Center for Medicare & Medicaid Innovation
Bundled Payments for Care Improvement

Understanding the Limited Data Set Utilization Files

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Please note: The transcript for this activity is based on the actual webinar recording. Minimal editorial/formatting changes have been made to the transcript text.

PAMELA PELIZARRI: Hello. This is Pamela Pellazari at the CMS Innovation Center, and we're very pleased, again, to have Marshall McBean here from the Research Data Assistance Center today to talk about the LDS Utilization Files for the CMS Bundled Payments for Care Improvement Initiative.

As you can see, you are now on day three of our four part data webinar series, so if you missed Monday or Wednesday's sessions you can visit our website at Innovations.CMS.gov. If you navigate to the Bundled Payments learning area, you'll find that all of this information has been posted there and, within the next week or so, we'll have all the live audio transcripts and an audio file recording of each of these webinars available for you to download, so that you or any other members of your team who weren't able to attend the entire conference can look at that information. With that, I would love to turn it over to Marshall.

MARSHALL MCBEAN: Okay. Again, thank you, Pam, and my thanks to all the people who made this webinar possible from a technical as well as a content perspective.

And in the second regard, to thank my colleagues here at ResDAC, Barbara Frank and Faith Asper, who helped develop this presentation, and also Pam and Jay Desai from CMS.

The educational objectives for today are, first, to have a short review of the Medicare claim payment process relevant to the Bundled Payments for Care Improvement Initiative. Then I want to describe, today, the non-payment information contained in the Limited Data Set Utilization Files. So this will largely be to measure the use of services, but it will also be important in defining your populations.

Tomorrow's webinar, which will be presented by Barbara Frank, will describe the payment and related variables.

As yesterday, if you are able to do it, I would recommend that you open a data file, which is actually called a metadata file, which is on the Bundled Payments Learning and Resources Area website, the URL is there, and I recommend that you open it, if you can, or print it, because I will be referring to variables in the column name column — sounds a little silly, but column name column — throughout the presentation. And so if you have that handy, it might make it a little bit easier to follow.

Yesterday, we had a lot of fun, I think, because we were talking about one file and it had 26 variables. Today, we're going to talk about six files or maybe actually 24 files, depending on how you count them, with a gazillion variables. So I will try, and Barb will try tomorrow, to highlight

the variables that we think are the most important and needed in terms of understanding the data and preparing your proposals for CMS.

As we'll say at the end of today and tomorrow's talk, if you have additional questions or information that you'd like to present to us — questions for us — we'll give you that opportunity through emails.

Okay. So the organization of the utilization files — and this was mentioned on Monday by our friends from Buccaneer — we have two major categories — the institutional files and the non-institutional files. Within that first group, we have inpatient files, which are hospital claims for Part A services. We have a skilled-nursing facility file, which includes SNF claims also for Part A services. And then we have the outpatient file, which contains hospital claims for Part B services, not A services, but for B services. And, then, finally, you will also be receiving the home health agency file, and that contains claims from the home health agencies for both Part A and for Part B services.

The non-institutional files are the carrier and the durable medical equipment or DME files. These are files created when providers submit claims for Part B services.

There was a question after Monday's talk. It was something like, What is this carrier file or why is it called a carrier file? Briefly stated, the carrier file contains primarily claims submitted by physicians or other Part B providers, and I'll describe those in more detail later. And the name comes from the contractors who used to process these claims for CMS. They were called carriers, and so the file got the name carrier file. At this point in time, it has almost no significance, but that's the genesis of the name carrier file.

To continue describing the institutional files, what I thought I'd do is just spend a couple of minutes describing how these files are created from the point of the completion of a claim by the provider to the time it then comes into CMS and the institutional files that you will get.

So the institutional files are claims that come from providers of Part A services only, as well as providers of both Part A and Part B services. What is special is that they use something called the UB04 form to submit these claims, and then this information is available in the institutional files, repeating what I said a couple of slides ago, the inpatient, skilled nursing facility, outpatient and home health agency files.

Here is a copy of the UB04 form, not readable at all. So let me just skip ahead to a couple of important fields. And I don't know whether on your computer you can enlarge this. I can't do it on mine, but there are a couple of areas to point out, because we'll come back to them later.

And in the upper left-hand corner, there is something called REV code, number 42. That's the revenue center code, and perhaps that's a new term to many of you, but we will come back and refer to revenue centers and revenue center codes. And you can see there that, for this hospitalization, there was a semi-private room, some pharmacy and some operating-room services.

The next column to the right, if you can read it, becomes a little bit confusing, because it looks like there's an amount there of $200, but, in fact, the column heading has words like HCPCS, HPPS, and so when you look at claims forms, one of the things to remember is that the form is

used by multiple types of providers, so some of the column headings and some of the information may not be intuitively clear.

The only way I know to accurately interpret what's supposed to be completed and submitted on these forms is really to go to the internet sites that describe how to complete the forms.

I haven't done this for a couple of years, but when I did, there were about 76 pages describing how to fill out this UB04 form, and the form I'll show you in a couple of minutes called the CMS1500, there are about 38 pages. So excellent bedtime reading, if you have insomnia, but essential if you want to truly know what's in the forms.

In the lower portion here, you see some numbers. There's a number there, 3930. That is actually the principal diagnosis for the person who was hospitalized. Turns out that is the diagnosis for acute rheumatic pericarditis. Right below it in red, the 4280, was the admission diagnosis, which turns out to be congestive heart failure. And then below that you'll see two other red entries for the first procedure and the date of that procedure.

So, this, again, is the origin of the diagnosis information, the procedure information and, up above, the revenue center information.

Now, for the non-institutional files, these claims come from providers who provide only Part B services. They use this form that I'll show you in a second, the CMS 1500, and that information winds up in the non-institutional files.

These two files, the carrier file and then the durable medical equipment file, again, are the Part B only files.

There's a definition here, for those of you who perhaps aren't familiar with durable medical equipment. It is something that should withstand repeated use, primarily be used to serve a medical purpose, not be useful in the actions of any injury or illness and appropriate for use in the home. So a walker would be a prime example of something that was a piece of durable medical equipment.

Here's the CMS 1500 form — again, not intelligible when you look at the whole thing, but I wanted to focus on a certain portion of it near the bottom. Later on, we'll talk about the line items. And so if you look where it says, on the left-hand side, 123456, for each claim submitted by a physician, let's say, there's an opportunity to have up to actually 13 different what we call line items, and these would be specific procedures done by that physician or other provider for the patient. Now, they might all be done on one day or they might be done over several days, although usually it's just on one day.

So there is this line-item portion, and you can see entries across here, which I'm not going to go into in any detail, but each one of those was, if you will, of data are called a line item, and they do include things like dates of service, an indication of where the service was provided, what that service was and the diagnosis related to that service.

At the upper portion of this slide, you'll see some codes there which are the actual diagnoses that were submitted for this patient — in this case, four different diagnoses. And I should mention, for the diagnoses and the procedure codes, they are all left justified. So even though

there's no decimal point in any of these entries, we know where the decimal point is because they're all left justified.

Now, the Medicare Part B services, just to briefly remind you, are physician services and other what are called Part B providers. So this could include ambulatory surgery centers, nurse practitioners and even health departments. Part B services are also the facility charges for hospital outpatient services, and then, finally, the durable medical equipment.

So what happens for a person who is seen in a hospital, you will generally have a Part A claim or claims from the hospital and then Part B claims from the attending physicians and others.

A person seen in the hospital outpatient department will often generate two Part B claims, one from the facility, and that winds up in the hospital outpatient file, and one from the physician, which winds up in the carrier file. We'll talk about this a couple of more times before we're done today.

Now, having gone through some of this claims-processing information, let me put before you the other topics that I want to talk about in the time we have.

First, I want to talk about how do we find acute-care hospitalizations, which will be important to you in constructing your or doing your data analysis and constructing your proposal. Then, how do you construct inpatient stays? Where do you find this anchoring event, the MSDRG? I'll talk briefly about dates. And then there's a list of required types of services that has been put out by CMS for this bundled-payment initiative, and I want to go through how you find all of these services in the various utilization files.

Lastly, I'll be repeating the slide that I showed yesterday regarding the limitations of the demographic information in the utilization files and reminding you for demographic information that you must use the LDS denominator file.

My final comment here is that in red in the next 20 or so slides is this column name value in that LDS metadata table I mentioned earlier. So you'll be able to go back or look as we're talking at these specific variables that I mention.

Okay. So finding the acute-care hospitalizations. The way you do that is by using the provider number or provider-number variable in the inpatient file. Some of you may have heard this also called the CMS certification number, the CCM, but the variable name is provider number.

As most of you know, I believe, the anchoring of events for Models 2, 3 and in the Bundled Payments for Care Improvement Initiative is a stay in an acute-care hospital for one of the MSDRGs that you select.

So how do we find these acute-care hospitalizations? Well, we use the inpatient file. Sort of a duh [phonetic] statement. We use the inpatient file. Then, as I said a minute ago, we use the provider number variable. This is a six-column variable. Columns 1 and 2 are the state, based on the Social Security Administration state code that we talked about yesterday. So the first two digits tell you the state.

Some states have enough providers that, in fact, they have more than one state number. So, at the current time, if you live in any of these states listed here — California, Texas, Florida, Iowa,

Minnesota or Illinois — you need to look at the data dictionary to determine exactly which of the state values apply, and there are more than one for your state.

Columns 4 through 6 in this variable indicate the type of facility. And I'll be coming back to these four columns several times before we're done today.

For the acute-care hospitals, the way you identify them is to select values for these four columns from 0001 through 0879 and then 1300 through 1399.

The first group are what we might call traditional acute-care hospitals, and the second group are what have been created or now labeled as critical-access hospitals, but these are the two types of hospitals that would be considered acute-care hospitals.

When you do this selection, write your code so that there are no alpha characters within these ranges. The reason for that will become clear, hopefully, in a little while.

Now, once you've found all of the claims for an acute-care hospital inpatient stay, we now have to create the episode of care, the inpatient episode. Some of you may have heard of the medpar file, M-E-D-P-A-R file, that CMS has created for a couple of decades now. That file, all of the claims are rolled into one episode of care. You are not getting that file. You are getting the inpatient file, which contains all of the claims, and you need then to create the stay record or the episode of care.

The good news is that there are variables listed here that will allow you to do that. The second piece of good news is that the great majority of acute-care hospitalizations have only one inpatient claim, hence, the frequency code variable will have a value of one.

In order to find those hospital stays for which there is more than one claim, our suggestion is if you program do a proc sort by the DESY_SORT_KEY, which identifies the beneficiary, claim admission date and provider number. If all of these are the same on more than one record, then you can take the claim admission date and the claim through dates from each record to build the episode.

You could also use the frequency code to place the claims in the proper order, and at the end of the day, you will have one record per stay containing the final MS-DRG.

Okay. Now, once you've identified these acute-care hospitalizations, one of the things that you may have heard, which is true, is that not all hospitals are paid using the inpatient prospective payment system, the IPPS. So the logical conclusion might be if the hospital is not paid on the IPPS, how can there be an MS-DRG? Let me go through the slide and we'll calm any concerns that you have.

So looking for the — ultimately, the MS-DRG, you would, as I've said already, limit your search to the acute-care hospitalizations, and then you might look at this variable called Claim PPS Indicator Code, and it will indicate whether the hospital is paid under IPPS or not. If it is, then the value is two, and, if not, then the value is blank.

And in the next bullet here I've indicated where you would find this to be blank. There are no inpatient prospective payment hospitals in the State of Maryland. That goes back to the Hospital Cost Review Commission in Maryland, which was doing a great job and so they were exempted.

There are 10 cancer hospitals that are IPPS-exempt, and the critical-access hospitals, which we talked about earlier, are not paid under IPPS. However, there is an MS-DRG code for the records for all of these non-PPS hospitals. It is the claim DRG code. And this code is inserted during the claims processing. So not to worry when you get the claims and build the episodes for the acute-care hospitalizations. You will be able to find the MS-DRG and it will be in the claim DRG code, and that will be your anchoring event.

To switch now to dates, there are two date variables, a claim from date and a claim through date, in all of the files you will be receiving. This is perhaps the major difference between the regular LDS utilization files and what you will be getting for the Bundled Payments for Care Improvement Initiative.

In the regular LDS utilization files, the dates have been arranged; that is, it indicates the quarter of the year in which the service was provided, but not the actual date. A vast improvement for the Bundled Payments for Care Improvement Initiative is that these LDS utilization files have the actual dates. So that's wonderful for the work that you have to do.

Now, something that was mentioned, I believe, on Monday is that the claim through date is used to place the event in the annual file; that is, in 2008 file or 2009 file. So a hospital claim with a claim through date in 2008 will be in the 2008 file, even if the hospitalization started in 2007. So that just takes a little bit of getting used to, again, recognizing that all of the information for, let's say, hospitalizations in 2008 won't be in the 2008 file. They'll be in the 2008 and the 2009 file.

These two date variables are present on all the records in all of the institutional and the non-institutional files, and, obviously, they're the key for creating episodes of care, identifying readmissions within certain time periods and identifying services received after your anchoring event.

What I want to do now is refer to a list of types of services that has been put up by CMS. These are the required types of services that should be included in your bundle. I'll read them to you, and then we'll spend the next portion of our time going through trying to indicate how you find these services within each of the various file types. Some are pretty easy. Some are pretty hard. Some are very specific and some are not so specific. So we'll go through these one at a time. Let me just read them to you: Physician services, inpatient hospital services, inpatient hospital readmissions, long-term care, inpatient rehab facilities, skilled nursing, home health, hospital outpatient, clinical laboratory, durable medical equipment and Part B drugs.

So let's turn first, going down the list, to physician services, which I've relabeled physician and other professional services, because, repeating something I said earlier, physicians and other providers will use or are providing Part B services to Medicare beneficiaries. They will be submitting claims and they will be — these claims will wind up in the carrier file.

Now, as I was getting ready this morning, I thought maybe I need to digress a little bit at this time and talk about, in more detail, the actual files that you are getting. I said earlier you'll be getting six files or maybe 24, and, actually, I made a mistake, because if you add the denominator that's another file, and you'll be getting them for two years. So now you start doing the math and you're up to about 50 files. So let me try to go back and explain things clearly.

The reason I showed the CMS 1500 form and talked about the line-item portion is that when you get the files for the carrier data there is a B carrier claims file and a B carrier line file. The first one of those two refers to items that are constant for all of the things that the physician or other provider would have done. So it includes things like the demographics, the costs around the claim, the claim first and last dates of service.

But because these claims can have more than one entry, more than one line item, there is a separate file that contains the line items, and if you have time or after this presentation you need to go to the Learning and Resources page and there's a file called Listing of Sort Order, which indicates each of the files that you will get for each of these larger file categories.

And I know this may not be terribly clear for those of you who haven't looked at it, but let me just say that for the carrier claims and the DME claims, there will actually be two files, the carrier claims file, so called, and then the carrier line item.

For the home health, inpatient, outpatient and SNF, there will actually be five separate files, and I'll talk about those and give you those names in just a few minutes. So little bit confusing, but something you need to look at as you start considering the information that you're getting.

So going back on point here, as I said earlier, when you're looking at Part B services, you might have two claims submitted, and the example that's most frequently given is a diagnostic X-ray, that will be done in a hospital outpatient department.

If an institution owns the equipment, then it will submit a claim for Part B payment of the technical component and it will use the UBO 4 form and this claim will appear in the outpatient file.

If the physician only reads or interprets the X-ray, he or she would then submit a claim for Part B services or professional services using the CMS 1500 form and the claim will appear in the carrier file. So, again, one service, two possible claims.

If, on the other hand, the radiologist actually owns the equipment and the X-ray is, let's say, done in his or her office, wherever that is, then only one Part B claim would be submitted and it would include both the professional service and the technical component as one CMS form line item and would appear in the carrier file. The danger here is that when you start counting services sometimes you might over count, unless you recognize this issue.

Another issue, in terms of the carrier file and physician services, is what do you mean by physician services? Do you mean physicians only or do you mean physicians and nurse practitioners? Do you mean physician services only in the office setting or do you want to limit your discussion or your search to certain physician specialists?

There is information in the line-item portion of the carrier file, this B carrier line portion, that will allow you to make these kinds of distinctions. There is a provider specialty code. There's a line CMS type of service code and a line CMS place of service code variable.

So, for example, if you wanted to limit it to certain types of physician specialists, you would use the provider specialty code variable and perhaps you would also use the type of service, so that you might want to say, I only want medical care, and then you would perhaps just include

general practice and internal medicine people and maybe physician assistants using the provider specialty code.

If you were looking for surgery, you might use the type of service code of two and then select general surgeons and other physician specialties that are surgical in nature.

If you want to find only services provided in the office, this is an example that the Dartmouth Institute for Health Services uses in terms of defining office. They take Place of Service Codes 11, 22, 50 and 72. That might be a good model for you to use or maybe, again, you only want services provided in the office using Code No. 11.

Another way that you might want to be looking for or limiting procedures done by physicians is using the CPT # HCPCS codes. There is a variable called HCPCS codes or HCPCS code — I'll talk about that in a minute — and that will allow you to select certain procedures very precisely.

I also want to talk, in a minute, about evaluation and management visits, and let's move on to both of those.

So the HCPCS codes, for those of you who have not heard of these before, HCPCS is an acronym for Healthcare Common Procedure Coding System. There are three levels, so called, of HCPCS codes — Level 1, Level 2, Level 3. Many of you, I'm sure, have heard of CPT codes, Current Procedural and Terminology Codes of the American Medical Association. And if I were to say, How would you identify services provided by a physician? You might say, Let's use the CPT codes.

Well, within the Medicare data files, we now switch from saying CPT to HCPCS. The Level 1 HCPCS codes are absolutely identical to the CPT codes, so that all the CPT codes are contained in the HCPCS codes and they are called, again, Level 1. These are all numeric — five-character numeric codes, and an example here is 99201, Office or Other Outpatient Visit for the Evaluation and Management of a New Patient.

Let me just pause here and talk for a second about these evaluation and management codes. They all begin with 99, so they're 99XXX, and, basically, they describe, based on the location and the duration of the service. So whether the physician sees a patient in a hospital, in a nursing home or in the office, whether the patient sees the patient for a short, medium or long visit or if it is a new or an established patient, there are these codes that say, The patient came for a visit and was evaluated and certain things were done.

There's not a lot of specificity here, and if you read the descriptions it might be hard for you to actually figure out what was done by the physician with this CPT or HCPCS code entered in the claim.

The Level 2 HCPCS codes are also by physician, but they are alpha-numeric, they begin with a letter. As you know, CMS may pay for things that are not included in the AMA CPT codes, and so here's an example of screening mammogram has a code G0202.

There are Level 3 codes, which are codes that exist for short periods of time. If a claims processor needs to pay a claim, but there isn't an existing code, they will create one. It sounds like this might cause a lot of confusion, but it's not done very often and there actually is a lot of

coordination between the claims processors and CMS to keep these to a minimum, but I need to mention them just for completeness.

Here are examples of the CPT or Level 1 HCPCS codes. They generally follow the way medicine is divided into specialties, so there are anesthesia codes, surgery codes, radiology, et cetera.

Now, that last portion was about finding services provided by physicians and other specialists. Now, I want to move to the second item on the list that you need to consider in terms of your bundled payment projects; that is the inpatient hospital and inpatient readmission services. And, here, we switch from HCPCS to ICV9 procedure codes, which there could be from one to six, and the revenue center variables.

In terms of looking for inpatient and inpatient readmission services, obviously, limit that to the acute-care hospitals that we have talked about earlier, and then look for either the procedure codes I mentioned above or the revenue center codes.

For the procedures, there are up to six procedures per record. As many of you know, major procedures will actually determine the MS-DRG, and all of these procedures are four columns left justified.

For the revenue center, you need to look in what is labeled in your data set, your set of data files, the inpatient revenue portion of the inpatient claims.

One thing that's a little bit daunting is that there are up to 450 revenue center — possibly up to 450 revenue center records per inpatient base record. Now, the average number is much less than that, but you will find for every inpatient claim a number of revenue center claims to be attached to that that will describe services received by the patient.

Now, these are not as precise as the ICV9 procedure codes, and I've given some examples below, but can be useful because they do tell you whether or not the person was in coronary care, was in intensive care, had some pharmacy, some laboratory services or radiology.

In the first two, coronary care and intensive care, I think that's actually a pretty useful variable, but knowing that the person received some pharmacy without knowing the specific drug may have limited value. Similarly, you know they had laboratory tests, but you don't know either the test nor the values, and you do not know what radiology examination they had either.

So these revenue center codes can provide additional information regarding what kinds of services someone received, but they're not perhaps as specific as some of you might like.

In terms of long-term-care hospital services, we would use the same variables, the ICV9 procedure codes, and the revenue center variables, but, first of all, we need to find the long-term-care hospital admissions. And this we go back to the provider number that I talked about about 15 minutes ago. Remember that that provider number was a six-character variable, and, after getting rid of the state designation in columns 1 and 2, you can use the last four columns to identify long-term-care hospitals.

The values that you would use in selecting these long-term-care hospitals are from 2000 to 2299, and, as I said earlier, once you've found the place of service, then you can identify the services that were provided. The information is very similar to that for the inpatient hospital,

except both the procedures and revenue center codes are much more in tune with long-term care rather than acute care.

In terms of finding inpatient rehabilitation facility services, the actual variables are the same again, the ICV9 procedure codes and the revenue center codes. However, there is a little bit of an extra issue here in terms of finding all the inpatient rehabilitation facilities. So if you look at the second bullet, we again return to the provider number and we take the values 3025 to 3099 in those last four columns.

But, in addition, you need to search on the third column for the letter T or the letter R and select those facilities also. So the inpatient rehabilitation facilities are a combination of those facilities with the values 3025 to 3099 and those that begin with the letter T or R in the third position of the six columns.

One thing to note — and we checked this just last week — 60 percent of the claims for inpatient rehabilitation facility services are from that second source. So you need to make sure that you do a search on both of these — using both of these methods.

So, again, what I've said before now, two or three times, you can identify the ICV9 procedure codes, and that's in the inpatient claims portion of the inpatient claims, and then there is, again, the revenue center.

Now, beginning with the inpatient rehabilitation facilities, there's a little bit of a twist in the revenue centers. The revenue centers that will be listed, the first one will be a 0024, which says, Heads up. The next several records will be about inpatient rehab facility. Then, the subsequent entry will tell you about what was done. And then the final one has a value of 0001, and it just has the total charges for that claim.

So the revenue center, once you get to the inpatient rehab facilities, will have different values and different meanings than the more simple SNF and — I'm sorry — long-term-care hospital and inpatient hospital.

In terms of SNF services, if you're trying to identify specific services, we recommend using the revenue center variable. The ICV9 procedure code fields are present in the SNF records, but they're not frequently populated, and, in fact, less than two percent of SNF records have an ICV9 CM procedure code.

So using the revenue center variables in the SNF revenue portion of the SNF claims, the first revenue center code will indicate and verify that this is, in fact, a SNF facility, and then the subsequent entries are for what was provided by the skilled-nursing facility, and the final one, again, in that format, 0001, with, then, an entry for the total charges for that claim.

The home health agency services, in order to identify those, we're limited to the revenue center and the HCPCS code variables. There are no ICV9 procedure-code fields, so you cannot look for ICV9 procedure codes, and you need to then look in the home health agency revenue portion of the home health agency file for these other two variables.

Again, similar to the last two files I've been talking about, or three, actually three files, the first listed revenue center code indicates that this is actually a home health agency service, and then

the subsequent entries are for different revenue centers that are appropriate for home health agency. Some examples, 0421 for physical therapy, 0551 for skilled nursing.

And then, as with the other claims, the final revenue center value will be 001 and you will have the total charges for the claim.

Now, home health agencies may also use, or not may, they are required to submit HCPCS codes which allow you, then, to search for HCPCS codes in this — Oh, my goodness. I said SNF revenue center portion. That is a copy paste error. So look for the HCPCS codes — and I apologize — in the home health agency revenue portion of the home health claim.

Similar to what I've been discussing, the first HCPCS code actually is not a service or procedure. It is a special health insurance prospective payment or HIPPS code which describes the clinical and functional status of the patient. So not very useful in terms of describing services, but is there, again, to describe the type of patient being treated.

Then the next revenue center that you will find include appropriate HCPCS codes in the range from G0151 to G0156. They're all for 15 minutes of care and they are for things like physical therapy, occupational therapy, speech, pathology, skilled-nursing care, social worker, home-health aide. And, again, the final entry is blank.

So in the home health agency claims, you are able to get a fair amount of detail, but the detail is perhaps not as precise as you would like.

Out-patient services, there are no ICV9 CM procedure codes. The fields are there, but they are not populated. They used to be populated, but that is not true anymore.

Therefore, in order to find out what kind of outpatient services have been provided, you need to look at the revenue center trailer or the outpatient revenue portion of the outpatient file and look at the HCPCS codes, and something new to our discussion, the revenue center APC HIPPS code variable.

The HCPCS codes are very similar to the codes we've talked about before, and, in fact, are very important for pricing and payment. The revenue center APC HIPPS code variable, the one we just described that briefly, because hospital outpatients are paid on the outpatient PPS, which uses the ambulatory payment classification code, this variable will be there.

Now, this variable is nice, but it's less specific than the CPT HCPCS codes. Examples here would be if the person had some debridement of a wound, there's a Level 1 through Level 6 category. If they had endoscopy, there's a Level 1 through Level 5 designation. A spinal tap is just a spinal tap. But if you want precision and are trying to identify hospital outpatient services, it's probably better to be using the HCPCS code rather than these APC HIPPS codes.

Clinical laboratory services. We're getting close to the end here. If you want to find out the clinical laboratory services that were provided, you need to look in either the carrier or the outpatient file. One of the things you don't have to worry about is duplicate claims. They would either be in one of the files or the other. And then the B carrier line-item portion of the carrier file you can look at either the type of service variable — diagnostic laboratory has a value of five — or the line place-of-service variable, which has a value of 81.

The other thing you can do is, of course, look for a specific laboratory test, and, in that case, you would look at the HCPCS code variable.

In the outpatient revenue portion of the outpatient file, you would also find clinical laboratory services based on the revenue center having a value of between 300 and 319, and then associated with that revenue center would be a specific HCPCS code that would identify the laboratory test.

In terms of durable medical equipment, if you want to find out exactly what equipment was being provided, you use, obviously, the durable medical equipment file and the DME line portion of that file.

I've already described what durable medical equipment is, and here you see the types of HCPCS codes that are used to designate durable medical equipment. They usually begin with the letter E, and so a walker, a nebulizer, an infusion pump all having E as their first character.

Part B drugs, the last thing that CMS asked you to consider in your bundled payments. Most of you probably think of drugs as being a Part D Medicare service. There have been, since the beginning of Medicare, certain drugs that are covered under Part B. These are drugs that beneficiaries cannot self administer, and while there are not lots of them, there are some, particularly chemotherapy, that can be readily studied using these various — this information.

So there are three possible sources for Part B drug information. One is in the DME file. One is in the carrier file and one is in the outpatient file. So you look in the DME file at a variable called line national drug code. In the carrier file, they would be in the HCPCS codes in the line-item portion and these are all J codes, so they are Level 2 HCPCS codes that begin with the letter J.

And then somewhat similarly in the outpatient revenue portion of the outpatient file, you can look at the revenue center codes that have values in the range of 0250 to 0259, and then the HCPCS code will tell you exactly which drug was being provided.

One thing I wanted to say, as I was thinking about, you know, looking for Part D drugs was that sometimes when you're working on your proposals, you might want to look at the data and let the data inform you of what is there, so that rather than spending a lot of time after you've chosen your MS-DRG and thinking which drugs might there be and looking them up and all of that, I would suggest just going directly to the data file and see for people who have your MS-DRG what kinds of drugs or Part B drugs they've been treated with, and that will help you decide whether or not that's something you want to include in your study or not. So doing some of these empirical tests might be useful as you try to prepare your proposals.

I've gone on for a long time here, and let me just quickly repeat what I said yesterday that if you want to work with the demographic information, use only the demographic information in the denominator file. The demographic information in the utilization files is incomplete and you should not use that.

In summary, there are beneficiary identifiers and precise dates of service that allow the building of episodes of care for each beneficiary. Services can be identified in all the utilization files, but with a varying degree of specificity.

You need to take care that you avoid undercounting services in the inpatient rehabilitation facilities. In particular, you need to worry a little bit about over counting where two claims could be submitted for the same service, and then use only the demographic information from the denominator file.

If you have questions, we are happy to try to answer them today. Some of you, I'm sure, have already been submitting questions, and we'll stay on the line to try to answer those or you may submit questions to ResDAC. And if you do send us an email, please indicate in the subject line that this is about bundled payments, and if you would also include your DUA number and the request ID. So thank you for hanging in there, and we will now go to questions.

PAMELA PELIZARRI: Thanks very much, Marshall. This is Pamela Pellazari again at the Center for Innovation, and while Marshall is pulling up the questions — let's just give him a minute — I'm going to go over a couple of logistical things.

So you can submit your questions through the chat feature now. We don't have a lot of time left, so if your question doesn't get answered, we would encourage you to email it to the ResDAC email address that's currently up on your screen.

And they'll be responding to questions via email, and also through some phone calls, which we sent emails out yesterday, and if you have any questions about that, you can let us know, but more information about those will be forthcoming in a couple of weeks.

I do see one question that I think would be a good place to start, and I'll go ahead and answer it. It says that you've been told that you'll receive 100 percent of the data and does this mean that you'll get information for providers and services in the HRC that are not participants in your application?

And I can verify that it's true that you will receive 100 percent files for the HRCs that you've been approved to receive. So if you're getting, you know, HRC number 57, you'll get all the data for all beneficiaries who lived there regardless of what providers they went to. So that will include providers and services that aren't part of your application.

Because of the way that our research process is set up, your DOA only covers you analyzing the data that's relevant towards your application for those institutions that you are representing or you have approval to represent, so that means that, for instance, if you're a hospital, you shouldn't be analyzing episodes of care for a certain DRG that initiated another hospital, unless you have permission to do so from that hospital.

We would anticipate that you're looking at services that happen at providers other than yourself, because you're setting up episodes that span outside of your particular care setting. However, while you're doing that, we would anticipate that you're only looking at relevant beneficiaries, so you're looking at the people who would be initiated into an episode given the collection of providers that you're working with.

If you have more questions sort of to that end, those would be the kind of questions that you can email to us at bundledpayments@cms.hhs.gov.

I'll turn it back over to Marshall, because I know there's a lot of questions he can probably answer in here as well.

MARSHALL MCBEAN: Sorry, I had it on mute here. First of all, let me thank Mike who found a mistake on Slide 14 that is highly embarrassing, but let me correct it right away.

When I talked about the provider number, I said columns 4 through 6 indicate the type of facility and that this is a four-character — and these were four columns. You're right, Mike, these are only three columns. So I apologize for that.

The provider number — just to go through it slowly — the first two columns are the SSA stae value and the last four columns, columns 3 through 6 — not 4 through 6, which is what I said — identify the type and the actual facility. We'll fix that in the slides as we put them up, but thanks, again, for pointing that out.

The next question was about the actual dates of services, and, in case I misspoke, the LDS files, the regular LDS files, in terms of dates of service, are arranged and they just indicate the quarter in which the service was provided. The files that you will be sent actually have the actual date. So they're not ranged in your data. They're the actual date.

There's a question here about, Please repeat the names of the two types of carrier files. I didn't do a very good job of explaining that, partly because I only thought of it as I was preparing the last minute or two before the presentation, but let me not use that excuse.

When you get these files, there will be two files that have the word carrier in them, one called B Carrier Claims, one called B Carrier Line. The claim and the line can be linked using the DESY_SORT_KEY, the claim number and the line number to build one claim. I don't know whether that helps or not.

I also said, but then didn't describe the five files that you will get with each of the institutional claims, so there will be an inpatient claim file, an inpatient institutional condition file, an inpatient occurrence code file and an inpatient value code file and an inpatient revenue file.

If you haven't looked at the information about these different files, this is all very confusing, but, basically, for each of the claims, there is a base record which includes most of the information you will use, but not all, and that base record can then have appended to it these additional, if you will, trailers that provide precise information about certain things. All of them may occur more than once, and, as I said, the revenue center trailer might occur up to 450 times, usually it's much, much less than that.

So I know if I continue talking, I'm going to confuse most of you even more than you are confused now, and I really encourage you to go to the Learning and Resources page and click on the listing of sort-order option and you'll begin to see how these files are organized.

Again, please submit questions about this by email and we'll try to do an FAQ that responds to this to give you better information.

Question here is how to identify inpatient readmissions. I think the first question on inpatient readmissions is one to ask yourself, which is which hospitalizations after the initial episode am I going to count as a readmission, and which ones am I going to say they're not really part of our investigation? But the way to identify readmissions is by the dates of service.

PAMELA PELIZARRI: Sorry, Marshall, can I just jump in there? So I think — I see another question about excluding readmissions to other hospitals, and is that something you can do, and I just want to reiterate that from the program perspective here within the Center for Renovation, that's not something you're able to do, so you'll be — if you choose to be an awardee for this program, then you'll be responsible for the cost of readmissions, even if they occur at another hospital. So that means that you should be looking at all the readmissions that happen, as Marshall says, within the date range after the admission for the MS-DRG that you're looking at to determine how much that payment was and factor it into your target price.

I think this all goes back to a bigger question we have also been getting that relates to what I said before about if you're only at episodes that are initiated in your setting, how are you going to know the true cost of providers and services in your region? And we just wanted to reiterate again that your target price should be set based on the historical costs for your institution.

So for the patients that would initiate their episode in whichever way you're choosing to apply — so if you're a post Q [phonetic] provider and you're initiating post-Q episodes, they might be going to different providers, and you should be looking at that, but really what you're looking at is the cost per episode for beneficiaries who initiate an episode in the way that they would if you were participating in the bundled-payment program.

You shouldn't be basing your target price on the estimate that you come up with in your market area. It should be based on specifically your institution and the pattern of care that patients take at and after they attend your institution or receive services from your providers.

MARSHALL MCBEAN: Okay. Let me go on to another question particularly seeing it relates to the typo. Question is on Slide 28. Can you restate the typo you caught?

Yes, the slide is entitled Home Health Agency Services, and in the middle, there's a bullet that begins, "May also use HCPCS code variable in the SNF revenue portion of the SNF claim."

That should be changed. Where it says "SNF," it should say, "home health agency." So it would read, "May also use HCPCS code variable in the HHA revenue portion of the HHA claim." And I apologize for that, and we'll fix that on the — when we post the web — the questions — when we post the presentation.

PAMELA PELIZARRI: Unfortunately, it looks like our time is just about up, Marshall, but I want to reiterate to people that, first of all, we'll be having another session tomorrow, so if you want to tune in tomorrow at this same time and hear more from ResDAC about these claims files, we would strongly encourage you to do so.

There's also a survey at the bottom of your page that we would love for you to take and give us some feedback about if these sessions have been useful for you and what more we can do to help prepare you to receive this claims data for the Bundled Payments for Care Improvement Initiative.

If you have a question that did not get answered today, please email it to us either at the ResDAC email address that's currently showing on your screen or at bundledpayments@cms.hhs.gov, and be sure to include bundled payments in your subject line,

and your DUA number and request ID, and we'll make sure that that question gets answered as soon as possible.

Thank you so much for coming. We really appreciate it. We got a lot of great questions today and we wish we had more time to answer them. So please let us know if you still have a question that hasn't been answered. And we'll look forward to having all of you back tomorrow. Thank you so much.

[END OF FILE]