The Source of Payment Typology
A National Standard

Presentation to ASC X12

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Agenda

- Background
- Description
- Purpose
- Uses
- Maintenance

Background of Source of Payment Typology

- A hierarchical, standardized categorization of payers
- Created by the Public Health Data Standards Consortium (PHDSC)
- Supported by the AHIMA/PHDSC Payer Typology Committee and the National Center for Health Statistics

Current Claim Filing Indicator
List Used in 835 Implementation Guide

12 Preferred Provider Organization (PPO)
This code is also used for Blue Cross/Blue Shield participating provider arrangements.
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
This code is also used for Blue Cross/Blue Shield non-participating provider arrangements.
16 Health Maintenance Organization (HMO) Medicare Risk
17 Dental Maintenance Organization
AM Automobile Medical
CH Champus
DS Disability
HM Health Maintenance Organization
LM Liability Medical
MA Medicare Part A
MB Medicare Part B
MC Medicaid
OF Other Federal Program
Use this code for Black Lung Program
TV Title V
VA Veteran Administration Plan
WC Workers' Compensation Health Claim
ZZ Mutually Defined / Unknown

Issues with Claim Filing Indicator

- No Definitions for Concepts
- Neither comprehensive or mutually exclusive
  - Missing Concepts –
    - For example: bad debt and charity care, ASO
  - Overlapping Concepts
    - For example: Health Maintenance Organization

Source of Payment Typology

- Hierarchical structure
  - Can be rolled up into the level of granularity needed for specific purpose
- Definitions for ALL the concepts
- Companion User Guide for each version of the Source of Payment Typology – currently version 6 as of September, 2015

Source of Payment Typology Hierarchy

- Major payer categories
  - Allows payer classification at a general level of detail
  - Assigned first place value of the code set
- 2nd level sub-classification for major categories
  - Allows more specificity for source of payment classification
  - Assigned second place value of code set
- Additional sub-classification for major categories
  - Allows classification at highest level of granularity (where available)
  - Assigned third, fourth, fifth, and six place value of the code set

Major Payer Categories

1	Medicare
2	Medicaid
3	Other Government (not Medicare, Medicaid or corrections)
4	Department of Corrections
5	Private Health Insurance
6	Blue Cross/Blue Shield
7	Managed Care, unspecified (*)
8	No payment from organization
9	Miscellaneous/other

Typology Categories:
Major and Sub-classifications

1	**MEDICARE**
11	**Medicare (Managed Care)**
111	Medicare HMO
112	Medicare PPO
113	Medicare POS
119	Medicare Managed Care Other
12	**Medicare (Non-managed Care)**
121	Medicare FFS
122	Medicare Drug Benefit
123	Medicare Medical Savings Account (MSA)
129	Medicare Non-managed Care Other
19	**Medicare Other**

Second Level Sub-classification

2	**MEDICAID**
21	**Medicaid (Managed Care)**
211	Medicaid HMO
212	Medicaid PPO
213	Medicaid PCCM (Primary Care Case Mgt)
219	Medicaid Managed Care Other
22	**Medicaid (Non-managed Care Plan)**
23	**Medicaid/SCHIP**
24	**Medicaid Applicant**
25	**Medicaid - Out of State**
29	**Medicaid Other**

Third Level Sub-classification

2	**MEDICAID**
21	**Medicaid (Managed Care)**
211	Medicaid HMO
212	Medicaid PPO
213	Medicaid PCCM (Primary Care Case Management)
219	Medicaid Managed Care Other

Additional Level Classification

32	**Department of Veterans Affairs**
321	Veteran care--Care provided to Veterans
3211	**Direct Care--Care provided in VA facilities**
3212	**Indirect Care--Care provided outside VA facilities**
32121	**Fee Basis**
32122	**Foreign Fee/Foreign Medical Program(FMP)**
32123	**Contract Nursing Home/Community Nrsing Home**
32124	**State Veterans Home**
32125	**Sharing Agreements**
32126	**Other Federal Agency**

Note: The CFI has only 1 value for VA. The VA has adopted the EDI transactions and now this has become even more important

Additional Level Classification

8	NO PAYMENT from an Organization / Agency / Program / Private Payer Listed
81	Self Pay
82	No Charge
821	Charity
822	Professional Courtesy
823	Research / Clinical Trial
83	Refusal to Pay / Bad Debt
84	Hill Burton Free Care
85	Research / Donor
89	No Payment, Other

Additional Requirements

- Differentiation for Medicaid and Medicare managed care versus non-managed care

- Ability to distinguish among different types of plans within major payer programs:
  - Medicare Advantage Plans

- Ability to separate out self-pay from other reasons of nonpayment: charity care, professional courtesy, and bad debt

- Includes Administrative Services Only (ASO) plan

Advantages

- Flexible, expandable and allows for different levels of detail
- Able to respond to dynamic industry changes and requirements
- Can be used by all providers, surveys, and others who collect or analyze source of payment data
- Allows for consistent comparison of the payment category from various data sets and across different types of providers
- More uniform, accurate and reliable data that will enhance multi-state/national analyses.

Importance of Source of Payment Data

- Critical need for policymakers and researcher examining effects of payment policy to compare across databases
- Standardized source of payment data needed to monitor healthcare trends such as access to healthcare and treatment patterns across payer categories
- Standard recommended by ONC for representing patient insurance in the Electronic Health Record
- Designated as the value set for the required supplemental data element "payer" for the CMS 2014 Meaningful Use Clinical Quality Measures (CQM).
- Improve the ability of administrative data to support analyses of the impact of the Affordable Care Act (ACA) and other Federal initiatives in which the type of payer may have an impact on cost, quality and access to care

States that use the Source of Payment Typology

- Georgia
  - Assigned state specific codes within the hierarchy, thus eliminating proprietary codes
- Kansas
- Missouri
- New Hampshire
- New York
  - proprietary data element contained no definitions for the concepts which made reporting very inconsistent across the state
- Oregon
  - Improved granularity of self-pay and charity care concepts
  - Legacy code set not adequate for multitude of uses
- Rhode Island

Relationship to National Standards

- SOP approved as an ANSI Standard - as an external code set
- The ASC X12 Health Care Service Data Reporting Guide supports the reporting of the Source of Payment Typology in the K3 segment for the 5010
    - 6020 and beyond will accommodate it in the SBR10 segment
    - Reporting guide can accommodate both the SOP and the CFI
- The 835 will support the SOP in the next version. Plan to sunset the use of the CFI

Maintenance Activities

- The Source of Payment Typology is maintained as an external code list recognized by ASC X12 and the UB-04.

- As an external code list changes made to the Source of Payment Typology do not have to be approved by the ASC X12 organization.

- Once changes are made by the Payer Typology Committee, any new or deprecated codes will be incorporated into any ASC X12 implementation that now references the Source of Payment Typology without any additional approvals.

- Source of Payment Typology categories and / or definitions have a proven/established process updated every March as part of the ongoing work of the AHIMA/PHDSC Payer Typology Committee.

Contacts

- Public Health Data Standards Consortium Web Site
  - http://www.phdsc.org/standards/payer-typology.asp

- Payer Typology Committee Contacts
  - Committee Chairs:
    - Jonathan Teague, CA OSHPD, Jonathan.Teague@oshpd.ca.gov
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Questions??