Institutional Relations

# Claims Pricing Manual

for Institutional Providers

BlueCross BlueShield Kansas

bcbsks.com

# Contents

# 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. Please 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) program offers providers an opportunity to earn increase reimbursement incentives. Please refer to QBRP Brochure. QBRP incentives are applied to both inpatient and outpatient MAP allowable excluding pharmacy or when billed charge is less than the MAP.

IMPORTANT NOTE: For training purposes, the QBRP incentives calculated for the claim examples in this document are presented as a lump sum. BCBSKS claim processing system applies each individual incentive earned separately to each qualifying claim line. The QBRP information below 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) | x 1.0375 |
| • QBRP Rate | $10,478.69 |

Step 2 – Calculate Inpatient Incentive

| | |
|---|---|
| • Claim's Total Charge | $11,500.00 |
| • QBRP Rate | -$10,478.69 |
| | $1,021.31 |
| • Inpatient Incentive (21%) | x .21 |
| • 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 | + $214.48 |
| • New MS-DRG Allowable | **$10,693.17** |

### 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 | - 4 |
| • 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 | ÷ 4.00 |
| • 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 | x 6.00 |
| • 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 | + $15,149.94 |
| • New MS-DRG MAP | $25,249.88 |

Step 4 – Calculate QBRP

| | |
|---|---|
| • New MS-DRG MAP | $25,249.88 |
| • QBRP (3.75%) | + $946.87 |
| • QBRP Rate | $26,198.75 |

Step 5 – Calculate Inpatient Incentive

| | |
|---|---|
| • Claim's Total Charge | $55,500.00 |
| • QBRP Rate | - $26,198.75 |
| • Inpatient Incentive Figure | $29,301.25 |
| • Inpatient Incentive (21.00%) | x .21 |
| • 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 | + $6,153.26 |
| • New MS-DRG allowable | **$32,352.01** |

**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%) | x 0.0375 |
| • Total QBRP Rate | $378.75 |

Step 2 – Calculate New MS-DRG MAP

| | |
|---|---|
| • Total MS-DRG MAP | $10,099.94 |
| • Total QBRP Rate | + $378.75 |
| • 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%) | x .21 |
| • 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%) | x .05 |
| • 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 | $523.93 |
| • 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 | + 2,200.52 |
| • New MS-DRG allowable | **$12,155.28** |

**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 | - 4 |
| • 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 | ÷ 4.00 |
| • 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 | x 6.00 |
| • 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 | +$15,149.94 |
| • New MS-DRG MAP | $25,249.88 |

Step 3 – Calculate QBRP

| | |
|---|---|
| • New MS-DRG MAP | $25,249.88 |
| • QBRP (3.75%) | + $946.87 |
| • New MS-DRG MAP plus QBRP incentive | $26,198.75 |

Step 4 – Calculate Inpatient Incentive

| | |
|---|---|
| • Claim's Total Charge | $55,500.00 |
| • QBRP Rate | -$26,198.75 |
| • Inpatient Incentive Figure | $29,301.25 |
| • Inpatient Incentive (21.00%) | x .21 |
| • 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%) | x .05 |
| • 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 | - $1,459.94 |
| • 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 | +$6,153.26 |
| • New MS-DRG allowable | **$30,892.07** |

# 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 price with outpatient reimbursement outlined below.

## 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 or "add-on" but no MAP has been assigned; the non-mapped code will price at non-MAP percent of billed charge per the facility contract.

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

### 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<br>(15%)<br><br><br>New allowable | $80.22<br>x .15<br>$12.03<br><br>**$68.19** |
| 0300 | 81015 | $15.00 | No, because Revenue Code 450 is billed on the same claim. Apply Contractual Discount | Charge<br>(15%)<br><br><br>New allowable | $15.00<br>x .15<br>$2.25<br><br>**$12.75** |
| 0450 | 99281 | $105.00 | Yes | MAP<br>Apply QBRP<br><br><br>New allowable<br>Apply BC Discount<br>New allowable | $70.00<br>x .080<br>$5.60<br><br>$75.60<br>x .05<br>**$71.82** |
| **TOTALS** | | **$200.22** | | | **$152.76** |

Visit us at bcbsks.com

BlueCross BlueShield Kansas

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