-DRG MAP plus QBRP Incentive	\$26,198.75I
• Blue Choice Discount (5.00%)	<u>    x    .05</u>
• Total Blue Choice Discount	\$1,459.94
Step 6 – Calculate new MS-DRG MAP minus Blue Choice Discount	
• MS-DRG MAP plus QBRP Incentive	\$26,198.75
• Total Blue Choice Discount	<u>- \$1,459.94</u>
• New MS-DRG MAP plus QBRP minus Discount	24, 738.81
Step 6 – Calculate Final MS-DRG	
• New MS-DRG MAP plus QBRP incentive minus Discount	\$24,738.81
• Total Inpatient Incentive	<u>+\$6,153.26</u>
• New MS-DRG allowable	<b>\$30,892.07</b>

# BCBSKS Outpatient Claims

## Pricing an Outpatient BCBSKS Claim

BCBSKS prices outpatient claims using one of the following methodologies:

- Claim Level Pricing
- Outpatient Pricing (Line Level Pricing)
- Accident Claim Pricing

Providers should refer to their individual provider contract and Payment Attachment to determine the specific guidelines and MAP applicable under their provider contract.

Review codes reported on the claim to codes on the MAP listing to determine if there are claim level codes reported. Claim level codes are marked with an 'X' in the Claim Level Column on the provider's MAP listing. If there are no claim-level codes on the claim, then the claim will be priced with outpatient reimbursement as outlined.

### Claim Level Pricing

Review codes reported on the claim to codes on the MAP listing to determine if there are claim level and add-on codes reported. These codes are marked with an 'X' on the provider's MAP listing in either the Claim Level or Add-on column.

Payment for outpatient claim level procedures are reimbursed at an all-inclusive rate based on the MAP for the claim level procedure billed. Reimbursement for items and procedures identified on the MAP list as an add-on code will allow charges up to the MAP for the line item, in addition to the MAP'd claim level procedure. Reported codes that are not on the MAP listing or are not considered add-on codes are considered part of the claim level reimbursement.

When multiple claim level codes are reported on the same claim, the allowable is based on the highest MAP'd code plus any add-on allowances.

In the event the MAP listing includes a CPT or HCPCS code that is marked as claim level but no MAP has been assigned, the claim will be reimbursed at the line level; the non-mapped codes will price at non-MAP percent of the provider's billed charge for covered services per the facility contract.

For all claims except Federal Employee Program (FEP), claim level pricing is allocated across each line that is considered part of the claim level service. When claims are priced at the claim level, providers should look at the total amount allowed for the claim, rather than the payment for each line when reviewing the remittance advice. For FEP claims, claim level pricing is reflected on the line on which the claim level code is reported. All lines considered part of the claim level service are provider write off.

## Outpatient Reimbursement – Line Level Pricing

For services to which a MAP has been assigned, the following reimbursement will apply:

- **CAP:** The allowed amount will be the lesser of the provider's billed charge for covered services or the CAP MAP.
- **Blue Choice:** The allowed amount will be the lesser of the charge for covered services or a percent of the CAP MAP.

Except as otherwise stated in the Outpatient Pharmacy section of the Policies and Procedures – for services to which no MAP has been assigned – the following reimbursement will apply:

- **CAP:** The allowed amount will be a percent of the provider's billed charge for covered services.
- **Blue Choice:** The allowed amount will be a percent of the provider's billed charge for covered services.

## Accident Claim Pricing

If services are due to an accident and the outpatient services – which are the result of an accidental injury – occurred on the same date as the accident, then reimbursement will be as follows:

1. When the occurrence code field has a value of 1-6 and the accident date matches the date of service(s) on the claim, then any claim level pricing is bypassed, and the claim is priced at the line-level.
2. Any claim level surgery will price at non-MAP percent of the provider's billed charge for covered services.
3. If Revenue Code 45X or 762 is on the claim, then lab is priced at non-MAP'd percent of the provider's billed charge for those lines. If 45X or 762 is not on the claim, then labs that are MAP'd price at MAP.
4. All other MAP'd codes price at MAP and non-MAP'd codes price at percent of the provider's billed charge for covered services

Outpatient services which are the result of an accidental injury that are not provided on the same date as the accident will process per Claim Level Pricing methodology.

# Outpatient MAP Listing

## EXAMPLE ONLY

Code	Nomenclature	2017 Map	Unit Limit	Add On Code	Claim Level Code	Newly Added Code
0510	CLINIC - GENERAL CLASSIFICATION	\$18.00	1.00			
0683	TRAUMA RESPONSE - LEVEL III	\$200.00	1.00			
0684	TRAUMA RESPONSE - LEVEL IV	\$1.00	1.00			
0762	TREATMENT OR OBSERVATION ROOM - OBSERVATION ROOM	\$700.00	1.00			
0102T	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN, REQUIRING ANES	\$1,500.00			X	
10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTAN	\$650.00			X	
10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTAN	\$1,070.00			X	
10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE	\$850.00			X	
10081	INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED	\$1,300.00			X	
10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE	\$665.00			X	
10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED	\$802.00			X	
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION	\$875.00			X	
10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST	\$638.00			X	
10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION	\$2,500.00			X	
11000	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE	\$150.00		X		
11010	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL AT THE SITE OF AN OPEN FRACTUR	\$150.00		X		
11011	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL AT THE SITE OF AN OPEN FRACTUR	\$150.00		X		
11012	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL AT THE SITE OF AN OPEN FRACTUR	\$150.00		X		
11042	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED);	\$150.00		X		
11043	DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS	\$150.00		X		
11044	DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/O	\$150.00		X		
11045	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED);	\$150.00		X		
11046	DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS	\$150.00		X		
11047	DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/O	\$150.00		X		
11055	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE L	\$200.00			X	
11056	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); 2 TO 4 L	\$75.00			X	
11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THA	\$207.00			X	
11100	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE CLO	\$433.00			X	
11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND INCLUDIN	\$1,200.00			X	
11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESIO	\$65.00			X	
11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESIO	\$65.00			X	
11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESIO	\$65.00			X	

## Outpatient Claim Examples

### Outpatient – CAP

This claim example is for an emergency room visit, including charges for drugs and lab. Because the lab is billed with an ER service the MAP does not apply, and we allow percent of the provider's billed charge.

Contract Type: CAP  
 QBRP: 8.0%  
 Contractual Discount: 0% MAP'd  
 10% Non-Map'd

**NOTE:** Pharmacy services do not qualify for QBRP.

Revenue Code	HCCPS/CPT	Charge	Is there a MAP?	Allowance	
0250	N/A	\$80.22	No, apply Contractual Discount	Charge (10%)	\$80.22 <u>x .10</u> \$8.02
				New allowable	<b>\$72.20</b>
0300	81015	\$15.00	No, because Revenue Code 450 is billed on the same claim. Apply Contractual Discount	Charge (10%)	\$15.00 <u>x .10</u> \$1.50
				New allowable	<b>\$13.50</b>
0450	99281	\$105.00	Yes	MAP Apply QBRP	\$70.00 <u>x .080</u> \$5.60
				New allowable	<b>\$75.60</b>
<b>TOTALS</b>		<b>\$200.22</b>			<b>\$161.30</b>

**Outpatient – Blue Choice (BC)**

This claim example is for an emergency room visit including charges for drugs and lab. Because the lab is billed with an ER service the MAP does not apply, and we allow percent of the provider’s billed charge.

Contract Type: Blue Choice  
 QBRP: 8%  
 Contractual Discount: 5% MAP'd  
15% Non-MAP

**NOTE:** Pharmacy services do not qualify for QBRP.

Revenue Code	HCPCS/ CPT	Charge	Is there a MAP?	Allowance	
0250	N/A	\$80.22	No, apply Contractual Discount	Charge (15%)	\$80.22 <u>x .15</u> \$12.03
				New allowable	<b>\$68.19</b>
0300	81015	\$15.00	No, because Revenue Code 450 is billed on the same claim. Apply Contractual Discount	Charge (15%)	\$15.00 <u>x .15</u> \$2.25
				New allowable	<b>\$12.75</b>
0450	99281	\$105.00	Yes	MAP Apply QBRP	\$70.00 <u>x .080</u> \$5.60
				New allowable Apply BC Discount	\$75.60 <u>x .05</u>
				New allowable	<b>\$71.82</b>
<b>TOTALS</b>		<b>\$200.22</b>			<b>\$152.76</b>

**Revisions:**

04/28/2026	Page 11 – Updated Claim Level Pricing section to reflect current processes
	Page 16 – Revisions section created

Visit us at [bcbsks.com](http://bcbsks.com)



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