EXAMINATION OF INPATIENT, SKILLED NURSING FACILITY AND HOME HEALTH CLAIMS AT DIFFERENT LEVELS OF CLAIMS MATURITY

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INTRODUCTION

Medicare is interested in monitoring cost and utilization of services. Timely feedback allows evaluation of the benefits and limitations of programs to make modifications. Administrative claims data, which is useful for monitoring hospitalization and physician claims, generally takes many months to be considered final—and may not mature enough that the data produces stable estimates of service use and payments.

General Dynamics Information Technology (GDIT) obtains Medicare claims data files from CMS each week on a nearly real-time basis as claims are processed by CMS and then loaded to the CMS Chronic Condition Warehouse (CCW). There is a lag between the date of service and when a claim is processed. However, the provider must submit the claim, the Medicare Administrative Contractor (MAC) processes the claim for payment, and the claims are uploaded into the CMS National Claims History File (NCH) before they are available to the CCW. Also, it is common for claims to undergo more than one round of processing to make adjustments, edits, and deletions before the claim becomes final. Because of these lags, use of nearly real-time data to make inferences about service cost and utilization would not be valid.

The objectives are to describe the completeness of Medicare Part A institutional claims and Part B institutional claims (which are also known as the Hospital Outpatient claims) at different levels of claims maturity (i.e., after different amounts of time have elapsed from the service date to the claim processing date). We illustrate the length of time needed to accurately evaluate cost and utilization metrics derived from different types of administrative claims.

METHODS

Study Design: For all Part A claims, which include inpatient, skilled nursing facility (SNF), hospice, and Part B Institutional (HOP) services rendered in 2011, we examined the number of claims processed at one month intervals for 12 months of run out. We compared the monthly interval data to the final 2011 data by each claim type.

Some key variables often used for data analysis, such as reason for service (diagnosis and the DRG) [diagnosis related group; for inpatient claims] and payments, were evaluated to determine changes that occurred through the claim reconciliation process.

Population: We used 100% Medicare Part A claims (inpatient, SNF, hospice, HPH, and HOP) for services in 2011.

RESULTS

Medicare claims are more complete the number of months from the service date increases. The percent of claims considered mature at any particular time interval differs by service type on a Part A claim (Table 1). Over 95% of inpatient, SNF, hospice, and HOP claims are completely reconciled and in their final form (i.e., final action) at 12 months post service. Home health claims are slightly more mature, with 94.6% of claims considered final after 12 months.

In the first few months after the service date, many adjustments to the claims occur (Figures 1 and 2). For inpatient claims, after around six months of maturity, the edits and adjustments to the claims level off.

For home health services, it takes several months before the majority of claims are available, and adjustments are common for at least the first eight months after the service date (Figure 3). Home health providers may submit requests for anticipated payment (RAP), which CMS uses to make interim payments. These RAP claims are the final version of the claim; there is always an updated/reconciled version which may explain the adjustments seen later in maturity than other services.

CONCLUSIONS

Over 95% of inpatient, hospice, SNF and HOP claims are identified within 12 months of a service. Among the inpatient claims, 95% are identified within 6 months of the service. Adjustments to the claims are not a common occurrence however they typically occur quickly after the initial claim is submitted. Among inpatient claims, nearly 97% of the claims are adjusted. Cost and primary diagnosis codes, which are incorporated to evaluate costs and utilization are modified at differing rates in the Part A claim types. The largest percent of adjusted claims affecting payment were seen in HOP and hospice claims, where over 50% of the adjusted claims identified a change in payment.

REFERENCES

GDIT typically delivers final claims data to researchers once claims have reached 12 months post-service maturity. Claims that are not stable enough and unchanging are reconciled and then released, and therefore are ideal for a variety of research, policy and programmatic purposes.

Some investigations may have a need for relatively timely data, and are willing to make the tradeoff for somewhat less stable data and therefore more error. Depending on how mature the data are for the setting of interest, different types of error are more common—in particular the payments take longer to stabilize than the information regarding the diagnosis or DRG.

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