

**DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
CALIFORNIA EMERGENCY DEPARTMENT AND
AMBULATORY SURGERY PATIENT DATA REPORTING MANUAL, FIFTH EDITION**

EXPECTED SOURCE OF PAYMENT

Section 97265

The patient's expected source of payment, defined as the type of 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 categories:

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission:

EXPECTED SOURCE OF PAYMENT		<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </table>		
09	Self Pay	DS	Disability	
11	Other Non-federal programs	HM	Health Maintenance Organization	
12	Preferred Provider Organization (PPO)	MA	Medicare Part A	
13	Point of Service (POS)	MB	Medicare Part B	
14	Exclusive Provider Organization (EPO)	MC	Medicaid (Medi-Cal)	
16	Health Maintenance Organization (HMO) Medicare Risk	OF	Other Federal program	
AM	Automobile Medical	TV	Title V	
BL	Blue Cross/Blue Shield	VA	Veterans Affairs Plan	
CH	CHAMPUS (TRICARE)	WC	Workers' Compensation Health Claim	
CI	Commercial Insurance Company	00	Other	

(a) Self-pay. *Payment directly by the patient, 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 third party.*

(b) Other Non-Federal Programs. *Include any form of payment from local, county, or state government agencies. Include payments from county funds, whether from county general funds or from other funds used to support county health programs. Include County Indigent Programs, County Medical Services Program (CMSP), California Healthcare for Indigent Program (CHIP), County Children's Health Initiative Program (C-CHIP), and Short-Doyle funds. Also include the State Children's Health Insurance Program (SCHIP), Managed Risk Medical Insurance Board (MRMIB), Healthy Families Program (HFP), and Access for Infants and Mothers (AIM).*

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DISCUSSION

This category **does not** include Title V for California Children Services (CCS) payments. See (q).

(c) Preferred Provider Organization (PPO).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under a PPO arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

This category **does not** include Medi-Cal patients covered under a PPO arrangement. See (o).

(d) Point of Service (POS).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under a POS arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

This category **does not** include Medi-Cal patients covered under a POS arrangement. See (o).

(e) Exclusive Provider Organization (EPO).

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies under an EPO arrangement.

This category **does not** include Blue Cross/Blue Shield or commercial insurance companies on a Fee for Service basis. See (h) and (j).

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This category **does not** include Medi-Cal patients covered under an EPO arrangement. See (o).

(f) Health Maintenance Organization (HMO) Medicare Risk. Medicare is defined by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Include Medicare patients covered under an HMO arrangement.

DISCUSSION

This category includes Medicare patients covered under an HMO arrangement only. Medicare Knox-Keene HMO is reported here.

(g) Automobile Medical. Include PPO, POS, EPO, HMO and Fee for Service or any other payment resulting from automobile coverage.

(h) Blue Cross/Blue Shield. Include only Fee for Service payments. Report PPO, POS, EPO, and HMO under the appropriate stated categories.

DISCUSSION

This category includes Blue Cross/Blue Shield on a Fee for Service basis only.

This category **does not** include Blue Cross/Blue Shield under a PPO, POS, EPO, or HMO arrangement. See (c), (d), (e), and (l).

(i) CHAMPUS (TRICARE). Include any PPO, POS, EPO, HMO, Fee for Service, or other payment from the Civilian Health and Medical Program of the Uniformed Services or from TRICARE.

(j) Commercial Insurance Company. Report payment from insurance carriers on a Fee for Service basis. Exclude PPO, POS, and EPO payments.

DISCUSSION

This category includes commercial insurance companies on a Fee for Service basis only.

This category **does not** include Blue Cross/Blue Shield on a Fee for Service basis. See (h).

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This category does not include commercial insurance companies, Automobile Medical, or CHAMPUS (TRICARE) under PPO, POS, or EPO arrangements. See (c), (d), (e), and (g).

(k) Disability.

DISCUSSION

This category includes payments resulting from disability coverage.

(l) Health Maintenance Organization (HMO). Report HMO payors. Include Knox-Keene licensed plans as well as out of State HMO plans. No Plan Code Number or Plan Code Name is required for ED or AS records. Report Medicare payments covered under an HMO arrangement as Health Maintenance Organization (HMO) Medicare Risk. Report Medi-Cal payments covered under an HMO arrangement as Medicaid.

DISCUSSION

This category includes Blue Cross/Blue Shield or commercial insurance companies HMOs. Both California HMOs (Knox-Keene) and out-of-state HMOs are included.

This category **does not** include Medicare or Medi-Cal under a HMO arrangement. See (f) and (o).

(m) Medicare Part A. Defined by Title XVIII of the Social Security Act. Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

(n) Medicare Part B. Defined by Title XVIII of the Social Security Act. Covers some outpatient hospital care and some home health services.

(o) Medicaid. Medicaid is called Medi-Cal in California. Defined by Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97). Report all Medi-Cal including Fee for Service, PPO, POS, EPO, and HMO.

DISCUSSION

Report Medi-Cal Knox-Keene HMOs here.

(p) Other Federal Program. Report federal programs not covered by any other category.

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DISCUSSION

Included in this category is Federal reimbursement of emergency health services furnished to undocumented and other specified aliens as part of the Medicare Prescription Drug Improvement and Modernization Act (MMA) in this category.

(q) Title V. Defined by the Federal Medicare Act (PL 89-97) for Maternal and Child Health. Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Include a Maternal and Child Health program payment that is not covered under Medicaid (Medi-Cal). California Children Services (CCS) payment should be reported here.

(r) Veterans Affairs Plan. Include any PPO, POS, EPO, HMO, Fee for Service, or other payment resulting from Veterans Administration coverage.

(s) Workers' Compensation Health Claim. Payment from Workers' Compensation Health Claim insurance should be reported under this category.

(t) Other. Include payment by governments of other countries. Include payment by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners, etc. Include payments not listed in other categories.

DISCUSSION

This category includes cases where no payment will be required from the patient. Patients admitted under a grant, a medical study, special research, charity care, organ donations, fertility treatment donations, or general courtesy treatments are included in this Payer category.

It is illogical to report a "no charge" record in any payer category other than the "Other" category, which contains true courtesy patients who were never expected to pay a bill. However, if your facility generated a bill and later wrote off the charges as bad debt, you must report Total Charges as the full established rate before adjustment. Financial write-offs after a bill was generated should never be reported as \$1. For data quality purposes, HCAI encourages the reporting of Expected Source of Payment for records written off as bad debt with the category that most closely matches the payer who was expected to pay but did not.

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DISCUSSION FOR ALL CATEGORIES

The payer that is expected to pay or did pay the greatest share of the patient's bill is the primary payer. Report only the primary payer to HCAI.

The list of payer categories are found in three implementation guides:

- 1) 837 Health Care Service: Data Reporting Guide,
- 2) 837 Health Care Claim: Institutional, and
- 3) 837 Health Care Claim: Professional

Due to lack of definitions, five payer categories were not included in this data element and are not accepted by HCAI as valid payers. They are Central Certification, Indemnity Insurance, Liability, Liability Medical, and Mutually Defined or Unknown. If your facility uses any of these payer categories, please assign them to "Other" when reporting to HCAI. See (t).