blue of california

BlueCross BlueShield Cost Estimate Methodology Overview

The BlueCross BlueShield Axis℠ (BCBS Axis℠) cost estimate methodology[1] is an analytic calculation designed to define cost estimates for procedures that populate the BCBS Axis national data base. The methodology is mandated by the BlueCross BlueShield Association (BCBSA) and is uniformly applied across all Blues Plans.

Facility Cost Estimate Data

The facility procedure component of the methodology includes the following four steps by which the values (i.e., cost ranges) displayed in Axis are determined:

1. A selected set of raw claims data is compressed into individual cases of care for each treatment category.
2. As described below, the cases are then analyzed to remove those that might skew the facility average for the treatment category.
3. Next, cost bands are created for each procedure and provider in the category.
4. Finally, volume data is attached to the treatment category cost bands and the cost information is ready for display.

The creation of the cases is a basic methodology that encompasses the following steps:

1. The proper facility and professional claims are selected, excluding such items as secondary payer and non-PPO claims. The selection of facility claims is based on either DRGs or MS DRGs for inpatient services (IP) or CPT codes for services that are outpatient (OP) and diagnostic (Dx).
2. Once the requisite facility claims have been selected, professional services associated with the facility services are combined with the facility claims in order to get an estimate of total cost for the case. The professional services are selected by including the appropriate information, depending on the case, using the following criteria:
    - For IP claims, all professional claims incurred on or between the admission and discharge dates for a member are included.
    - For OP claims, professional services incurred on the same day of service are included.
    - For Dx claims, all those claims related to that specific service are included.

[1] The BlueCross BlueShield Axis cost estimate methodology and all descriptions thereof are proprietary information of the BlueCross BlueShield Association.

After the cases are created, certain IP, OP, and Dx cases are removed from the dataset. The selection for removal of cases is determined by the following criteria in the order they are listed below.

1. Cases that contain an emergency room revenue code or place of service code are removed.
2. Any Dx without a corresponding technical component coded within the procedure modifier field is removed.
3. Any inpatient case that does not meet certain thresholds of facility or professional costs is removed.
4. Any case that is two standard deviations away from the average for a facility-related treatment category is removed.
5. Any facility-related treatment category that does not have at least two cases for fixed pricing (DRG and case rate) or three cases for non-case rate pricing (percent of charge and per diem) is removed.

Health plans submit revised data at least every six months and they may or may not adjust the payment amounts within their historical claims data for recent changes in negotiated provider arrangements. Regardless of the frequency of claims data updates, for each facility-related treatment category the average (mean) amount is determined and a standard deviation is calculated.

For each facility-related treatment category, a cost range is assigned that is plus or minus one standard deviation from the average point, with a minimum plus or minus of 5 percent. If the standard deviation is significantly wide, the lowest cost case is used as the "low" end of the cost range.

The final step of the methodology assigns volume data to each provider and treatment category combination for the claims used in the analysis. The data is then compiled and used for the *Treatment Cost Estimato*r.