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Definitions of 'Cost' in Medicare Utilization Files

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What is the "Cost"?

- Type of Service/Provider
- To Whom
- Defining 'Costs'
  - Methods
  - Variables

Type of Service/Provider

- Providers
  - Institutional
    - » Hospital (Inpatient & Outpatient)
    - » SNF
    - » HHA
    - » Hospice
  - Non- Institutional
    - » Physicians/other practitioners, Ambulatory Surgical Centers (ASCs), and DME suppliers

Cost to Whom?

- Medicare
- Beneficiary
- Other Payor
- Provider

‘Cost’ Definitions

- Provider ‘Cost’ using cost-to-charge ratios
- Claim file variables
  - DRG Price
  - Medicare Payment/Reimbursement Amount
  - Beneficiary Responsibility
  - Primary or Other Payor
  - Charges

Payment Calculations for Utilization Files

- MedPAR file: Institutional ‘Stay’ record file
- Standard Analytical Files
  - Inpatient
  - SNF
  - HHA
  - Outpatient
  - Carrier

MedPAR Payment Variables

- MEDPAR DRG Price Amount
- MEDPAR DRG Outlier Approved Payment Amount
- MEDPAR Total Pass Through Amount

MedPAR Payment Variables

- MEDPAR Medicare Payment Amount
- MEDPAR Beneficiary Inpatient Deductible Liability Amount
- MEDPAR Beneficiary Part A Coinsurance Liability Amount
- MEDPAR Beneficiary Blood Deductible Liability Amount
- MEDPAR Beneficiary Primary Payer Amount

MedPAR Payment Variables

- Payment Made by Medicare
- Payment Made by Beneficiary (Patient Responsibility)
- Payment Made by Primary Payer
- Payment Due TO the Provider

MedPAR Payment Variables

- Payment Made by Medicare
- To calculate the total payments made by Medicare sum:
  - MEDPAR Medicare Payment Amount

    AND
  - MEDPAR Total Pass Through Amount

MedPAR Payment Variables

- Payment Made by Beneficiary (Patient Responsibility)
- SUM the following 3 variables:
- MEDPAR Beneficiary Inpatient Deductible Liability Amount

AND

- MEDPAR Beneficiary Part A Coinsurance Liability Amount

AND

- MEDPAR Beneficiary Blood Deductible Liability Amount

MedPAR Payment Variables

- **Payment Made by Primary Payer**
  - MEDPAR Beneficiary Primary Payer Amount

MedPAR Payment Variables

- Payment Due TO the Provider
- Two ways to calculate:
  1. Sum the Medicare, Beneficiary and Primary Payer MedPAR Payment Variables **OR**
  2. Sum DRG Price, Outlier Amount and Pass Thru Amounts

Inpatient SAF Payment Variables

- Claim Payment Amount
- Claim Pass Thru Per Diem Amount
- Claim Utilization Day Count
- NCH Beneficiary Inpatient Deductible Amount
- NCH Beneficiary Part A Coinsurance Liability Amount
- NCH Beneficiary Blood Deductible Liability Amount
- NCH Primary Payer Claim Paid Amount

Inpatient SAF Payment Variables

- Payment Made by Medicare
- To calculate the total payments made by Medicare:

- Claim payment amount + (Claim Pass Thru Per Diem Amount * Claim Utilization Day Count)

Inpatient SAF Payment Variables

- Payment Made by Beneficiary (Patient Responsibility)
- SUM the following 3 variables:
- NCH Beneficiary Inpatient Deductible Amount

  AND
- NCH Beneficiary Part A Coinsurance Liability Amount

  AND
- NCH Beneficiary Blood Deductible Liability Amount

Inpatient SAF Payment Variables

- Payment Made by Primary Payer
  - NCH Primary Payer Claim Paid Amount

Inpatient SAF Payment Variables

- Payment Due TO the Provider
- Must calculate as the sum of payment made by Medicare, Beneficiary and Primary Payer

Inpatient SAF Payment Variables

- Revenue Center Payments variables are in the Inpatient SAF
- HOWEVER, since Inpatient hospitalizations are paid PPS, the revenue center variables are not correctly populated (zero filled)
- Therefore, only Claim level payment calculations can be made

SNF SAF Payment Variables

- SNF SAF variables are the same as the Inpatient SAF

HHA SAF Payment Variables

- Payment Made by Medicare
  - Claim Payment Amount
- Payment Made by Primary Payer
  - NCH Primary Payer Claim Paid Amount

HHA SAF Payment Variables

- Payment Made by the Beneficiary (Patient Responsibility)
- No Claim level variable – Why?

- Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount
  - Populated less than 0.05%

HHA SAF Payment Variables

- Payment Due TO the Provider

- Sum of Claim Payment Amount and NCH Primary Payer Claim Paid Amount

  And

- (Sum of Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount)

Outpatient SAF Payment Variables

- **Payment Made by Medicare**
  - Claim Payment Amount
- **Payment Made by Primary Payer**
  - NCH Primary Payer Claim Paid Amount

Outpatient SAF Payment Variables

- Payment Made by Beneficiary (Patient Responsibility)
- SUM the following 3 variables:
- NCH Beneficiary Part B Deductible Amount

  AND
- NCH Beneficiary Part B Coinsurance Liability Amount

  AND
- NCH Beneficiary Blood Deductible Liability Amount

Outpatient SAF Payment Variables

- Payment Due TO the Provider
- Must calculate as the sum of payment made by Medicare, Beneficiary and Primary Payer
- 5 Variables total

Outpatient SAF Payment Variables

- Revenue Center Payment Variables are populated.
- Payment Made by Medicare
  - Revenue Center Payment Amount
- Payment Made by Primary Payer
  - Revenue Center 1st (& 2nd) Medicare Secondary Payer Paid Amount

Outpatient SAF Payment Variables

- Beneficiary Responsibility
  - Revenue Center Cash Deductible Amount
  - Revenue Center Blood Deductible Amount
  - Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount
  - Revenue Center Reduced Coinsurance Amount

Carrier SAF Payment Variables

- **Payment Made by Medicare**
  - Claim Payment Amount
- **Payment Made by Primary Payer**
  - Carrier Claim Primary Payer Paid Amount

Carrier SAF Payment Variables

- **Payment Made by Beneficiary (Patient Responsibility)**
  - **Must Calculate as the SUM of:**
    - » **SUM (of Line Coinsurance Amount)**

      And

    - » **SUM (of Line Beneficiary Part B Deductible Amount)**

      OR

    - » **Carrier Claim Cash Deductible Applied Amount**

Carrier SAF Payment Variables

- Payment Made (Due) to the Provider
- Sum of payment made by Medicare, Beneficiary, and Primary Payer

Carrier SAF Payment Variables

- Payment Calculations at the Line Item
- Variables
  - Line NCH Payment Amount
  - Line Beneficiary Part B Deductible Amount
  - Line Coinsurance Amount
  - Line Beneficiary Primary Payer Paid Amount

Charges

- Charges include those submitted by the Provider (Institutions or Physician) and those “Allowed” or “Covered” by Medicare and Total Charges

Medicare Covered Charges: Definition

- Also referred to as 'Allowed' Charges
- Applies only to Medicare covered services
- This is the portion of the total charge that Medicare covers or allows the provider to collect from all sources
  - Medicare
  - Primary payors
  - Beneficiary (deductible, coinsurance)

Medicare Covered Charges: Variables

- Inpatient SAF – Not a variable within the file but can be calculated.
  - **Claim level:** Claim Total Charge Amount – NCH Inpatient Noncovered Charge Amount
  - **Revenue Center level:** Revenue Center Total Charge Amount – Revenue Center Noncovered Charge Amount

Medicare Covered Charges: Variables

- MedPAR file
  - **Stay level:** Total Covered Charge Amount

Total Charges: Definition

- The total amount that the provider charges for services rendered
- The total charge is determined by the provider

Total Charges: Variables

- Inpatient SAF
  - **Claim level:** Claim Total Charge Amount
  - **Revenue center level:** Revenue Center Total Charge Amount

Total Charges: Variables

- MedPAR File
  - **Stay level:** Total Charge Amount
  - **Revenue Center Grouping level:** [Revenue center group name] Charge Amount

Carrier SAF Charge Variable

- Allowed Charges in the Carrier file is the Amount Medicare “allows” the Provider to be paid.
- The variable “Allowed Charge Amount” at both the Claim level and Line level can be used for the Payment Made to the Provider (generally).

Things to Consider

- Denied Claims and/or Line Items
  - Carrier file contains Denied Claims (variable is the Carrier Claim Payment Denial Code or use the Line Processing Indicator Code)
- Example: What is the average amount paid for XXXXX Part B service?
  - If denied claims included - $36.95
  - Without denied claims included - $42.82
- Institutional File – Claim Medicare Non Payment Reason Code

Things to Consider

- Zero payment amounts for line item services that are allowed.
- Usually due to deductibles paid by beneficiary

Things to Consider

- Negative Payment Amounts
  - Can occur when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays.
  - May be due to transfer also and Beneficiary Deductible on first hospital's claim with no deductible on second hospital's claim.
  - Or when a beneficiary is charged a coinsurance during a long stay and the coinsurance exceeds the amount Medicare pays (occurs mostly with psych hospitals stays).

Things to Consider

- **Embedded Payment Classification Categories in Revenue Center HCPCS Field**
  - Inpatient Rehabilitation Facilities
    - » Revenue Center Code ‘0024’ has CMG
  - Skilled Nursing Facilities
    - » Revenue Center Code ‘0022’ has HIPPS (RUG-III)
  - Home Health Agencies
    - » Revenue Center Code ‘0023’ has HIPPS (HHRG)

Sounds great, BUT

- Variables 'Provider Payment Amount'
  - The total payments made to the provider for this claim
  - It reflects only what Medicare paid
  - Most are duplicate of 'Payment/Reimbursement Amount'
- Variables 'Beneficiary Payment Amount'
  - The amount paid to the beneficiary
  - Populated most often when Medicare does not "pay" the provider

Example of Calculating 'Costs'

- Consider this MedPAR record
- Admission date: 7/8
- Discharge date: 7/12
- Primary Diagnosis Code:
  - 820.09 (fracture of femur)
- Secondary Diagnoses:
  - 427.31 (atrial fibrillation)
  - 424.0 (Mitral valve disorder)
  - 401.9 (essential hypertension)
  - 414.01 (coronary atherosclerosis)

Example Continued

- Procedures:
  - 79.35 (open reduction of fracture with internal fixation)
- From revenue center codes: pharmacy, supplies, physical therapy, OR, anesthesia, lab, radiology
- Total charges: $42,361
- Total reimbursements by CMS:
  - Total Pass thru Amount + Reimbursement Amount
  - $268 + $12,800 = $13,068
- Deductible: $792
- Total Due the Provider: $13,860

Example Continued

- But that isn't the total story.
  In the Carrier file you can find claims for professional services related to that stay.

Claim from date: 7/8

Claim through date: 7/8

Number of line-items: 1

Specialty: 93 (Emergency Medicine)

Diagnosis:

959.6 (Injury to hip and thigh),

820.8 (fracture of femur),

E855.9 (Accidental poisoning by drug acting on central nervous system)

HCPCS:

99285 (Emergency department visit)

Claim Payment Amount by CMS: $132.12

Total Deductible/copayment: $33.03

Claim from date: 7/8 - Claim through date: 7/9

Number of line-items: 2

Specialty: 20 (Orthopedic surgery)

Diagnosis: 717.45 (internal derangement of knee), 820.21 (fracture of femur)

HCPCS:

99223 (initial hospital care, high complexity)

modifier 57 (Decision for surgery)

27244 (Open treatment of femoral fx, plate/screw type implant)

Modifier: RT (right side)

Claim Payment by CMS: $996.10

Total deductible/copayments: $249.03

Claim from date: 7/9

Claim through date: 7/9

Number of line-items: 1

Specialty: 43 (Certified registered nurse anesthetist)

Diagnosis: 820.10 (fracture of femur)

HCPCS:

01210 (Anesthesia for open procedures involving hip joint)

Modifier: QK (supervised by an anesthesiologist overseeing 2-4 patients)

Claim Payment by CMS: $206.16

Total deductible/copayment: $51.54

Claim from date: 7/8 - Claim through date: 7/9

Number of line-items: 3

Specialty: 30 (Diagnostic Radiology)

Diagnosis: 820.8 (fracture of femur)

HCPCS:

71020 (radiologic examination of the chest, two views)

72170 (radiologic examination of pelvis)

73510 (radiologic examination of hip, two views)

Modifier: 26 (professional component)

Claim Payment by CMS: $28.73

Total deductible/copayments: $7.17

And the hospital care is comprised of:

- 5 claims
- Total payments by CMS:
  - $13,068 + 132.12 + 996.10 + 206.16 + 28.73
  - $14,431.11
- Total deductible/copayments:
  - $792 + 33.03 + 249.03 + 51.54 + 7.17
  - $1,132.77
- Total Payment Made (Due) to Provider
  - $15,563.88

Summary

- Understanding of the payment system will drive what payment variables are available in the CCW data files
- Can only analyze payments at the claim level for Inpatient, SNF and HHA
- Can analyze at the “service” level for Outpatient, Carrier and DME