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.

Professional Cost Estimate Data

The professional procedure component of the methodology includes a process by which the values (i.e., cost ranges) displayed in the tool are determined. The four steps of the process occur in the order that they are listed below.

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

The creation of each of the cases used 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 professional claims is based on common procedural terminology (CPT) codes for services that are office visit (OV), outpatient (OP), and diagnostic (Dx).
2. Once the requisite professional claims have been selected, all claim information associated with the professional services are combined by including the appropriate information for each case, with adherence to the criteria listed below.
   a. For OV claims, all professional and general clinic cost information incurred during a single visit for a member is included.
   b. For OP claims, all facility, professional, and other related cost information incurred between the service start date and service end date for a member is included.
   c. For Dx claims, all outpatient radiology (facility and professional) and freestanding radiology cost information incurred on the same date of service for a member at a given facility is included.

[1] The BlueCross BlueShield Axis cost estimate methodology and all descriptions thereof are proprietary information of the BlueCross BlueShield Association. ©2015 BlueCross BlueShield Association. All rights reserved.

3. For OV claims, depending on the nature of the treatment, cost is calculated using only one of the following methods:
    a. Average of the total costs per visit by specialty type
    b. Weighted average of all CPT codes
    c. Sum of the average of the primary and secondary CPT codes
4. For OP claims, once claim information has been combined, a primary physician and primary facility are identified, for a specific treatment, by allowed amount.
5. For Dx claims, once claim information has been combined, only the facility and professional data associated with the identified CPT code and specific treatment are kept for a given member or a given service date.

After each case is created, certain 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. Any OP case where the treatment category CPT code was not the primary procedure, with the exception of anesthesiology, pathology, implants, radiology, labs, durable medical equipment, orthotics/prosthetics, or assistant surgeons and physicians
2. Any OP case that occurred in an inpatient (IP) setting
3. Any Dx case with facility claims that have a global modifier or include a professional claim with a professional component are removed.
4. Any Dx case with only professional claims that does not contain either a technical component coded with a global modifier or a technical component coded with a professional component
5. Any case that contains an emergency room revenue code or place of service code
6. Any case that is two standard deviations away from the average for a treatment category
7. Any non-OV treatment category that does not have at least two cases

Health plans submit revised data at least every six months to BCBSA 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, the average (mean) for each professional-related treatment category is calculated. The final step of the methodology assigns volume data to each provider and treatment category combination. The data is then compiled and used for the *Treatment Cost Estimat*or.

T10327-MO (10/18)