

Revisions

Release 17.0 – removed release # from heading per guidelines

Overview

Communicating Payment and Pricing Information

As a local Plan, you must determine how to communicate your discount and provider payment arrangements to the processing site so that it can adjudicate the claims you send and determine appropriate BCBS and subscriber liability.

The UPF provides a structured format that enables you to communicate both your own pricing method (percent of charges, case allowance, per diem, et cetera) and the rules for applying that method. These rules determine whether the subscriber shares in the discount and how reductions for noncovered services should be applied to inclusively priced claims.

How to Price UPF Claims

To price claims for the UPF, you need to define your local pricing and payment agreements in UPF terms. This requires that you:

1. Identify your discount for out-of-area or national account claims.
2. Break down your discount into definable elements. For example:
 - Separate line items that may have variable discount arrangements, such as percentage factors.
 - Separate line items such as convenience items, blood products, private duty nursing, et cetera, which are not included in the discount. These line items can be priced using a different pricing method (for example, 100% of charges, pricing method 10/rule 003), and allows the processing site to adjudicate these items separately.
3. Identify any appropriate modifications to your discount.
4. Identify any supplemental percentage amount requirements.
5. Identify any surcharge requirements.
6. Determine whether any payment maximum conditions apply.
7. Translate these elements and modifications into an appropriate UPF pricing method, rule(s), and SF message code(s), and special pricing conditions code(s), if applicable, with any additional data, defined to include percentage factors, per diem or case allowance amounts, local rate, et cetera.
8. For COB, the level of payment the provider expects based on Host Plan provider arrangements expressed by the secondary payer pricing qualifier code (SPPQC) and the Host OPL provider arrangement code (HOPAC).

9. For Medicare, the level of payment the provider expects based on Host Plan provider arrangements expressed by the Medicare payer pricing qualifier code (MPPQC).

The following sections of this chapter describe the process of defining your local pricing and payment arrangements in terms the UPF can use. The following chapter explains how to pass this information to the processing site using the ITS Submission Format (SF).

Pricing and Payment Elements

Analyzing Your Provider Agreements

The UPF calculator software at the processing site determines BCBS and subscriber liability for a number of different discount and payment arrangements. As a local Plan, you must identify these discount and payment conditions and communicate them in the ITS SF.

You must begin by identifying the following aspects of your provider relationships:

1. The Discount

You must identify the specific pricing method you use to determine your discount. The UPF supports a range of different discounts for both institutional and professional claims. For COB, you must identify whether the discount is available for use by the Home Plan. For Medicare, you must identify the provider's expectation for Medicare assigned and unassigned claims.

2. The Application Sequence of Subscriber Cost Sharing and Discounts

The sequencing of subscriber cost sharing and discounts as supported by your provider agreements determines how provider payments are calculated.

- If the subscriber shares in the discount, the subscriber cost sharing is applied to the discounted amount.
- If the subscriber does not share in the discount, the cost sharing is applied to the remaining covered service charges (billed charges less service limitations). This is not valid for Inter-Plan claims, except for those Plans exempted by state law.

3. Payment Maximums

Host Plans must identify whether Home Plans can apply payment maximum on an unrestricted basis, with some restrictions, or not at all. For example, if price exceeds charges, the use of an "X" modifier will prevent the application of a payment maximum.

4. SF Message Codes

In addition to these generic considerations, you may have some exceptions that affect how you price claims. These exceptions, such as the application of subscriber cost sharing liability or managed care penalties, might negate or modify the discount you indicated.

You may not know whether these exceptions apply to a specific claim or relate to subscriber contract issues. You will nevertheless inform the processing site of these exceptions so it can apply your discount properly when adjudicating the claim.

Note: UPF will process conditional message codes only at the claim level. In addition, you may have some prospective provider settlements (that is, supplemental percentage amounts) and surcharges that can be accommodated by using the action SF message codes.

Translating Local Pricing into ITS Uniform Pricing Facility Input

How to Translate Your Pricing into UPF Input

Once you have identified your Plan's specific pricing arrangements, you must translate those arrangements into input for the UPF calculator at the processing site. To do this, you must complete the following steps:

1. Translate your pricing arrangements into the pricing method codes that the UPF supports.
2. Identify the primary rule that accommodates the following:
 - Your pricing method(s)
 - Your application sequence for determining subscriber liability and cost sharing.
3. Identify a secondary rule that determines how noncovered ancillary or secondary services are processed for inclusively priced claims only.
4. Identify any exceptions to the discount that apply and submit them as an SF message code.
5. Append the appropriate pricing data to the ITS SF and send it to the processing site. Refer to Chapter 4, Appending Pricing Information to Claims, for additional information.

The following sections of this chapter will help you complete each of these tasks.

Identifying Appropriate UPF Calculator Pricing Method Codes

UPF Pricing Methods

You must translate all of your specific discounts with your providers into pricing methods the UPF calculator supports. The UPF supports a wide range of Plan discount agreements for both institutional and professional claims at the line-item level, claim level and a combination of line-item and claim-level pricing.

Table 3-1 lists the available pricing methods for both institutional and professional claims and defines these methods.

Table 3-1: UPF Pricing Methods

Code	Pricing Method	Definition
01	Charges	The amount a provider bills a patient for a particular service. Use for IP or OP claims priced at the claim level or line level and for professional claims to indicate that a claim is from a provider with no hold harmless agreement. Do not combine this pricing method with any other pricing method.
10	Percent of charges	The percentage discount applied to the covered or billed charges. Use for IP or OP claims priced at the claim or line level and for professional claims.
14	Percent of allowed amount per category of service	The percentage discount based on the local Plan's rate (as opposed to billed charges). This rate represents the price for the service, regardless of the number of units that comprise the service. Use for IP or OP claims priced at the line level and for professional claims.
15	Percent of allowed amount per unit of service	The percentage discount based on the local Plan's rate (as opposed to charges). This rate represents the price per unit of service provided. Use for IP or OP claims priced at the line level and for professional claims.
20	Per diem	The all inclusive daily reimbursement rate accepted as payment in full for accommodations as well as most, if not all, ancillary services incurred during the stay. Use for IP claims priced at the claim or line level.
30	DRG (case allowance)	Diagnosis-related groups (DRG) is the fixed rate established by case allowance method and is accepted as payment in full for accommodations and ancillary services incurred during the stay regardless of the length of stay. Use for IP claims prices at the claim level.
33	Case allowance/ percent of Charges	A combination of case allowance (inclusive) pricing with percent of charges pricing. The subscriber liability is based on the case allowances and the BCBS liability is based on the percent of charges discount. Use for IP claims priced at the claim level.
40	Flat fee or allowance per category of service	The fixed dollar amount accepted as payment in full for a category of service. This amount represents the ceiling or maximum dollar amount that would be allowed by the local Plan for a given category of service. The allowed amount may be zero priced or may exceed the billed charge for negotiated rates. For UCR reimbursed services, when the allowed amount is greater than charge, the Host Plan must reduce the allowed amount to equal the billed charge. Use for IP or OP claims priced at the line level and for professional claims.
41	Flat fee or allowance per unit of service	The fixed dollar amount accepted as payment in full for a unit of service. This amount represents the ceiling or maximum dollar amount that would be allowed by the local Plan for a given unit of service. The allowed amount may be zero priced or may exceed the billed charge for negotiated rates. For UCR-reimbursed services, when the allowed amount is greater than the charge, the Host Plan must reduce the allowed amount to equal the billed charge. Use for IP or OP claims priced at the line level and for professional claims.
42	Multiple service allowance	An allowance for a specific ancillary or procedure that includes other associated ancillaries and/or procedures. Specify pricing method 42 and the local rate for the primary ancillary or procedure on the primary (first)

Code	Pricing Method	Definition
		line of the claim. Specify pricing method 42 and a local rate of 0 for the ancillaries or procedures that are included in the rate on the secondary lines of the claim. Use for OP claims priced at the line level or for professional claims. UPF supports more than one occurrence of a primary line with pricing method 42 (Multiple inclusive groupings)
43	Multiple service allowance/ percent of charges	A combination of multiple services (inclusive pricing with percent of charges pricing. The subscriber liability is based on the inclusive price and the BCBS liability is based on the percent of charges discount. Use for OP claims priced at the line level and for professional claims.

Identifying Subscriber Discount Sharing

UPF Rule Numbers

You identify how subscriber liability should be calculated and the sequence in which it is calculated by specifying a UPF rule number. Local Plans must append the primary rule number to all claims for each claim or line item (except Pricing Method 01) to which it has appended a price. In addition, a secondary rule number, which defines how noncovered services are processed, is appended to all inclusively priced claims.

The primary rule number you specify on the SF claim determines:

1. The exact sequence in which the calculator computes BCBS liability and subscriber liability for each of the following factors:
 - Service limitations
 - Subscriber benefits management penalties
 - Subscriber cost sharing
 - Pricing percentage factor
 - Payment maximum factor
 - Supplemental amount factor
 - Surcharge amount factor

Table 3-2 below defines each of these factors.

2. The base amount for calculating BCBS liability for each factor (that is, whether based on remaining covered charges, remaining allowed amount, et cetera) and the cap for the calculated amount.
3. The base amount for calculating subscriber liability for each factor (that is, whether based on remaining covered charges, remaining allowed amount, et cetera) and the cap for the calculated amount.

The secondary rule number you specify on the SF claim determines how the calculator computes any noncovered items on an inclusively priced claim.

Table 3-2: Uniform Pricing Facility Calculation Factors

Factor	Definition	Source
Contractual Limitation Factors		
Noncovered services	Accommodations, ancillaries, or procedures not covered based on the subscriber's contract.	Adjudication system
Noncovered days/visits/units	Subscriber-based contract limitations for specific accommodations, ancillaries or procedures.	Adjudication system
Maximum dollar amount allowed	Subscriber-based contract limitations on the amount paid for a specific accommodation, ancillary or procedure. Can also limit the amount paid for a defined period of time for the specified accommodation, ancillary or procedure.	Adjudication system
Private room differential	Subscriber-based contract benefit for a private room stay, defined as full, partial or none.	Adjudication system
Subscriber Benefits Management Reductions		
Noncovered service	Accommodations, ancillaries or procedures not covered based on the subscriber's contract.	Adjudication system
Noncovered days/visits/units	Subscriber-based contractual limitations for specific accommodations, ancillaries or procedures.	Adjudication system
Maximum dollar amount	Subscriber-based contractual limitations on the amount paid for a specific accommodation, ancillary or procedure. Can also limit the amount paid for a defined period of time for the specified accommodation, ancillary or procedure.	Adjudication system
Dollar reduction amount	The dollar amount by which the BCBS payment will be reduced. The subscriber's remaining out-of-pocket maximum can cap this amount.	Adjudication system
Percentage reduction amount	The percentage amount used to calculate a reduction in BCBS payment. The subscriber's remaining out-of-pocket maximum can cap this amount.	Adjudication system
Provider Benefits Management Reductions		
Dollar amount reduction	The dollar amount by which the BCBS payment will be reduced. The subscriber liability will not be impacted by this reduction	Adjudication system
Percentage reduction	The percentage amount used to calculate a reduction in BCBS payment. The subscriber liability will not be impacted by this reduction	Adjudication system
Excess Days Dollar amount reduction	The dollar amount by which the BCBS payment will be reduced based on a flat dollar amount. The subscriber liability will not be impacted by this reduction	Adjudication system
Excess Days Per	The dollar amount by which the BCBS payment will be reduced	Adjudication

Factor	Definition	Source
Day Dollar amount reduction	based on a per day dollar amount. The subscriber liability will not be impacted by this reduction	system
Subscriber Cost Sharing		
Deductible remaining	The amount the subscriber must still pay for a given benefit period for covered medical expenses before becoming eligible for reimbursement. The subscriber's remaining out-of-pocket maximum can cap this amount. UPF supports up to three claim level deductibles.	Adjudication system
Deductible code	This code indicates whether to apply one or more deductible(s) to a claim and which deductible to use.	Adjudication system
Copayment	A fixed amount for covered medical expenses for which the subscriber is responsible. The subscriber's remaining out-of-pocket maximum can cap this amount. UPF supports two copayment amounts.	Adjudication system
Coinsurance	An amount calculated from a fixed percent for covered medical expenses for which a subscriber is responsible. The remaining out-of-pocket maximum can cap this amount.	Adjudication system
Discount		
Pricing percentage factor	The percentage discount (if applicable) as determined by the local Plan.	Local Plan
Supplemental Amount		
Supplemental Percentage Factor	The supplemental percentage (if applicable) as determined by the local Plan. . Applied only to BCBS liability, calculated excluding cost sharing reductions .	Local Plan
Payment Maximum		
Payment maximum factor	The maximum limit that a Plan will pay on a claim or a line.	Adjudication system
Surcharge Amount		
Surcharge percentage factor	The surcharge percentage (if applicable) as determined by the local Plan.	Local Plan

The Effect of Different UPF Rules

The effect of different pricing rules on the calculator is easy to understand: for any given pricing method, the rule number you submit will determine whether the subscriber shares in the discount (to base the subscriber liability on the billed charge or the priced amount).

In addition, any Host Plan restrictions on the application of a Home Plan's payment maximum adjudication input results in three versions of the base set of UPF rules.

1. Set #1 With no restrictions on the application of payment maximum (use "G" modifier)
2. Set #2 With restrictions on the application of payment maximum (use "T" modifier)

3. Set #3 The application of payment maximum is not allowed (use “X” modifier).

For inclusively priced claims, the primary and secondary rule number you submit determines whether selected non-covered reductions can be applied.

A primary rule number is required with all pricing methods except pricing method 01 (charges). In addition, a secondary rule number is required for inclusively priced claims (pricing methods 20, 30, 33, 42¹ and 43).

Primary Rules define the processing for:

1. Institutional inpatient accommodations
2. Institutional outpatient primary ancillary
3. Professional primary service.

Secondary Rules define the processing for:

Institutional inpatient ancillaries
Institutional outpatient secondary ancillaries
Professional secondary services.

The secondary rule selected will instruct the UPF calculator on how to apply designated UPF reduction factors:

1. Base reductions on billed charges from the negotiated rate
2. Prorate reductions from the negotiated rate
3. Not apply reductions from the negotiated rate.

The calculator will flag claims if reductions cannot be applied and allow the processing site to manually review the claim. Reductions based on charges will increase the subscriber liability by the noncovered charge and reduce the BCBS liability by the noncovered charge. Prorated reductions will increase the subscriber liability by the noncovered charge and reduce the BCBS liability by the prorated amount. The proration factor is determined by dividing the inclusive price by the total charge.

The combination of rules you select will designate whether to ignore reductions, base reductions on billed charges or prorate reductions. The calculator will flag claims if reductions cannot be applied and allow the processing site to manually review the claim.

Reductions based on charges will increase the subscriber liability by the noncovered charge and reduce the BCBS liability by the noncovered charge.

Prorated reductions will increase the subscriber liability by the noncovered charge and reduce the BCBS liability by the prorated priced amount. The proration factor is determined by dividing the inclusive price by the total charge.

¹ Pricing method 42 supports multiple inclusive groupings. Each unique “grouping” will have its own set of primary and secondary UPF rules

How to Select a Combination of Pricing Methods and Rules

How you combine your pricing method (discount) with a primary rule and secondary rule allows the processing site to process the claim without affecting your provider agreements. Table 3-3 shows the valid combinations of pricing methods and primary rules. Table 3-4 provides detailed descriptions of the rules and whether they can be used as primary and/or secondary rules. Not all rules can be combined and Table 3-5 provides the valid combinations that can accommodate your provider agreements.

Table 3.3 UPF Pricing Methods and Rules

If	And:	Then Enter	
The Pricing Method is	The Subscriber's Discount Sharing is	Pricing Method	Primary Rule
Set #1, G Modifier			
Charges	NA	01	NA
Percent of charges	Does not share	10	001
Percent of charges	Does not share	10	002
Percent of charges	Shares	10	003, 013
Percent of allowed amount per category of service	Does not share	14	004
Percent of allowed amount per category of service	Shares	14	005
Percent of allowed amount per unit of service	Does not share	15	004
Percent of allowed amount per unit of service	Shares	15	005
Per diem	Does not share	20	006, 010, 015, 016, 021, 022
Per diem	Shares	20	007, 012, 018, 019, 027, 028
DRG (case allowance)	Does not share	30	006, 010, 015, 016, 021, 022
DRG (case allowance)	Shares	30	007, 012, 018, 019, 027, 028
Case allowance/percent of charges	Shares	33	11, 24, 25
Flat fee or allowance per category of service	Does not share	40	008
Flat fee or allowance per category of service	Shares	40	009
Flat fee or allowance per unit of service	Does not share	41	008
Flat fee or allowance per unit of service	Shares	41	009
Multiple service allowance	Does not share	42	006, 010, 015, 016, 021, 022

If	And:	Then Enter	
The Pricing Method is	The Subscriber's Discount Sharing is	Pricing Method	Primary Rule
Multiple service allowance	Shares	42	007, 012, 018, 019, 027, 028
Set #2. "T" modifier			
Percent of charges	Does not share	10	029
Percent of charges	Does not share	10	030
Percent of charges	shares	10	031, 041
Percent of allowed amount per category of service	Does not share	14	032
Percent of allowed amount per category of service	shares	14	033
Percent of allowed amount per unit of service	Does not share	15	032
Percent of allowed amount per unit of service	Shares	15	033
Per diem	Does not share	20	034, 038, 043, 044, 049, 050
Per diem	Shares	20	035, 040, 046, 047, 055, 056
DRG (case allowance)	Does not share	30	034, 038, 043, 044, 049, 050
DRG (case allowance)	Shares	30	035, 040, 046, 047, 055, 056
Case allowance/percent of charges	Shares	33	039, 052, 053
Flat fee or allowance per category of service	Does not share	40	036
Flat fee or allowance per category of service	Shares	40	037
Flat fee or allowance per unit of service	Does not share	41	036
Flat fee or allowance per unit of service	Shares	41	037
Multiple service allowance	Does not share	42	034, 038, 043, 044, 049, 050
Multiple service allowance	Shares	42	035, 040, 046, 047, 055, 056
Multiple service allowance/percent of charges	Shares	43	039, 052, 053
Set #3, X Modifier			
Percent of Charges	Does not share	10	057
Percent of Charges	Does not share	10	058
Percent of Charges	Shares	10	059, 069
Percent of Allowed Amount Per Category of Service	Does not share	14	060
Percent of Allowed Amount Per Category of	Shares	14	061

If	And:	Then Enter	
The Pricing Method is	The Subscriber's Discount Sharing is	Pricing Method	Primary Rule
Service			
Percent of Allowed Amount Per Unit of Service	Does not share	15	060
Percent of Allowed Amount Per Unit of Service	Shares	15	061
Per Diem	Does not share	20	062, 066, 071, 072, 077, 078
Per Diem	Shares	20	063, 068, 074, 075, 083, 084
DRG (Case Allowance)	Does not share	30	062, 066, 071, 072, 077, 078
DRG (Case Allowance)	Shares	30	063, 068, 074, 075, 083, 084
Case Allowance/Percent of Charges	Shares	33	067, 080, 081
Flat Fee or Allowance per Category of Service	Does not share	40	064
Flat Fee or Allowance per Category of Service	Shares	40	065
Flat Fee or Allowance per Unit of Service	Does not share	41	064
Flat Fee or Allowance per Unit of Service	Shares	41	065
Multiple Service Allowance	Does not share	42	062, 066, 071, 072, 077, 078
Multiple Service Allowance	Shares	42	063, 068, 074, 075, 083, 084
Multiple Service Allowance/Percent of Charges	Shares	43	067, 080, 081

Notes on Table 3.3: UPF Pricing Methods and Rules

1. The percentage discount is applied to remaining covered charges (following the application of subscriber cost sharing) for UPF rules 001, 029 and 057.
2. The percentage discount is applied to the remaining covered charges (excluding cost sharing) for UPF rules 002, 030 and 058.
3. The percentage discount is applied to remaining covered charges, allowing the subscriber to share in the discount for UPF rules 003, 031 and 059. *(NOTE: For reductions including: percentage or dollar managed care, cost sharing calculations (deductible, copayment and coinsurance) and payment maximum.)*
4. The percentage discount is applied to remaining covered charges prior to the application of any reduction allowing the subscriber to share in the discount for UPF rules: 013, 041 and 069. *(NOTE: For reductions including noncovered, private room, managed care penalties, as well as cost sharing and payment maximum.)*
5. The following UPF rules are not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law:

001, 002, 004, 006, 007, 008, 010, 015, 016, 018, 019, 021, and 022
029, 030, 032, 034, 035, 036, 038, 043, 044, 046, 047, 049, and 050
057, 058, 060, 062, 063, 064, 066, 071, 072, 074, 075, 077, and 078

Table 3.4: UPF Pricing Rules

Rule			Description
Set #1, Pay Max modifier "G"	Set #2, Pay Max modifier "T"	Set #3, Pay Max modifier "X"	
Rule 001	Rule 029	Rule 057	The subscriber does not share in the discount. The percentage discount is applied to the remaining covered charges (following the application of subscriber cost sharing). <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 002	Rule 030	Rule 058	The subscriber does not share in the discount. The percentage discount is applied to remaining covered service charges (excluding cost sharing). <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 003	Rule 031	Rule 059	The subscriber shares in the discount. Subscriber liability is based on the lesser of the priced amount or covered charge, allowing the subscriber to share in the discount for cost-sharing calculations (deductible, co-payment and coinsurance).
Rule 004	Rule 032	Rule 060	The subscriber does not share in the discount. Subscriber liability is based on the lesser of the priced amount or covered charge. <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 005	Rule 033	Rule 061	The subscriber shares in the discount. Subscriber liability is based on the lesser of the priced amount or covered charge.
Rule 006 Rule 014 Rule 015 Rule 016	Rule 034 Rule 042 Rule 043 Rule 044	Rule 062 Rule 070 Rule 071 Rule 072	The subscriber does not share in the discount. Subscriber liability is based on covered charges. <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>

Rule			Description
Set #1, Pay Max modifier "G"	Set #2, Pay Max modifier "T"	Set #3, Pay Max modifier "X"	
Rule 007 Rule 017 Rule 018 Rule 019	Rule 035 Rule 045 Rule 046 Rule 047	Rule 063 Rule 073 Rule 074 Rule 075	The subscriber shares in the discount. Subscriber liability is based on priced amount. <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 008	Rule 036	Rule 064	The subscriber does not share in the discount. Subscriber liability is based on covered charges. <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 009	Rule 037	Rule 065	The subscriber shares in the discount. Subscriber liability is based on the lesser of the priced amount (case allowance) or covered charges.
Rule 010 Rule 020 Rule 021 Rule 022	Rule 038 Rule 048 Rule 049 Rule 050	Rule 066 Rule 076 Rule 077 Rule 078	The subscriber does not share in the discount. Subscriber liability is based on the lesser of the covered charges or 135.6% of the priced amount. <i>(Note: This rule is not valid for Inter-Plan Business claims (Plan profile program code A) except for Plans exempted by state law.)</i>
Rule 011 Rule 023 Rule 024 Rule 025	Rule 039 Rule 051 Rule 052 Rule 053	Rule 067 Rule 079 Rule 080 Rule 081	Subscriber shares in the discount. Subscriber liability is based on the lesser of the priced amount (case allowance) or covered charges.
Rule 012 Rule 026 Rule 027 Rule 028	Rule 040 Rule 054 Rule 055 Rule 056	Rule 068 Rule 082 Rule 083 Rule 084	The subscriber shares in the discount. Subscriber liability is based on the lesser of covered charges or priced amount.
Rule 013	Rule 041	Rule 069	The subscriber shares in the discount. Subscriber liability is based on the lesser of the priced amount or covered charges, allowing the subscriber to share in the discount for all subscriber liability calculations (noncovered, maximum dollar amount allowed, private room, managed care penalties, as well as cost sharing).

The following rules may be used when selecting the primary and secondary rules for inclusively priced claims (pricing methods 20, 30, 33, 42 and 43).

Primary Rules

006, 007, 010, 011, 012, 015, 016, 018, 019, 021, 022, 024, 025, 027 and 028

034, 035, 038, 039, 040, 043, 044, 046, 047, 049, 050, 052, 053, 055 and 056
062, 063, 066, 067, 068, 071, 072, 074, 075, 077, 078, 080, 081, 083, and 084

Secondary Rules

014, 015, 016, 017, 018, 019, 020, 021, 022, 023, 024, 025, 026, 027 and 028
042, 043, 044, 045, 046, 047, 048, 049, 050, 051, 052, 053, 054, 055 and 056
070, 071, 072, 073, 074, 075, 076, 077, 078, 079, 080, 081, 082, 083 and 084

The following rules will apply reductions for noncovered accommodations, non-covered ancillaries or noncovered secondary procedures as follows:

Base Reductions on Charges	Do Not Apply	Prorate Reductions
016, 019, 022, 025, 028	014, 017, 020, 023, 026	015, 018, 021, 024, 027
044, 047, 050, 053, 056	042, 045, 048, 051, 054	043, 046, 049, 052, 055
072, 075, 078, 081, 084	070, 073, 076, 079, 082	071, 074, 075, 080, 083

Table 3-5 contains three parts. This table provides instruction on how to choose a combination of UPF pricing methods (discounts) and rules (subscriber discount sharing) that accommodate your provider agreements.

Table 3.5 Set #1: Valid Pricing Method and Rules Combination Table for Inclusively Priced Claims (With No Restrictions on the Application of Payment Maximum)

Pricing Method	Primary/Secondary	Primary/Secondary	Primary/Secondary
20, 30, 42	006/014	006/015	006/016
20, 30, 42	015/014	015/015	N/A
20, 30, 42	016/014	N/A	016/016
20, 30, 42	007/017	007/018	007/019
20, 30, 42	018/017	018/018	N/A
20, 30, 42	019/017	N/A	019/019
20, 30, 42	010/020	010/021	010/022
20, 30, 42	021/020	021/021	N/A
20, 30, 42	022/020	N/A	022/022
20, 30, 42	012/026	012/027	012/028
20, 30, 42	027/026	027/027	N/A
20, 30, 42	028/026	N/A	028/028
33, 43	011/023	011/024	011/025
33, 43	024/023	024/024	N/A

Pricing Method	Primary/Secondary	Primary/Secondary	Primary/Secondary
33, 43	025/023	N/A	025/025

Table 3.5 Set #2: Valid Pricing Method and Rules Combination Table for Inclusively Priced Claims (With Restrictions on the Application of Payment Maximum)

Pricing Method	Primary/Secondary	Primary/Secondary	Primary/Secondary
20, 30, 42	034/042	034/043	034/044
20, 30, 42	043/042	043/043	N/A
20, 30, 42	044/042	N/A	044/044
20, 30, 42	035/045	035/046	035/047
20, 30, 42	046/045	046/046	N/A
20, 30, 42	047/045	N/A	047/047
20, 30, 42	038/048	038/049	038/050
20, 30, 42	049/048	049/049	N/A
20, 30, 42	050/048	N/A	050/050
20, 30, 42	040/054	040/055	040/056
20, 30, 42	055/054	055/055	N/A
20, 30, 42	056/054	N/A	056/056
33, 43	039/051	039/052	039/053
33, 43	052/051	052/052	N/A
33, 43	053/051	N/A	053/053

Table 3-5 Set #3: Valid Pricing Method and Rules Combination Table for Inclusively Priced Claims (The Application of Payment Maximum is Not Allowed)

Pricing Method	Primary/Secondary	Primary/Secondary	Primary/Secondary
20, 30, 42	062/070	062/071	062/072
20, 30, 42	071/070	071/071	N/A
20, 30, 42	072/070	N/A	072/072
20, 30, 42	063/073	063/074	063/075
20, 30, 42	074/073	074/074	N/A
20, 30, 42	075/073	N/A	075/075
20, 30, 42	066/076	066/077	066/078
20, 30, 42	077/076	077/077	N/A

Pricing Method	Primary/Secondary	Primary/Secondary	Primary/Secondary
20, 30, 42	078/076	N/A	078/078
20, 30, 42	068/082	068/083	068/084
20, 30, 42	083/082	083/083	N/A
20, 30, 42	084/082	N/A	084/084
33, 43	067/079	067/080	067/081
33, 43	080/079	080/080	N/A
33, 43	081/079	N/A	081/081

Effect on Subscriber Liability

The Release 8.2 changes allowed Home Plans greater flexibility in applying payment maximums. Based on Host Plan options, the calculation of payment maximums can be based on discount dollars. In general, the application of payment maximums on inclusively priced claims has fewer rule restrictions (for example, “Z” modifier) than the application of a covered maximum.

1. All UPF pricing methods will continue to allow price to exceed the charge on a line or on a claim.
2. The following UPF rules use charges as the base for subscriber liability, whether or not the charge exceeds the price.
 - Set #1 001, 002, 006, 008, 014, 015 and 016
 - Set #2 029, 030, 034, 036, 042, 043 and 044
 - Set #3 057, 058, 062, 064, 070, 071 and 072
3. The following UPF rules base subscriber liability on the lesser of the price or the charge. When the charge exceeds the price, the price will be used as the base for subscriber liability. When the price exceeds the charge, the charge will be used as the base for subscriber liability.
 - Set #1 003, 004, 005, 009, 011, 013, 023, 024 and 025
 - Set #2 031, 032, 033, 037, 039, 041, 051, 052 and 053
 - Set #3 059, 060, 061, 065, 067, 069, 079, 080 and 081
4. The following UPF rules base subscriber liability on the priced amount on the claim, regardless of whether the price exceeds the charges.
 - Set #1 007, 017, 018 and 019
 - Set #2 035, 045, 046 and 047
 - Set #3 063, 073, 074 and 075

5. The following UPF rules base the subscriber liability on the lesser of charges or 135.6% of the priced amount.
 - Set #1 010, 020, 021 and 022
 - Set #2 038, 048, 049 and 050
 - Set #3 066, 076, 077 and 078
6. The following UPF rules base the subscriber liability on the lesser of the price or the charge.
 - Set #1 012, 026, 027 and 028
 - Set #2 040, 054, 055 and 056
 - Set #3 068, 081, 083 and 084
7. The following UPF rules instruct the calculator to ignore specified noncovered reductions.
 - Set #1 014, 017, 020, 023 and 026
 - Set #2 042, 045, 048, 051 and 054
 - Set #3 070, 073, 076, 079 and 082
8. The following UPF rules instruct the calculator to prorate specified noncovered reductions.
 - Set #1 015, 018, 021, 024 and 027
 - Set #2 043, 046, 049, 052 and 055
 - Set #3 071, 074, 077, 080 and 083
9. The following UPF rules instruct the calculator to reduce specified noncovered reductions based on charges.
 - Set #1 016, 019, 022, 025 and 028
 - Set #2 044, 047, 050, 053 and 056
 - Set #3 072, 075, 078, 081 and 084

Prorated reductions, as well as reductions based on charges, will increase the subscriber liability by the noncovered charge.

The Release 8.2 changes allowed Home Plans greater flexibility in applying payment maximums. Based on Host Plan options, calculation of payment maximums can be based on discount dollars. In general, the application of payment maximums on inclusively priced claims has fewer rule restrictions (for example, "Z" modifier) than the application of a covered maximum.

1. All UPF pricing methods will continue to allow price to exceed the charge on a line or on a claim.
2. The following UPF rules use charges as the base for subscriber liability, whether or not the charge exceeds the price.

Set #1 001, 002, 006, 008, 014, 015, and 016

Set #2 029, 030, 034, 036, 042, 043, and 044

Set #3 057, 058, 062, 064, 070, 071, and 072

3. The following UPF rules base subscriber liability on the lesser of the price or the charge. When the charge exceeds the price, the price will be used as the base for subscriber liability. When the price exceeds the charge, the charge will be used as the base for subscriber liability.

Set #1 003, 004, 005, 009, 011, 013, 023, 024, and 025

Set #2 031, 032, 033, 037, 039, 041, 051, 052, and 053

Set #3 059, 060, 061, 065, 067, 069, 079, 080, and 081

4. The following UPF rules base subscriber liability on the priced amount on the claim, regardless of whether the price exceeds the charges.

Set #1 007, 017, 018, and 019

Set #2 035, 045, 046, and 047

Set #3 063, 073, 074, and 075

5. The following UPF rules base subscriber liability on the lesser of charges or 135.6% of priced amount.

Set #1 010, 020, 021, and 022

Set #2 038, 048, 049, and 050

Set #3 066, 076, 077, and 078

6. The following UPF rules base subscriber liability on the lesser of the price or the charge.

Set #1 012, 026, 027, and 028

Set #2 040, 054, 055, and 056

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Set #1 016, 019, 022, 025, and 028

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Set #3 072, 075, 078, 081, and 084

Prorated reductions, as well as reductions based on charges, will increase the subscriber liability by the noncovered charge.

Identifying Special Pricing Conditions at the Local Plan

In addition to specifying your discount and whether the subscriber shares in that discount, you also must identify any special pricing conditions that apply to your claim. The Submission Format (SF) message code (S012) is a code that will define any local conditions the processing site needs to consider in adjudicating the claim.

You must apply these special pricing conditions message codes on a claim-by-claim basis using the SF message code field (S012) and the special pricing conditions code field (S053) on the SF submission record. A special pricing conditions amount (S052) and/or percent (S054) also is required if the appropriate SF message code is present.

There are four types of UPF message codes:

Unconditional - Based on the presence of a defined set of message codes. If the message is present, the claim is flagged for review.

UPF will calculate the claim but suspend for review. The processing site can automate the processing as required.

Conditional - Based on the presence of the SF message code, the special pricing condition codes, special pricing conditions amount and/or special pricing conditions percent.

UPF will calculate the claim based on the conditions attached to the claim in the SF message codes area by the Host Plan. UPF will test the claim for the condition and, if the claim meets the condition, the UPF calculator will compute the claim and a status code (0), successful, will be returned. If the claim violates the condition, the claim will be calculated and UPF will flag the claim with a status code (1), error. The processing site can automate the processing as required or suspend for manual review.

Note: Only one conditional message is allowed on a claim. UPF will process only conditional message codes at the claim level.

Informational - Based on the presence of the SF message code, UPF will do no additional calculation on the claim and will not alter the existing UPF claim status code at the time the informational SF message code is processed.

Action - Based on the presence of the SF message code, the special pricing condition codes, special pricing conditions amount and/or special pricing conditions percent.

UPF will calculate the claim based on the conditions attached to the claim in the SF message codes area by the Host Plan and return the results in the UPF calculator output area. The UPF claim status code remains unchanged after processing the action message code.

Note: UPF will process action message codes at the claim level or at the line item level consistent with the operative pricing method.

Table 3-6 lists the SF message codes and the special pricing conditions codes.

Table 3-6: UPF SF Message Codes

SF Message Code (S012)	Description
U001	Specific timeliness criteria that affect the discount apply to this claim.
U100	If the Home Plan is not primary, either subtract the other carrier payment amount and then apply the discount or coordinate to charges at your option.
U150	The charge data on the multiple surgeries on this claim are actually negotiated rates. If any part of the multiple surgeries is noncovered or if benefit maximums apply, contact the Host Plan.
U200	A state-mandated surcharge applies to this claim. The charge and priced amounts on this claim include the surcharge value specified in the special pricing conditions percent-claim field. Valid at the claim level only. (This is enforced with an ITS edit.) This is an Informational SF message code.
U201	A state-mandated surcharge applies to this claim. The surcharge amount is reflected in the special pricing conditions percent-claim field. For use at the claim and line level. This is an informational SF message code. For additional information, refer to ITS Data Definitions Manual, Addendum H.
U250 (also S060)	A supplemental percentage amount applies to this claim. The supplemental amount is reflected in the special pricing conditions percent – claim or line field. This is an action SF message code. A supplemental percentage modifies the price to accommodate additional payments or refunds.
U270	Used when there is a provider whole claim or excess days sanction indicated on the SF. The sanction amount and excess days amounts are reflected in the Special Pricing Conditions Amount and/or Percent - claim fields.
U280 (also S060)	A state-mandated surcharge applies to this claim. The surcharge amount is reflected in the special pricing conditions percent – claim or line field. This is an action SF message code.
U290	DME Rental to Purchase (dollar amount)

SF Message Code (S012)	Description
U291	DME Rental to Purchase (days)
U292	DME Rental to Purchase (months)
U293	DME Rental to Purchase (units)
U294	DME Rental to Purchase (dollar amount and days whichever is reached first)
U295	DME Rental to Purchase (dollar amount and months whichever is reached first)
U296	DME Rental to Purchase (dollar amount and units whichever is reached first)
U297	DME Rental Only
U298	DME Purchase Only
U299	DME No contract exists
U300	A state mandate applies to this claim. For use at the claim and line levels. The Host Plan also should send an NF record that identifies the day that applies to the state mandate. This is an unconditional SF message code.
U350 (conditional message code)	The application of a deductible of more than \$\$\$\$\$\$\$\$\$\$.cc, a copayment of more than \$\$\$\$\$\$\$\$\$\$.cc per/day (Host Plan calculated total or aggregate amount), or any percentage coinsurance will invalidate the discount on this claim. Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) Valid at the claim level only. (This is enforced by an ITS edit.) Used for hospital claims.
U400 (conditional message code)	The application of a deductible of more than \$\$\$\$\$\$\$\$\$\$.cc or a copayment of more than \$\$\$\$\$\$\$\$\$\$.cc will invalidate the discount on this claim. Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) Valid at the claim level only. (This is enforced by an ITS edit.)
U450 (conditional message code)	The application of a deductible of more than \$\$\$\$\$\$\$\$\$\$.cc, a copayment of more than \$\$\$\$\$.cc or any percentage coinsurance will invalidate the discount on this claim. Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) Valid at the claim level only. (This is enforced by an ITS edit.) Used for professional claims.
U600	Pend: Claim/service under review. For use at the claim and line levels. U600 should be used when the Host Plan is conducting a fraudulent investigation that it anticipates it will complete within a short timeframe. This is an unconditional SF message code.
U601	Pay: Claim/service is complete. For use at the claim and line levels. The Host Plan has completed a fraudulent investigation on the claim or service line and it was determined not to be fraudulent. This is an informational SF message code.
U602	Reject: Claim/service is complete. For use at the claim and line levels. Host Plan has completed a fraudulent investigation on the claim or service line and it was determined to be fraudulent. DF message code 1073 should be used for the reject reason. This is an informational SF message code.
U603	Pay: Additional information is required. For use at the claim and line levels. This is an informational SF message code.
U604	Reject: Additional information is required. For use at the claim and line levels. This is

SF Message Code (S012)	Description
	an informational SF message code.
U650	This claim is part of a larger claim that has been split because the total charges exceed the Plan's capacity for processing as a single claim. For use at the claim level only. (This is not enforced with an ITS edit.)
U700	This claim is part of a National Transplant Network claim. Handle according to the policies and standards of the National Transplant Network. For use at the claim level only. (This is not enforced with an ITS edit.)
U701	Identifies a claim for which the charges are included under the primary global fee amount. This claim is passed to the Home Plan to permit proper adjudication of the global fee claim.
U702	Identifies a claim for which the charges have not been included under the primary claim global fee amount. These claims are "stragglers" submitted to the Plan after the SF for the primary claim has been sent to the Home Plan.
U703	Identifies a claim not previously identified as part of a global fee, but for a service for which the Host Plan has negotiated a global fee. This claim will be populated with the Host price and will be subject to the access fee. This message code will alert the Home Plan that a global fee is available if it wishes to seek an adjustment.
U750	This managed care claim required investigation at the local Plan. For use at the claim level only. (This is not enforced with an ITS edit.)
U800 (conditional message code)	The application of any deductible to this claim will invalidate the discount. Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) For use at the claim level only. (This is enforced with an ITS edit.)
U850 (conditional message code)	The application of a managed care penalty that exceeds the total accommodation charges on the claim invalidates the discount. Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) For use at the claim level only. (This is enforced with an ITS edit.)
U900	The application of any subscriber liability, managed care penalty or cost sharing (deductible, copayment, or coinsurance) to this claim will invalidate the discount. If any subscriber liability must be assessed, change the pricing method to 01 and adjudicate the claim at charges. For use at the claim level only. (This is not enforced with an ITS edit.)
U951	This service should not be adjudicated. Home Plans should not pay these lines, nor should they hold the subscriber liable for them. The Host Plan will rebill these lines separately. For use at the line level only. (This is not enforced with an ITS edit.) Ordinarily, this code is used in cases for which professional lines are billed on an institutional claim, or institutional lines are billed on a professional claim.
U952 (conditional message code)	Payment may be reduced only by a copay not to exceed \$\$\$\$\$\$.cc. If additional cost sharing must be applied, reject the claim as a handle direct (reject code 1058, 1059 or 1087). Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) Valid at the claim level only. (This is enforced with an ITS edit.)
U953	This service must be paid at 100% of the PPO allowance or total charge. If additional cost sharing must be applied, reject the claim as a handle direct (reject code 1058,

SF Message Code (S012)	Description
	1059 or 1087). Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) For use at the claim and line levels.
U954	This service must be paid at 100% of the PPO allowance. If additional cost sharing must be applied, reject the claim as a handle direct (reject code 1058, 1059 or 1087). Cannot be used without the presence of SF message code 1005 or 1006. (This is enforced with an ITS edit.) For use at the claim and line levels.
U955	Do not change the pricing method to 01. For use at the claim level. The Host Plan should not use this code if it never pays a non-contractual amount to its providers. No override capabilities. This is an informational SF message code.
U956	This claim cannot be adjusted without an NF approval from the Host. The standard NF approval process must be followed. For use at the claim level only. This is an informational SF message code.

Note: Conditional message codes are valid only at the claim level and only one is allowed per claim. These codes may be present with other SF message codes, but not with each other. Use of these codes require a special pricing conditions code and the values (\$\$\$\$\$\$\$\$.cc) of these amounts are specified in the special pricing conditions amount/percent field. Five occurrences are allowed for SF message codes, special pricing conditions codes and special pricing amount/percent fields. UPF will process these conditional message codes only at the claim level.

Table 3-7: UPF Special Pricing Conditions Data Elements

Special Pricing Conditions Code (S053)	This field is used by UPF to indicate which limitation is being applied to the claim
002	Deductible limit-dollars
003	Copayment limit-dollars
004	Coinsurance limit-dollars
007	Managed care total subscriber liability-dollars
008 (also S057)	Surcharge percentage (affects BCBS liability only)
009	Prompt Pay Days
010	DME Rental to purchase dollar amount
011	DME rental to purchase days
012	DME rental to purchase months
013	DME rental to purchase units
014	Provider Sanction Amount from the Provider Contract
015	Provider Sanction Percent from the Provider Contract
016	Excess Days Provider Sanction Amount from the Provider Contract
017	Excess Days Per Day Sanction Amount from the Provider Contract

Special Pricing Conditions Code (S053)	This field is used by UPF to indicate which limitation is being applied to the claim
018 (also S057)	Supplemental amount percentage (affects BCBS liability only)
019	Excess Days from the Provider Contract – Host Plan Needs Number of Excess Days
Special pricing conditions amount (S052)	This field contains the dollar amount limitation for the associated special pricing conditions code.
Special pricing conditions percent (S054) (also S059)	This field contains the percent limitation for the associated special pricing conditions percent code.

Institutional Pricing Methods

Pricing Institutional Claims

As a local Plan, you can use UPF pricing methods on institutional inpatient and outpatient claims with the restriction that per diem (20) and case allowance (30) pricing apply only to institutional inpatient claims. In addition, depending on the pricing method chosen, you can price institutional claims at the claim level, the line-item level and at both the claim and line-item levels.

Claim-Level Pricing

Claim-level pricing specifies one pricing method and one set of pricing values for all of a claim's line items. Use this to apply one pricing method to a claim when there is a per-day, per-visit case allowance or bulk rate.

Line-Item Pricing

Line-item pricing specifies one pricing method and one set of pricing values for each line item on the claim. Within a claim, all line items can contain the same pricing method or different line items can contain different pricing methods.

Combination Pricing

Combination pricing specifies two or more pricing methods and sets of pricing values for a claim.

A claim can be priced at the claim level using a per-day, per-visit or case allowance that covers most but not all line items. These line items then are priced individually at the line-item level.

A claim can be priced at the line-item level using different pricing methods for different line items.

Table 3-8 identifies the pricing methods available for institutional and professional claims priced using a single pricing method. Table 3-9 shows how you can combine two or more of these pricing methods on the same claim.

Professional Pricing Methods

Pricing Professional Claims

You can price professional claims at the line-item level using one set of pricing methods for each line item. Within a claim, different line items can have different pricing methods; however, per diem (20) and case allowance (30, 33) pricing methods apply only to institutional inpatient claims.

Table 3-8 identifies the pricing methods available for institutional and professional claims using a single pricing method. Table 3-9 shows how you can combine two or more of these pricing methods on the same claim.

Table 3-8: Valid Institutional and Professional Pricing Methods for Claims Priced with a Single Pricing Method

NOTE: [Refer to Table 3-9](#) for details on how you can combine these different pricing methods on the same claim.

			Pricing Method Validity	
Pricing Method	Description	Claim Type	At the Claim Level	At the Line-Item Level
01	Charges	Inpatient	Yes	Yes
		Outpatient	Yes	Yes
		Professional	No	Yes
10	Percent of charges	Inpatient	Yes	Yes
		Outpatient	Yes	Yes
		Professional	No	Yes
14	Percent of allowed amount per category of service	Inpatient	No	Yes
		Outpatient	No	Yes
		Professional	No	Yes
15	Percent of allowed amount per unit of service	Inpatient	No	Yes
		Outpatient	No	Yes
		Professional	No	Yes
20	Per diem	Inpatient	Yes	Yes
		Outpatient	No	No
		Professional	No	No

			Pricing Method Validity	
Pricing Method	Description	Claim Type	At the Claim Level	At the Line-Item Level
30	Case allowance (DRG)	Inpatient	Yes	No
		Outpatient	No	No
		Professional	No	No
33	Case allowance/percent of charges	Inpatient	Yes	No
		Outpatient	No	No
		Professional	No	No
40	Flat fee or allowance per category of service	Inpatient	No	Yes
		Outpatient	No	Yes
		Professional	No	Yes
41	Flat fee or allowance per unit of service	Inpatient	No	Yes
		Outpatient	No	Yes
		Professional	No	Yes
42	Multiple service allowance	Inpatient	No	No
		Outpatient	No	Yes
		Professional	No	Yes
43	Multiple service allowance/ Percent of charges	Inpatient	No	No
		Outpatient	No	Yes
		Professional	No	Yes

Table 3-9 Valid Combinations of Two or More Pricing Methods Available on a Single Institutional or Professional Claim

NOTE: [Refer to Table 3.8](#) for a list of pricing methods you can use on claims priced with just a single pricing method.

Claim Type	If You Specify One of These Claim Level Pricing Methods	You Also Can Combine One or More of These Line-Item Pricing Methods
Institutional Inpatient	20 Per diem	10 Percent of charges
		14 % of allowed/category
		15 % of allowed/unit
		40 Allowed/category
		41 Allowed/unit
Institutional Inpatient	30 DRG 33 Case allowance/percent of charges	10 Percent of charges
		14 % of allowed/category
		15 % of allowed/unit
		40 Allowed/category

Claim Type	If You Specify One of These Claim Level Pricing Methods	You Also Can Combine One or More of These Line-Item Pricing Methods
		41 Allowed/unit

Claim Type	If You Do Not Use Claim-Level Pricing	You Can Combine Two or More of these Line-Item Pricing Methods
Institutional Inpatient	b (Leave the claim-level pricing method blank.)	10 Percent of charges 14 % of allowed/category 15 % of allowed/unit 20 Per diem <i>NOTE: Per diem pricing is only valid at the line-item level for accommodations.</i> 40 Allowed/Category 41 Allowed/Unit
Institutional Outpatient	b (Leave the claim-level pricing method blank.)	10 Percent of Charges 14 % of Allowed/Category 15 % of Allowed/Unit 40 Allowed/Category 41 Allowed/Unit 42 Multiple Service Allowance 43 Multiple Service Allowance/Percent of Charges <i>NOTE: Line item pricing methods 42 and 43 may be combined with other pricing methods, but not with each other.</i>
Professional	NA (Claim level pricing is not applicable.)	10 Percent of Charges 14 % of Allowed/Category 15 % of Allowed/Unit 40 Allowed/Category 41 Allowed/Unit 42 Multiple Service Allowance 43 Multiple Service Allowance/Percent of Charges <i>NOTE: Line item pricing methods 42 and 43 may be combined with other pricing methods, but not with each other.</i>

Unsolicited or Noncontracting Providers

Providers with No Hold Harmless Agreement

Local Plans can price claims from providers with no hold harmless agreement by using pricing method 01. Local Plans should always pass a zero access fee percentage on claims with pricing method 01.

Processing sites will adjudicate claims priced with pricing method 01 according to their own contracts. Even when the Local Plan has appended a maximum allowance or price to the claim, the processing site has the option of paying charges, local Plan priced amount or processing site priced amount as long as payment and patient liability equal billed charges.

1. The local Plan will append the charges, pricing method 01 (charges) and, optionally, its maximum allowance or price for the accommodation, ancillary or procedure.
2. The local Plan will set the Plan payer code, the payment disposition (payee) code, and the rep payee code (if applicable) on the SF.
3. The local Plan will specify that the access fee percentage on the SF is zero (0).
4. The processing site will adjudicate the claim and pay billed charges, the local Plan priced amount or the processing site priced amount. If payment is not at billed charges, the subscriber will be liable for the difference between the priced amount and charges.
5. Because no discount will apply to the claim, the processing site should not fill the payment reduction code 1 field with C, D, E, F, G, K, Q, U, or W (discount types). The net liability determination module will calculate an administrative expense allowance, but no access fee will apply.

Contracting Providers

When you receive claims from a provider with whom you have a discount agreement, the subscriber is liable only for managed care penalties, contract-based cost sharing (deductibles, coinsurance, amounts exceeding payment maximum dollar limits and copayments) and noncovered services. The subscriber is not responsible for any discounts included in your local provider agreement.

For claims priced at charges, the host Plan can append a 1024 SF message indicating that the claim is priced at charges because no non-par pricing is available for this provider)

Additionally the host Plan can append a pricing method and rule along with a 1022 Or 1023 SF message code. The subscriber may or may not be held-harmless when processing a non-participating provider BlueCard claim. This will be identified by the use of one of the two SF Message Codes:

- 1022 (Hold Harmless applies)
- 1023 (Hold Harmless does not apply)

Summary of Standard Rules and Pricing Methods

How the UPF Rules Pricing Methods, and SF Message Codes Work Together

UPF pricing methods identify a range of different discount arrangements that Plans use when pricing claims.

The UPF standard rules provide different ways of applying these discounts currently supported by the UPF calculator. The rules basically specify whether the subscriber shares in this discount.

NOTE: The UPF rule you submit with each claim determines: (a) the sequence in which the calculator computes BCBS and subscriber liability for service limitations, subscriber benefits management penalties, cost sharing and the percentage factor (if applicable) and (b) the base amount for each calculation and a cap for the calculated amount. However, the primary effect of using different rules for the same pricing method is to allow or not allow the subscriber to share in the discount.

The rules apply service limitations first and benefits management reductions second. The rules differ in the specific discount they apply and in how they factor in the subscriber's cost sharing. When required, secondary rules determine how reductions for noncovered services are applied to inclusively priced claims.

In addition, UPF SF message codes allow local Plans to identify any local conditions specific to their Plans that are not currently supported by the UPF software. [Refer to Table 3-6](#) for the local conditions Plans have requested to date.

After identifying the specific discounts (pricing methods) you will use as a local Plan, whether you will share this discount or not (rule number) and any local conditions (UPF message code), you will append this pricing information to the ITS SF claims you transmit to the processing site.

How to Append UPF Rules, Pricing Methods, and Local Conditions Codes

Chapter 4 of this manual describes in detail how local Plans append pricing information to the ITS SF they will send to the processing site. Chapter 6 provides a number of detailed examples of claims priced and calculated using the UPF procedures and software.