Outpatient Hospital Capped Fee Schedule ENCOUNTERS Valuation/Pricing Decision Tree
EFFECTIVE - 10/01/2011

Initial Filter – Claim/Encounter Bill type indicates Outpatient Hospital (13X, 14X), Critical Access Hospital (85X), Hospital Clinic (7XX), or Inpatient Hospital Same Day Admission/Discharge or Transfer (Admit and End Date of Service equal and patient status not 30, or death). Claim/Encounter must also be non-Medicare primary, non-I.H.S./638 provider (unless KidsCare) and have dates of service on or after 7/1/2005. Non-Voided lines only.

FAIL

Pass Detail Revenue Code Line Edits – Evaluate each line

PASS

Outpatient Valuation/Pricing Process

Is there a HCPCS procedure present on the Revenue Code Line?

Yes

Are bundling Trigger procedures present on other non-disallowed revenue code lines?

No

Is the revenue code on this line defined as bundled on RF796?

No

Flag Bundling Triggers as either Emergency (99281-99285), Surgery (all other values on RF797) or both. Note – No bundling applies to the Bundling Trigger revenue code lines regardless of the associated revenue code reported. If the Trigger is disallowed it will not be flag for bundling of associated lines.

Yes

Is the revenue code billed for the line 051X?

No

Disallow all line charges with a pricing type of NPY. Note: this will also occur if line billed charges and non-covered charges are equal.

Yes

Take action as specified on the edit worksheet

No

Is the HCPCS procedure present on the Revenue Code Line?

Yes

Are bundling Trigger procedures present on other non-disallowed revenue code lines?

No

Out of State Hospitals - Multiply Allowed Charges by the Statewide OP Cost to Charge Ratio (SCO) from RF618.

In State Hospitals - Multiply Allowed Charges by the Provider Urban or Rural OP Cost to Charge Ratio (UCO or RCO) from PR050.

A

No

Yes

Yes

No

Yes

Is the HCPCS procedure on this line an Observation Bundling Trigger as defined on RFC97?

No

Yes

Are there Observation bundling trigger procedures, as defined on RFC97, present on other non-disallowed lines.

No

Yes

Is the revenue code on this line defined as bundled on RF796?

No

Yes

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Continued on Page 2
Determine if Multiple or Bilateral Surgery applies (is there one HCPCS reported on the claim which is defined as multiple surgery per RF724 or is there a single HCPCS procedure which is defined as multiple surgery per RF724 that has allowed units greater than 1) or is there a modifier '51 and/or '50 present).

Apply multiple surgery-bilateral surgery logic

1. See qualifier above.
2. Identify the primary and secondary surgery (surgeries) as follows:
   • Primary = the procedure with the highest fee of the OP Fee Schedule.
   Multiple units = only the first unit is primary and all other units are secondary.
3. If the procedure is determined to be secondary and there is not a modifier '51 present, systematically apply the '51 modifier to the secondary procedure and/or units.
4. Apply all other modifiers (including modifier '50), and then apply any Provider Type Discounting.

Apply modifier % to the allowed amount calculated in step 9, or apply specified modifier amount in place of the previously calculated allowed.

Is a modifier present with the HCPCS?

Is the modifier % different from 100%, or an amount?

Multiply allowed units by the amount on the fee schedule effective for the claim begin date of service and clean claim date.

Was the line priced from RF126 or RF133?

Is the bundling trigger flagged as Surgery or Both?

Bundle the Revenue Code line as payment type/method of "NPY" with a value of $0.00

Is the procedure code billed with this revenue code line defined as a Bundling exception on RF739?

Determine if Multiple or Bilateral Surgery applies (is there one HCPCS reported on the claim which is defined as multiple surgery per RF724 or is there a single HCPCS procedure which is defined as multiple surgery per RF724 that has allowed units greater than 1) or is there a modifier '50 and/or '51 present).

Was the line priced from RF126 or RF133?

Apply appropriate PGM% from PR050 for the HCPCS code reported and effective on the begin date of service and clean claim date.

Add allowed amounts for all lines together, subtract other insurance payments.
A) Multiply Allowed Charges by SCO
B) Multiply allowed units by OPFS rates
C) Multiple allowed units by OPFS 051X rates
D) Modifier Logic
E) PGM decision
F) Calculate Final Net allowed

Disallowance Edits

<table>
<thead>
<tr>
<th>Table #</th>
<th>Description</th>
<th>How Used in Relation to the Outpatient Hospital Fee Schedule Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL276</td>
<td>OPFS Disallowance Edits</td>
<td>Provides a listing of those edits as noted above, which when failed will result in the disallowance of the affected revenue code line rather than denial of the full claim.</td>
</tr>
<tr>
<td>RFC97</td>
<td>OPFS Observation Bundled Rate Driver</td>
<td>Provides a listing of procedure codes (HCPCS/CPT) which trigger secondary Observation bundling of Outpatient claims.</td>
</tr>
<tr>
<td>RF121</td>
<td>Valid OPFS Procedure Modifiers</td>
<td>Provides a listing of valid modifiers for Outpatient claims, by procedure code (HCPCS/CPT.)</td>
</tr>
<tr>
<td>RF123</td>
<td>Procedure AHCCCS Coverage</td>
<td>Provides procedure code (HCPCS/CPT) coverage information.</td>
</tr>
<tr>
<td>RF126</td>
<td>Procedure OPFS Price</td>
<td>Provides the allowed Outpatient claims fees by procedure code (HCPCS/CPT). Note a blank or $0.00 segment for the procedure effective on the claim date of service and receipt date indicates default to the SCO.</td>
</tr>
<tr>
<td>RF127</td>
<td>Procedure OPFS Codes Indicators and Values</td>
<td>Provides valid procedure codes (HCPCS/CPT) and specific service limit information for Outpatient claims.</td>
</tr>
<tr>
<td>RF133</td>
<td>Procedure OPFS 051X Price</td>
<td>Provides the allowed Outpatient claims fees by procedure code (HCPCS/CPT) when associated with a 051X revenue code line. Note a blank or $0.00 segment for the procedure effective on the claim date of service and receipt date indicates default to RF126.</td>
</tr>
<tr>
<td>RF721</td>
<td>Revenue Codes</td>
<td>Provides a listing of valid Revenue Codes.</td>
</tr>
<tr>
<td>RF723</td>
<td>Limit Override Modifiers</td>
<td>Provides a listing of modifiers, which when billed with any applicable procedure code (HCPCS/CPT) on an Outpatient claim, require exception processing such as override of service limits or override of CCI editing as defined by the associated Action Code.</td>
</tr>
<tr>
<td>RF724</td>
<td>Standard Service Set</td>
<td>Provides a listing of procedure codes (HCPCS/CPT) which are subject to multiple surgical pricing considerations.</td>
</tr>
<tr>
<td>RF739</td>
<td>OPFS Bundled Exception Procedures</td>
<td>Provides a listing of procedure code (HCPCS/CPT) which when billed on an Outpatient claim, require exception processing such as override of bundling for claims qualified under Surgery triggers as defined by the associated Action Code.</td>
</tr>
<tr>
<td>RF773</td>
<td>Revenue Codes to Procedure Codes</td>
<td>Provides a listing of procedure codes (HCPCS/CPT) which can be validly reported for a revenue code on an Outpatient claim.</td>
</tr>
<tr>
<td>RF774</td>
<td>Revenue Codes to Bill Types</td>
<td>Provides valid relationships between revenue codes and type of bill, including coverage information. Also provides information on revenue code to procedure code (HCPCS/CPT) reporting requirements for Outpatient claims.</td>
</tr>
<tr>
<td>RF796</td>
<td>OPFS Bundled Revenue Codes</td>
<td>Provides a listing of Revenue Codes which are subject to OPFS bundling under Surgery or Emergency Room bundling triggers on Outpatient claims.</td>
</tr>
<tr>
<td>RF797</td>
<td>OPFS Bundled Rate Driver</td>
<td>Provides a listing of procedure codes (HCPCS/CPT) which trigger Surgery or Emergency Room bundling of Outpatient claims.</td>
</tr>
</tbody>
</table>