Cost Outlier Payment

Reimbursement Policy ID: RPC.0043.72KF

Recent review date: 03/2024

Next review date: 12/2025

Keystone First Community HealthChoices reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First Community HealthChoices may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes payment of cost outliers for inpatient providers contracted with Keystone First Community HealthChoices. A diagnosis-related group (DRG) qualifies as a cost outlier if the cost of the case exceeds 150% of the hospital's diagnosis-related group (DRG) base payment. The Department will calculate the cost of the case by multiplying the charges indicated on the invoice by the hospital's cost-to-charge ratio.

Exceptions

N/A

Reimbursement Guidelines

Medicaid makes outlier payments to hospitals to help cover significantly higher costs for certain inpatient admissions.

The premium payment (percent above Medicaid) would apply to increase the base rate of the DRG. The Keystone First Community HealthChoices payment is based on this rate. The outlier payment is calculated based on this enhanced contracted base rate."

Definitions

Base rate
Hospital specific values used to determine the DRG outlier costs.

Cost outlier
Inpatient services provided during a single visit that have an extraordinarily high cost as established by Medicaid are therefore eligible for additional payments above and beyond the base of DRGs.

Edit Sources

I. Current Procedural Terminology (CPT)
II. Healthcare Common Procedure Coding System (HCPCS),
III. International Classification, 10th revision, Clinical Modification (ICD-10-CM), and associated publications and services.
IV. Centers for Medicare and Medicaid Services (CMS), https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf
V. https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1163/s1163.56.html&d=reduce

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Policy Implemented by Keystone First Community HealthChoices
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section