Department:	BPO Operations	**Original Approval:**	05/24/2018
Policy No:	OP647	**Last Approval:**	10/18/2023
Policy Title:	Pricing (Default, By Report, and Non-Covered Codes) Policy		
Approved By:	Donna Arcieri, VP BPO Operations		
Dependencies:	Manual Pricing Desk Procedure - OP648 Custom Fee Schedule Procedure - OP600		

Purpose

This explains the Community Health Plan of Washington (CHPW) pricing policies for all lines of business. CHPW's BPO Operations department publishes this policy on the CHPW and CHPW Medicare Advantage external websites so that providers can easily access this information.

Policy

CHPW shall process and adjust all claims in accordance with the following, in order:

1. All federal and state laws;
2. CHPW provider contracts;
3. Rules defined and published by the Centers for Medicare & Medicaid Services (CMS), the Washington State Health Care Authority (HCA), and the Office of the Insurance Commissioner (OIC);
4. Nationally recognized coding standards and National Correct Coding Initiative (NCCI) payment system edits;
5. CHPW established policies; and
6. Health insurance industry standard best practices.

For Cascade Select, CHPW shall follow CMS billing rules and guidelines; in the absence of a relevant CMS rule or guideline, CHPW Cascade Select benefit plans follow HCA billing guidelines.

CHPW's default pricing policy is as follows: CHPW shall pay up to the provider's cost for durable medical equipment (DME), blood and blood products, and by report (BR) pricing for all lines of business. If no other options are available for BR pricing, CHPW shall follow the "By Report Pricing" section of this policy.

CHPW shall require that providers send us an itemization or invoice when billing for DME, blood and blood products, and by report (unlisted) procedure codes. In addition, CHPW shall require an invoice, manufacturer's suggested retail price (MSRP), or comparable code as follows:

- Any service identified as “by report” or “BR.”
- Any service identified as “acquisition cost” or “AC.”
- Any unlisted or miscellaneous CPT or HCPCS code.
- Durable medical equipment.
- A comparable standard code is required for unlisted and miscellaneous codes.

A valid invoice is one that is dated prior to or on the date of service. CHPW shall not accept an invoice dated after the service date. Upon receipt of an itemization or invoice for the above services and codes, CHPW shall allow up to the provider’s cost for these items/services, including for providers who are on a contract that allows more than 100% of Medicaid rates.

Claims that do not have an invoice, MSRP, or comparable code shall deny using message code, “Invoice or MSRP required for acquisition cost.” If unable to obtain pricing otherwise, CHPW shall apply the default pricing specified in this policy as a last resort on a case-by-case basis, upon CHPW management approval.

Default Pricing

CHPW shall pay the following:

- 100% of invoice for services that are “by report” or “BR”
- 100% of invoice for services that are “acquisition cost” or “AC”

  Note:
  CHPW shall pay the ***original*** acquisition cost (purchase price), not replacement cost (for example, if the provider depletes a stored item).
- 85% of MSRP for DME/supplies for purchase
- 85% of monthly rental cost for DME

DME

For specific DME codes, such as K0108 (miscellaneous wheelchair parts), CHPW must verify the MSRP in order to provide pricing. For other DME items, CHPW uses the actual MSRP if available; if not, CHPW will deny the claim invoice for MSRP required for acquisition cost.

The MSRP may be included in the X12 electronic claim transaction, or with the paper claim (for example, an invoice is attached), or in the authorization documents in Jiva (the care management system for authorizations and referrals).

By Report Pricing

Most medical services are included in a standard fee schedule. However, some services are not included in a standard fee schedule because they are unique. Procedures for such services are “by report” or “BR,” meaning the provider must submit a written report to justify the services.

CHPW shall price based on invoice, MSRP, and/or comparable code for BR. If none of these options are available for a procedure or supply that is listed as BR, or if the code is not covered in any fee schedule, CHPW shall use the following default pricing at a percent of billed.

Medical services	50%
Surgical services	45%
Radiology services	45%
Lab services	40%
DME	85% of the billed amount for DME/supplies for purchase 85% of the billed amount of the monthly rental cost

BR codes are set up in the claims processing system with the default percentages according to service. The BR pricing in the above table is applied to codes that have no pricing, but are payable due to prior authorization. CHPW does not compare this pricing with Medicare's relative value units (RVUs) or use Medicaid's facility/hospital conversion factor (rate). Acquisition cost does not apply as CHPW uses the invoice to price.

Non-Covered Codes Pricing

If a procedure code is not on a CHPW custom fee schedule or on the Medicaid or Medicare fee schedule (as appropriate for the line of business), claims shall deny as not covered unless:

- The service was approved in error; or
- CHPW had a single case agreement with the provider or another exception to the rule (ETR); or
- A medical doctor signed off on the procedure.

List of Appendices

A. Detailed Revision History

Citations & References

CFR		
WAC	182-500-0015, 182-530-7000, 182-550-6500, 182-543-9000, 388-835-0235	
RCW		
LOB / Contract Citation	☒ **WAHIMC**	
	☒ **BHSO**	
	☒ **MA**	
	☒ **CS**	

Other Requirements	
NCQA Elements	

Revision History

SME Review:	05/21/2018, 04/03/2019, 10/21/2019, 11/13/2019, 01/29/2020, 12/09/2020, 11/09/2021, 11/01/2022, 10/17/2023
Approval:	05/24/2018, 04/26/2019, 10/29/2019, 11/14/2019, 02/03/2020, 12/09/2020, 11/10/2021, 11/02/2022, 10/18/2023

Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
05/21/2018	Moved By Report information from desk procedure OP609 into new OP647; added default pricing, non-covered codes pricing	Roger Arnold / Renée Lillie
05/24/2018	Approval	Donna Arcieri
04/03/2019	Annual review; minor edits	C. Summerville / R. Lillie
04/26/2019	Approval	Donna Arcieri
10/21/2019	Updated default pricing; added blood/blood products; added AC pricing	Kris Shopin / Donna Arcieri / Renée Lillie
10/29/2019	Approval	Donna Arcieri
11/13/2019	Revised with general information about best practices; moved some information into *Manual Pricing* desk procedure (OP648)	Kris Shopin / Donna Arcieri / Renée Lillie
11/14/2019	Approval	Donna Arcieri
01/29/2020	Clarified conversion factor and when to use BR pricing	C. Summerville / J. Hovey / R. Lillie
02/03/2020	Approval	Donna Arcieri
12/09/2020	Updated lines of business; added OIG	Eric Asmussen / Renée Lillie
12/09/2020	Approval	Donna Arcieri
11/09/2021	Updated LOB (Medicaid and Medicare Advantage only); defined “valid invoice”; clarified pricing for DME, code not on any fee schedule, and BR	Angie Pino / Eric Asmussen / Zoe Graf / Jude Hovey / Chris Summerville / Renée Lillie
11/10/2021	Approval	Donna Arcieri
11/01/2022	Annual review; added Cascade Select	Joeleen Horning-Dinh / Eric Asmussen / Renée Lillie
11/02/2022	Approval	Donna Arcieri
10/17/2023	Annual review; minor edits	Joeleen Horning-Dinh / Robert Waskins / Renée Lillie
10/18/2023	Approval	Donna Arcieri