

# Hospital Price Transparency Frequently Asked Questions (FAQs) on Encoding Algorithms with Example Scenarios

**When is my payer-specific negotiated charge not an algorithm or percentage, in which case my hospital must calculate and encode the “payer-specific negotiated charge: dollar” data element and should not encode the “payer-specific negotiated charge: algorithm” or “payer-specific negotiated charge: percentage” data elements?**

We expect that many payer-specific negotiated charges can be encoded fully and completely as dollar amounts in the hospital’s machine-readable file (MRF). Payer-specific negotiated charges that can be fully and completely encoded as dollar amounts should be reported in the “payer-specific negotiated charge: dollar amount” data element, not the “payer-specific negotiated charge: algorithm” or “payer-specific negotiate charge: percentage” data elements. Table 1 provides example scenarios in which the payer-specific negotiated charge is not an algorithm or percentage and the payer-specific negotiated charge is not further modified by an algorithm or percentage. In these scenarios, the hospital must calculate a single dollar amount from the information available and the hospital should **not** encode the “payer-specific negotiated charge: algorithm” data element or the “payer-specific negotiated charge: percentage” data element.

Table 1: Example Scenarios Where the Payer-Specific Negotiated Charge is not an Algorithm or Percentage and the Hospital Should Calculate and Encode a Single Dollar Amount from the Information Available

Reimbursement Scenario	Encoding the “Payer-Specific Negotiated Charge: Dollar Amount” Data Element
<p><b>Flat DRG Case Rate:</b> My hospital has negotiated that DRG 470 is paid at \$14,000 per admission.</p>	<p>This hospital must encode 14000 in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “case rate” in the “standard charge methodology” data element.</p>
<p><b>MS-DRG Case Rate as a Percentage of Medicare:</b> My hospital has negotiated that inpatient MS-DRGs are paid at 200% of the Medicare IPPS Federal Operating and Capital Federal specific portion.</p>	<p>This hospital must calculate the dollar amount for each inpatient MS-DRG as 200% of the Medicare IPPS Federal Operating and Capital Federal specific portion and encode it in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “case rate” in the “standard charge methodology” data element. In the “additional generic notes” or “additional payer-specific notes” data elements, this hospital might state that “<i>Inpatient MS-</i></p>

	<i>DRGs are paid at 200% of the Medicare IPPS Federal Operating and Capital Federal specific portion.</i>
<p><b>Flat MS-DRG Rate:</b> My hospital has negotiated that MS-DRG 470 is paid at \$6,000 base rate x the MS-DRG v43 weight with no additional adjustments.</p>	This hospital must calculate the dollar amount for MS-DRG 470 as 6,000 x the MS-DRG v43 weight and encode it in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “case rate” in the “standard charge methodology” data element. In the “additional generic notes” or “additional payer-specific notes” data elements, this hospital might state that <i>“MS-DRG 470 is paid at \$6,000 base rate x the MS-DRG v43 weight.”</i>
<p><b>Level of Care Per Diem:</b> My hospital has negotiated with a payer that medical/surgical days are paid at \$1,400 per day.</p>	This hospital must encode medical/surgical days as a discrete item or service and encode 1400 in the “payer-specific negotiated charge: dollar amount” data element and would encode “per diem” in the “standard charge methodology” data element.
<p><b>Surgery Case Rate:</b> My hospital has negotiated that a surgery is paid at \$8,000 per case.</p>	This hospital must encode 8000 in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “case rate” in the “standard charge methodology” data element.
<p><b>Percentage of Gross Charge Applicable to Certain Services:</b> My hospital has negotiated with a payer that all laboratory services are paid at 50% of the gross charge.</p>	This hospital must calculate the dollar amount as 50% of the gross charge and encode it in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “fee schedule” in the “standard charge methodology” data element. In the “additional generic notes” or “additional payer-specific notes” data elements, this hospital might state that <i>“All laboratory services are paid at 50% of the gross charge.”</i>
<p><b>Global Percentage of Gross Charge:</b> My hospital has negotiated with a payer that all inpatient services are paid at 90% of the gross charge for an item or service.</p>	This hospital must calculate the dollar amount as 90% of the gross charge for the item or service and encode it in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “fee schedule” in the “standard charge methodology” data element. In the “additional generic notes” or “additional payer-specific notes” data elements, this hospital might state that <i>“All inpatient services are paid at 90% of the gross charge.”</i>
<p><b>Per Unit Rate:</b> My hospital has negotiated that each instance of an MRI on a claim is paid at \$400.</p>	This hospital must encode 400 in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “fee schedule” in the “standard charge methodology” data element.
<p><b>Percentage of Medicare Outpatient Prospective Payment (OPPS) Ambulatory</b></p>	This hospital must calculate the dollar amount as 140% of the Medicare OPPS APC rate and encode it in the “payer-specific negotiated charge: dollar amount” data element. This hospital would encode “fee schedule” in the “standard charge

<p><b>Payment Classification (APC) amount:</b> My hospital has negotiated with a payer that all outpatient services are paid at 140% of the Medicare OPPS APC rate.</p>	<p>methodology” data element. In the “additional generic notes” or “additional payer-specific notes” data elements, this hospital might state that <i>“All outpatient services are paid at 140% of the OPPS APC rate.”</i></p>
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**When is my payer-specific negotiated charge an algorithm or percentage, in which case my hospital must encode the “payer-specific negotiated charge: algorithm” or “payer-specific negotiated charge: percentage” data element and calculate and encode the allowed amounts data elements?**

A payer-specific negotiated charge is an algorithm or percentage when it cannot fully and completely be calculated as a single dollar amount at the item or service level at the time of posting the file because it depends on future, variable, or unknown factors. Table 2 below provides specific scenarios in which the payer-specific negotiated charge is an algorithm or percentage and offers exemplar (not mandatory) language that hospitals might consider including in the “payer-specific negotiated charge: algorithm” data element **only when the situation can be fully expressed by a single algorithm or percentage**. This information is meant to help facilitate standardized reporting of scenarios.

Table 2: Example Scenarios in Which the Payer-Specific Negotiated Charge is an Algorithm or Percentage and Recommended Language for Describing the Algorithm

Reimbursement Scenario	Recommended Language for Describing the Algorithm
<p><b>Case Rate Plus Per Diem After Set Number of Days:</b> My hospital has negotiated that the reimbursement for the item or service is a case rate of \$8,000 plus a \$3,000 per diem after 4 covered days.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode, <i>“Allowed amount = \$8,000 + MAX (0, (\$3,000 x (covered days - 4)).”</i> This hospital would encode “case rate” in the “standard charge methodology” data element.</p>
<p><b>Percentage of Invoice Cost:</b> My hospital has negotiated, as part of their contract, that the reimbursement is determined as 110 percent of the supplier invoice cost.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“Allowed amount for service is 110% of the actual cost, based on supplier invoice.”</i> This hospital would encode “other” in the “standard charge methodology” data element and encode “Methodology is explained in algorithm data element.” in the “additional generic notes” data element or the “additional payer-specific notes” data element.</p>

Reimbursement Scenario	Recommended Language for Describing the Algorithm
<p><b>Percent of Medicare Prospective Payment System (PPS) Fee Schedule:</b> My hospital has negotiated that the reimbursement for exempt psych services is 130 percent of the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Pricer amount.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“Allowed amount is 130% of the Medicare IPF PPS pricer amount; hospital cannot provide a single standard dollar amount due to the following variable factors: patient diagnosis, length of stay.”</i> This hospital would encode “other” in the “standard charge methodology” data element. and encode “Methodology is explained in algorithm data element” in the “additional generic notes” data element or the “additional payer-specific notes” data element.</p>
<p><b>Multi-Phase Transplant Bundle or Case Rate:</b> My hospital has negotiated that the reimbursement is a multi-phase transplant case rate.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“Phase 1 services prior to transplant admission are paid at 40% of charges; Transplant admission is paid at \$200,000 case rate; Phase 3 post-transplant services are paid at 30% of charges.”</i> This hospital would encode “case rate” in the “standard charge methodology” data element.</p>
<p><b>Lesser of Provisions (rate vs. percent of charges):</b> My hospital has negotiated that the reimbursement for the item or service is the lesser of a \$24,000 negotiated dollar amount and 80 percent of total billed charges.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“Allowed amount for service is the lesser of: \$24,000 and 80% of total billed charges associated with this specific service.”</i> This hospital would encode “other” in the “standard charge methodology” data element and encode “Methodology is explained in algorithm data element.” in the “additional generic notes” data element or the “additional payer-specific notes” data element.</p>
<p><b>Lesser of Provisions (rate vs. MS-DRG amount):</b> My hospital has negotiated that the reimbursement for the item or service is the lesser of a \$45,000 negotiated dollar amount and 95 percent of the total relevant MS-DRG amount.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“Allowed amount for service is the lesser of: \$45,000 and 95% of the total relevant MS-DRG amount for this specific service.”</i>. This hospital would encode “other” in the “standard charge methodology” data element and encode “Methodology is explained in algorithm data element.” in the “additional generic notes” data element or the “additional payer-specific notes” data element.</p>

Reimbursement Scenario	Recommended Language for Describing the Algorithm
<p><b>Percentage of Total Billed Charges (Unknown) Tied to a Specific Service on the Claim:</b> My hospital has negotiated that when Revenue Code 450 is on the claim, the negotiated reimbursement is 80 percent of total billed charges for an item or service, and this is not modified by an algorithm.</p>	<p>This hospital should encode 80 in the “payer-specific negotiated charge: percentage” data element since the billed charges are not known ahead of time. The hospital would encode “percent of total billed charges” in the “standard charge methodology” data element.</p>
<p><b>One-Day versus Multi-Day Case Rate:</b> My hospital has negotiated that the reimbursement for the item or service can be fully expressed as a one-day stay case rate of \$3,000 or a multi-day stay case rate of \$7,500.</p>	<p>In the “payer-specific negotiated charge: algorithm” data element, this hospital might encode <i>“For this specific service, if length of stay is less than 2 days, the admission is paid a one-day case rate of \$3,000. If length of stay is 2 days or greater, the admission is paid at \$7,500.”</i> This hospital would encode “case rate” in the “standard charge methodology” data element.</p>

**If my hospital has contract level provisions with a payer that apply broadly to a contract instead of a specific item or service, how should I reflect that in my MRF?**

We recommend that you provide this information in the optional “general contract provisions” data element. Some examples of this include the following:

- For a stop loss provision at the claim level, a hospital might encode in the optional “general contract provisions” data element: *“When total claim charges exceed \$200,000.00 for a Platform Health Insurance plan, the entire claim will be reimbursed at 50% of charges.”*
- For bundling rules and service exceptions, a hospital might encode in the “optional general contract provisions” data element: *“For Platform Health Insurance plans, if ER and surgery services are on the same claim, only the ER services are payable.”*