97232 Definition of Data Element for Inpatients-Expected Source of Payment

Effective with discharges on or after January 1, 1999, the patient's expected source of payment -- the entity or organization which is expected to pay or did pay the greatest share of the patient's bill -- shall be reported using the following:

(1)

Payer Category. Select one of the following: (A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers. (B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act. (C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, or Shriners. (D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored. (E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered. (F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections

(1)(A), (1)(B), (1)(D), or (1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration. (G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (1)(E) of this section. (H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan. (I) Other Payer. Any third party payment not included in Subsections (1)(A) through (1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(A)

Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B)

Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C)

Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, or Shriners.

(D)

Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E)

County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

(F)

Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (1)(A), (1)(B), (1)(D), or (1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G)

Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (1)(E) of this section.

(H)

Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I)

Other Payer. Any third party payment not included in Subsections (1)(A) through (1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2)

Type of Coverage. For each Payer Category, Subsections (1)(A) through (1)(F) of

this section, select one of the following Types of Coverage: (A) Managed Care -- Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems (COHS). (B) Managed Care -- Other. Health care plans, except those in Subsection (2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), and Point of Service (POS). (C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(A)

Managed Care -- Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems (COHS).

(B)

Managed Care -- Other. Health care plans, except those in Subsection (2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), and Point of Service (POS).

(C)

Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other

fee-for-service payers.

(3)

Health Plan Identification Number. If Type of Coverage is reported as category (A) above, report the specific plan providing coverage by listing the four digit health plan identification number assigned by the California Department of Managed Health Care (DMHC). If Type of Coverage is reported as category (A) above and if the health plan has a pending Knox-Keene license application with DMHC or if the health plan is a COHS that does not have a DMHC assigned number, the four digit health plan identification number shall be reported as 8000.