Raising Questions & Requesting Materials

- **During the meeting**
  - Please send all general-interest questions via Zoom's comments panel
  - Get ready: There will be pop quizzes during the session!
- **After the meeting**
  - Send client-specific and/or follow-up questions and requests for session materials to events@onpointhealthdata.org
  - Visit our "Resources" page for future event listings at www.onpointhealthdata.org/resources

Session Agenda
Exploring the Differences Between Commercial & Medicare/Medicaid Data Sources

- Payer Relationships

- Medicare Options

- Mapping Medicare Data

- Medicare & Medicaid Billing

Payer Relationships
Commercial, Medicare, & Medicaid

| Primary Insurance	Secondary Insurance	Tertiary Insurance
Commercial	Commercial Medicare	Medicaid
Commercial	Medicaid (third-party liability (TPL))	
Medicare	Commercial Medicare Supplemental (crossover claims)	Medicaid
Medicare	Medicaid (dual-eligible (crossover claims))	
Medicare Advantage	Commercial ~~Medicare Supplemental~~	Medicaid
Medicare Advantage	Medicaid	
Medicaid		

ONPOINT Health Data

Payer Relationships
Member Month

Member	Year & Month	Medical Product Code	Medical Submitter ID	Medical Eligibility ID	Medical Commercial Eligibility ID	Medical Medicare Eligibility ID	Medical Medicaid Eligibility ID
123	201801	PR	13154	1111	1111	2222	3333
123	201802	PR	13154	1111	1111	2222	3333
123	201803	PR	13154	1111	1111	2222	3333

Payer Relationships
Medicare Secondary Payer (MSP)
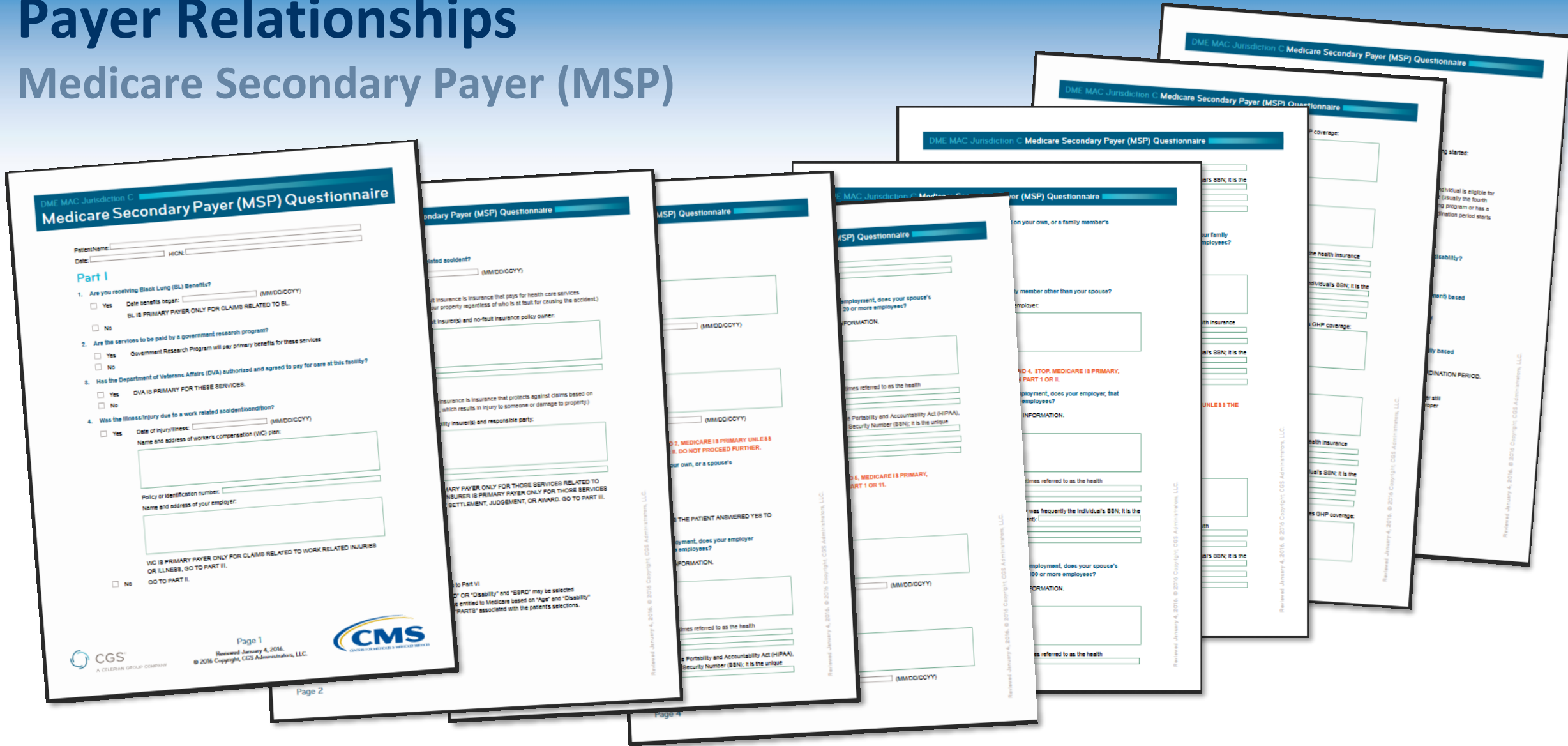
Payer Relationships
Medicare Secondary Payer (MSP)

MSP Criteria	Who is Primary?
Member is **over** 65 and group health plan employer has more than 20 employees	Commercial
Member is **under** 65 and group health plan employer has more than 100 employees	Commercial
Medicare entitlement reason ESRD and the first 30 months of Medicare coverage	Commercial
Retirees still covered under employer's group health plan	Medicare

Payer Relationships
Dual Eligibility

| Dual Eligibility Code	Dual Eligibility Description	Dual Eligibility Indicator	Plan Type
-2	Submitter supplied an invalid value.	Neither Dual Eligible or TPL	All
-1	Submitter did not supply a value.	Neither Dual Eligible or TPL	All
0	No dual eligibility at end of month	Neither Dual Eligible or TPL	Medicaid
1	Dual eligibility at end of month	Dual Eligible	Medicaid
00	Not Medicare enrolled for the month	Neither Dual Eligible or TPL	Medicare
NA	Non-Medicaid	Neither Dual Eligible or TPL	Medicare
01	QMB only	Dual Eligible	Medicare
02	QMB and Medicaid coverage including RX	Dual Eligible	Medicare

Payer Relationships
Dual Eligibility

Member	Payer	Dual Eligibility Reported
111	Medicaid	Dual Eligible
111	Medicare	Dual Eligible
222	Medicaid	Dual Eligible
222	Medicare	Neither Dual Eligible or TPL
333	Medicaid	Neither Dual Eligible or TPL
444	Medicaid	Dual Eligible

Payer Relationships
Medicare Crossover Claims
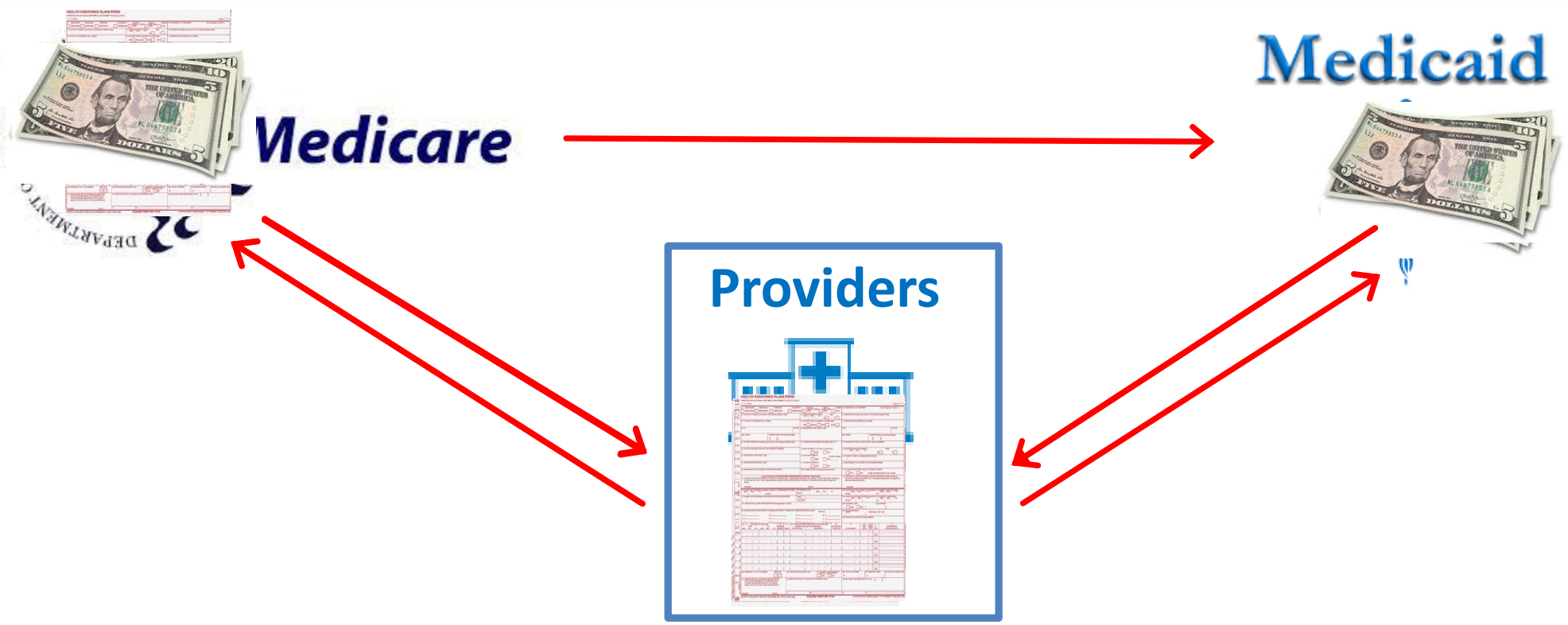
User Group Pop Quiz #1

Q	What is MSP?
A	Medigap Secondary Plan
B	Medicare Secondary Payer
C	Medicare Secondary or Primary
D	None of the above

Medicare Options
For Members with Part A & B

Option 1:
Original Medicare

Part A
Hospital Insurance

+

Part B
Medical Insurance

You can add:

Part D
Medicare Prescription
Drug Coverage

You can also add:

Medigap
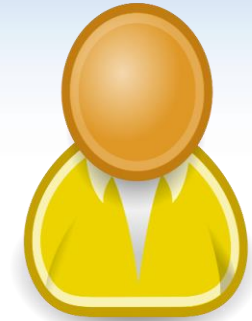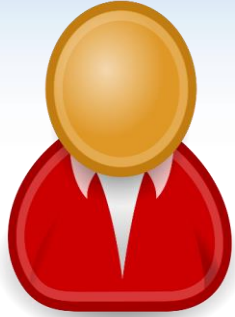Medicare Supplement Insurance

Option 2:
Medicare Advantage (Part C)

Part A
Hospital Insurance

+

Part B
Medical Insurance

+

Part D
Medicare Prescription
Drug Coverage

Medicare Options
Reported to the APCD

File	Medicare FFS (Parts A & B)	Medicare FFS (Parts A, B, & D)	Medicare Advantage (Including Part D)	Medicare Advantage (Separate Part D Plan)
Eligibility	Medicare FFS	Medicare FFS Commercial Part D plan	Medicare FFS Medicare Advantage	Medicare FFS Medicare Advantage Commercial Part D plan
Medical	Medicare FFS	Medicare FFS	Medicare Advantage	Medicare Advantage
Pharmacy		Medicare FFS Commercial Part D plan	Medicare FFS Medicare Advantage	Medicare FFS Commercial Part D plan

Medicare Options
Open Enrollment

- Annual

  – October 15 through December 7

  – Switch from Medicare FFS to Medicare Advantage or vice versa

  – Switch from one Medicare Advantage plan to another and from one Medicare Part D plan to another

  – Enroll in a Medicare Part D plan if they hadn't already when they were first eligible (a late-enrollment penalty may apply)

  – Changes in enrollment take effect in January

ONPOINT Health Data
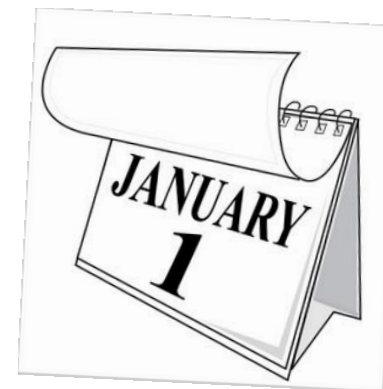
Medicare Options
What's New in 2020

- Elimination of Medigap plans covering Part B deductibles
- Elimination of pharmacy "donut hole" for generic drugs
  - Members pay 25% of the costs until catastrophic level
  - Increase in catastrophic level to $6,350
- Part D maximum deductible increase to $435
- Increase in member responsibility amounts

Medicare Options
What's New in 2020

| Year | Part A | | Part B | |
	Coinsurance / Per Day	Deductible	Coinsurance	Deductible
2018	Day 1-60: $0 Day 61-90: $335 Day 91+: $670	$1,340	$183	20%
2019	Day 1-60: $0 Day 61-90: $341 Day 91+: $682	$1,364	$185	20%
2020	Day 1-60: $0 Day 61-90: $352 Day 91+: $704	$1,420	$197	20%

User Group Pop Quiz #2

Q	Which of the following statements is true?
A	Medicare Part C includes coverage for parts A, B, and D
B	Medicare Part C includes coverage for parts A, B, and sometimes D
C	Traditional Medicare includes coverage for parts A, B, and D
D	All of the above
E	None of the above

Mapping Medicare Data
Medicare Files Received

- Non-APCD format
  - Member crosswalks
  - Medical files: 7 different files
  - Pharmacy: Part D event
  - Eligibility: Multiple files
  - Provider information: Very limited

ONPOINT Health Data

Mapping Medicare Data
Medicare Beneficiary Identifier (MBI)

Mapping Medicare Data
Medical Files – Data Source Type

Who Pays?	What is Covered?	Data Source Type	Claim Form
Part A	Inpatient Hospital	INP	Facility (UB-04)
Part A	Skilled Nursing Facility	SNF	Facility (UB-04)
Part A	Home Health (Some)	HHA	Facility (UB-04)
Part A	Hospice	HSP	Facility (UB-04)
Part B	Outpatient (Including ED)	OUT	Facility (UB-04)
Part B	Skilled Nursing Facility	OUT	Facility (UB-04)
Part B	Home Health (Some)	HHA	Facility (UB-04)
Part B	Physician Services	PHY	Professional (HCFA-1500)
Part B	Durable Medical Equipment (DME)	DME	Professional (HCFA-1500)

Mapping Medicare Data
Eligibility – Reasons for Entitlement

- Reasons for entitlement (entitlement_code)
  - Aged
  - Disabled
  - ESRD (End-stage renal disease)
  - Disabled and ESRD

Example: Under 65 becomes a Medicare beneficiary due to disability and then turns 65:

- Original reason for entitlement: Disabled
- Monthly reason for entitlement: Aged

ONPOINT Health Data

Mapping Medicare Data
Medicare FFS & Medicare Advantage

Medicare Advantage Code	Medicare Advantage Description	Fee for Service or Managed Care Enrollee?
0	Not a member of HMO	Fee for service
1	Non lock-in, HCFA to process provider claims	Managed care
2	Non lock-in, GHO to process in-plan Part A and in-area Part B claims	Managed care
4	Fee for service participant in case or disease management demonstration project (effective 2005 forward)	Fee for service
A	Lock-in, HCFA to process provider claims	Managed care
B	Lock-in, GHO to process in-plan Part A and in-area Part B claims	Managed care
C	Lock-in, GHO to process all provider claims	Managed care

User Group Pop Quiz #3

Q	What does MBI stand for?
A	Master Beneficiary Identifier
B	Medicaid Beneficiary Identifier
C	Medicare Beneficiary Identifier
D	Medicare Best Insurance

Medicare & Medicaid Billing
Physician-Owned Practice

Member	Payer	Provider	Place of Service	Procedure Code	Charge	Paid	Copay	Coinsurance
789	Commercial	Physician	11	99214	$297.00	$212.60	$25.00	
123	Medicare FFS	Physician	11	99214	$297.00	$87.52		$21.89

Medicare & Medicaid Billing
Hospital-Owned Practice

Member	Payer	Provider	Place of Service Code	Type of Bill Code	Revenue Code	Procedure Code	Charge	Paid	Copay	Coinsurance
789	Commercial	Physician	11			99214	$297.00	$212.60	$25.00	
123	Medicare FFS	Physician	22			99214	$109.00	$63.58		$16.22
123	Medicare FFS	Hospital		13	0510	G0463	$188.00	$103.98		$26.00

Medicare & Medicaid Billing
Hospital-Owned Practice – Place of Service

Place of Service Code	Description	Additional Detail	Effective Date
19	Off Campus – Outpatient Hospital	A portion of an off-campus hospital provider-based department that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization	1/1/2016
22	On Campus – Outpatient Hospital	A portion of a hospital's main campus that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization	Definition change: 1/1/2016

Medicare & Medicaid Billing
Comparison of Costs

Comparison of Medicare and Beneficiary Payments for the Same Service at a Provider-Based Facility and Freestanding Facility

Hospital & Provider-Based Facilities

$74.02	Outpatient Prospective Payment System
+	
$40.41	Medicare Physician Fee Schedule
+	
$28.61	Beneficiary Co-Pay

$143.04

Freestanding Facilities

$59.61	Medicare Physician Fee Schedule
+	
$14.90	Beneficiary Co-Pay

$74.51

Same Service

$68.53

DIFFERENCE

Medicare & Medicaid Billing
Payer-Specific Codes

- Medicare G codes
    - Preventive screenings
    - Wellness visits
    - Vaccine administrations
- Medicaid T codes
    - Medicaid-specific services
        » Encounter/clinic visit
        » Alcohol and/or substance-abuse services
        » Sign language / interpreter services
        » Case management

Medicare & Medicaid Billing
Medicare G-Codes – Annual Wellness Visit, Initial

CPT/HCPCS Code	Description	CPT/HCPCS Code & Description (Medicare)
99381	Initial Preventive Medicine New Patient Age <1yr	G0402 (Initial preventive physical examination; new beneficiary during the first 12 months of Medicare enrollment) G0438 (Annual wellness visit, initial)
99382	Initial Preventive Medicine New Patient Age 1-4yrs	
99383	Initial Preventive Medicine New Patient Age 5-11yrs	
99384	Initial Preventive Medicine New Patient Age 12-17yrs	
99385	Initial Preventive Medicine New Patient Age 18-39yrs	
99386	Initial Preventive Medicine New Patient Age 40-64yrs	
99387	Initial Preventive Medicine New Patient Age 65yrs&>	

Medicare & Medicaid Billing
Medicare G-Codes – Annual Wellness Visit, Subsequent

CPT/HCPCS Code	Description	CPT/HCPCS Code & Description (Medicare)
99391	Periodic Preventive Med Established Patient <1yr	G0439 (Annual wellness visit, subsequent)
99392	Periodic Preventive Med Est Patient 1-4yrs	
99393	Periodic Preventive Med Est Patient 5-11yrs	
99394	Periodic Preventive Med Est Patient 12-17yrs	
99395	Periodic Preventive Med Est Patient 18-39yrs	
99396	Periodic Preventive Med Est Patient 40-64yrs	
99397	Periodic Preventive Med Est Patient 65yrs&>	

Medicare & Medicaid Billing
Medicare Flu Shot Billing

CPT Code	Description	HCPCS Code	Description	Diagnosis Code	Diagnosis Description
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content	G0008	Influenza virus vaccination administration		
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted				
90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 ml dosage			Z23	Encounter for immunization
90670	Pneumococcal conjugate vaccine, 13 valent (PCV13)	G0009	Pneumococcal vaccination administration		
90732	Pneumococcal polysaccharide vaccine, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older				

Medicare & Medicaid Billing
Medicare Flu Shot Billing – Roster Billing

- One claim form

- Roster of members, MBIs, gender, date of birth, etc.

- Professional claim (HCFA-1500)

  - Place of Service Code = 60 (Mass Immunization Center)

  - Provider Specialty Code = 73 (Mass Immunization Roster Biller)

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Medicare & Medicaid Billing
Flu Shot Billing – Roster Billing

- One claim form

- Roster of members, MBIs, gender, date of birth, etc.

- Institutional claim UB-04

  – Outpatient Type of Bill codes

  – Patient Status '01' (Discharged to Home or Self Care (Routine Discharge))

  – Revenue codes

    » 0636 (Drugs/Detail Code): Vaccine

    » 0771 (Vaccine Administration): Administration

  – Provider Specialty Code = 73 (Mass Immunization Roster Biller)

Medicare & Medicaid Billing
FQHCs & RHCs

- Facility claims (UB-04, 837I)
- Type of Bill codes
    - 71: Rural Health Clinics
    - 77: Federally Qualified Health Centers
- Revenue codes
    - 052X: FQCH/RHC clinic visits
- HCPCS codes
    - G0466–G0470: FQHC visits
- Provider types
    - Rendering: FQHC
    - Attending: Individual provider

Medicare & Medicaid Billing
Medicaid as Secondary Payer

Service	Charge	Commercial Payer Amounts				Medicaid Amounts	
		Paid	Copay	Coinsurance	Deductible	Allowable	Paid
1	$200	$100	$25	$0	$0	$125	$25
2	$150	$100	$25	$0	$0	$80	$0
3	$500	$280	$0	$70	$0	$300	$20

Medicare & Medicaid Billing
Medicare Timely Filing

- Within 12 months of service date

- Exceptions

  - Administrative error: Additional 6 months

  - Retroactive Medicare enrollment: Additional 6 months

  - Retroactive Medicare entitlement involving state Medicaid agencies

  - Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-Inclusive Care of the Elderly (PACE) provider organization

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Medicare & Medicaid Billing
Timely Filing

State	From Date of Service
CA	6 months
CT	Varies by plan type (120–365 days)
MN	12 months
OR	365 days
RI	365 days
VT	6 months
WA	365 days

User Group Pop Quiz #4

Q	Hospital-owned physicians are required to bill differently than physician-owned practices. The name for this is known as:
A	Split billing
B	Provider-based billing
C	Hospital-based billing
D	A and B
E	A and C

ONPOINT Health Data

Questions & Answers

Looking Ahead to the Next User Group Session

Next User Group Session

Understanding Your Enhanced Summary Tables: A User Training on Inpatient Stay Summary and Medical Claim Header

January 15, 2020; 12:00pm - 1:00pm ET

Presenter: Gina Robertson, Data Operations Manager

Intended Audience: General

APCDs serve as valuable resources for getting a granular look at healthcare services performed over time. In any given year, a payer may report millions and millions of medical claim service lines— one record per service rendered within the same claim, same episode, or same inpatient stay. With no simple way of linking these related services together, it can be difficult to ensure you're attaining all the information from a claim or episode that you're seeking. Onpoint's Inpatient Stay Summary and Medical Claim Header tables do this linkage for you, delivering information about related services in condensed, yet comprehensive summary records. This training is geared towards delineating what information the Inpatient stay Summary and Medical Claim Header tables provide and how to use that information in your independent analyses.
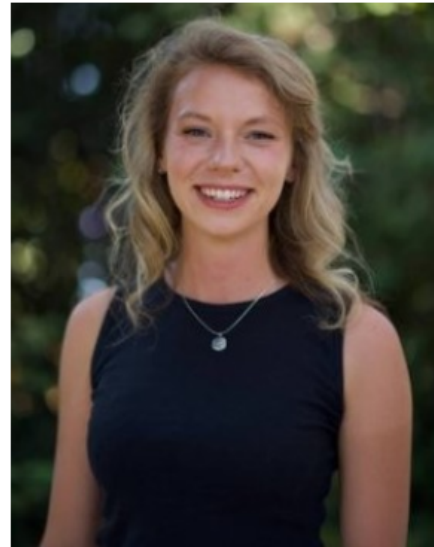
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