FY 2020 Quarter 4 Data Forum

June 12, 2020

HSCRC
Health Services Cost Review Commission

Agenda

- Announcements
  - Case Mix Weights and Grouper Transition Update (Claudine)
  - Update on FY 2021 DSR Revisions (Oscar)
  - Point of Origin for Telemedicine (Claudine)
  - Alternate Treatment Sites due to COVID Surge (Claudine)
  - REMINDER: Data Forum Survey (Claudine)
- Data Processing Vendor Update (Mary)
- Case Mix Data Audits Findings (Brenda)
- Date Issues for Discussion
  - COVID-19 Coding and Quality Reporting (Brenda and Dianne)
  - Discontinuing MedCHI and 2-Digit SPCC Provider ID Number (Claudine)
  - OP Bundling of SDS cases with IP Rehab (Nduka)
- Next Steps & Next Meeting
  - Volunteers for upcoming workgroups (Oscar)

Announcements

- Case Mix Weights and Grouper Transition Update
- Update on FY 2021 DSR Revisions
- Alternate Treatment Sites due to COVID Surge
- Point of Origin of for Telemedicine
- Data Forum Survey

Grouper Transition: Case Mix Weights

Rate Year	APR/PPC/EAPG Version	Timeline	Implementation Date
RY2021	**Weights Used in Temporary Market Shift**		
	(January – June) IP weights: Version 35 OP weights: Version 3.12	Using Data from: CY 2016 applied to CY 2019	January 2020
	Weights Used in Full Year Market Shift		
	(January – December) IP weights: Version 36 OP weights: Version 3.14	Using Data from: CY 2018 applied to CY 2019	July 2020

Case Mix Weights (based on 18 mons (CY 2018 - July 2019), APR/EAPG v36/3.14) are posted on the HSCRC website (https://hscrc.maryland.gov/Pages/gbr-adjustments.aspx). Additionally, HSCRC created a de-identified dataset (with programs) for parties interested in recreating the weight calculations. Please submit a request to hscrc.data-requests@maryland.gov.

HSCRC will be convening a workgroup to discuss Market Shift and Weight development with the industry. More information is forthcoming.

Grouper Transition: Market Shift

Rate Year	APR/PPC/EAPG Version	Timeline	Implementation Date
RY2021	**Temporary Market Shift**		
	(January – June) APR: Version 35 EAPG: Version 3.12	Base Period: January – June 2018 Performance Period: January – June 2019	January 2020
	Full Year Market Shift		
	(January – December) APR: Version 36 EAPG: Version 3.14	Base Period: January – December 2018 Performance Period: January – December 2019	July 2020

HSCRC has available a de-identified Market Shift dataset for parties interested in reviewing the statewide results. To obtain access, submit the Public Use File Application and DUA available on the HSCRC website: (https://hscrc.maryland.gov/Pages/hsp-data-request.aspx). HSCRC is planning to release updates to the Market Shift di-identified dataset at least semi-annually. More information to come on the timing and availability.

Grouper Transition: MHAC, RRIP, QBR

Rate Year	APR/PPC Version	Timeline	Implementation Date
RY2022:	APR/PPC: Version 37.1	Base Year: MHAC: FY 2018-2019 QBR/Mortality: FY 2019 RRIP: CY2018 Performance Year: All Programs: CY2020	Base: Available on CRS Portal Performance: Ongoing through CY 2020 data processing

FY 2021 Update: New Edits & Error Threshold

- All of the newly adopted edits (except the edits for Expected Payers and Health Plan Payers) are highlighted in red in the DSRs.
  - An additional edit is being proposed for FY 2021 to address negative charges that are reported in the case mix data:
  - Record Type 3, Total Charge: Fatal Error: If value is < 0
- The following are the edits that are currently labeled Fatal Errors
  - Missing Patient County of Residence (County Code)
  - Missing Residence Zip Code
  - Missing Point of Origin (Source of Admission)
- Discharges will not be dropped from the downstream data processing until January 1, 2020

FY 2021 Update: New Edits & Error Threshold

- All of the newly adopted edits (except the edits for Expected Payers and Health Plan Payers) are highlighted in red in the DSRs.
- Reduce the error threshold **from 10 percent to 5 percent** for final quarterly submissions, effective January 2021
- Assess the state of affairs in the fall to determine whether another delay is necessary.
- **Implementation Timeline:**
  - **July 1, 2020:** Sandbox in DAVE will be available, new edits will be flagged as warnings.
  - **October 1, 2020:** New edits will be displayed as warning in production
  - **January 1, 2021:** New Edits will be switched to errors
  - **April 2021:** 5% error threshold in effect for FY 2021 Q3 Final and subsequent Final Quarters

FY 2021 DSR Revisions for IP, OP, PSYC

- Added usage notes for codes
- New codes for Newborns: NO and NI
- Removed requirement to provide associated provider ID for transfers from and discharges to SNFs and Medicaid Certified nursing homes
- Reinstated code for Not Applicable (77) for Expected Payer Codes
- Updated health plan names and removed terminated health plans
- Removed "777777" as a valid code and allowing only blanks for Not Applicable Provider Specific Admission Source
- Removed code for recurring claims (00). HSCRC is no longer tracking recurring claims. Hospitals should report the actual discharge disposition of the patient (i.e., if the patient went home, then report code 01 (Home))
- Expanded max length for Units of Service from 5 to 6 for IP and PSYC.

Revision Delayed Until FY 2022

- New naming convention for case mix data submitted via RepliWeb
- Consolidation of Expected Payer Codes and the associated edits
- Consolidation of Health Plan Payer Codes and the associated edits

Point of Origin for Telemedicine Services

Question: If a patient is being sent to the ED or being directly admitted to the hospital from a telemedicine physician visit (but they are physically at home prior to arriving at the hospital), should this be coded as Point of Origin 'Home' or Point of Origin 'Physician Office/Clinic'?

Original Answer: The Point of Origin should be coded "02," from a clinic or physician office (includes urgent care, immediate care clinics, on site clinic or off-site clinic).

Revised Answer: **The Point of Origin should be coded "01" From a Non- Healthcare Facility.**

Alternative Clinical Sites Due to COVID-19 Surge

- In order for the HSCRC to identify the patients provided services in non-traditional settings, hospitals must use the Reserve Flag "A" for patients being seen at the alternative site using the Reserve Flag for IP and OP, effective April 1, 2020.
- Alternative site is defined as **"a building or structure that is not located on the hospital campus that is being used to provide clinical services during the COVID-19 emergency."**
- **This code only applies to alternative sites where services will be billed under an existing Hospital Medicare ID.** If the alternative site has its own temporary State Medicare ID, please report these cases under that designated Medicare ID.

Alternative Clinical Sites: Examples

- Examples of when to use the reserve flag:
  - Patients triaged in the hospital ER, then later transferred to a field hospital set up at a nearby hotel for IP services then discharged. Charges are billed under existing Medicare ID.
  - Hospitals relocating outpatient services to alternative sites not on the campus

- Examples of when **not to** use the reserve flag:
  - Hospitals using temporary tents on their campus for containment/isolation and diagnostic purposes (lab testing or triage)
  - Modular units constructed on the hospital campus for clinical care.
  - Clinical spaces created in non-clinical areas (auditoriums, conference rooms, or cafeterias) within the hospital campus
  - Sub-acute beds that are converted to acute beds within the hospital
  - Telemedicine services

Reminder: Complete the Data Forum Survey!

- Opportunity to provide feedback on
  - Meeting logistics (meeting notice, registration, ease of participation)
  - Topics covered during the prior meeting
  - Topics for discussion for future meetings
- After this Data Forum, participants will receive a link to a survey via Survey Monkey
- Questions about the survey: contact hscrcteam@hmetrix.com

Data Processing Vendor Update

Points of Contact

HSCRC	hMetrix / Burton Policy
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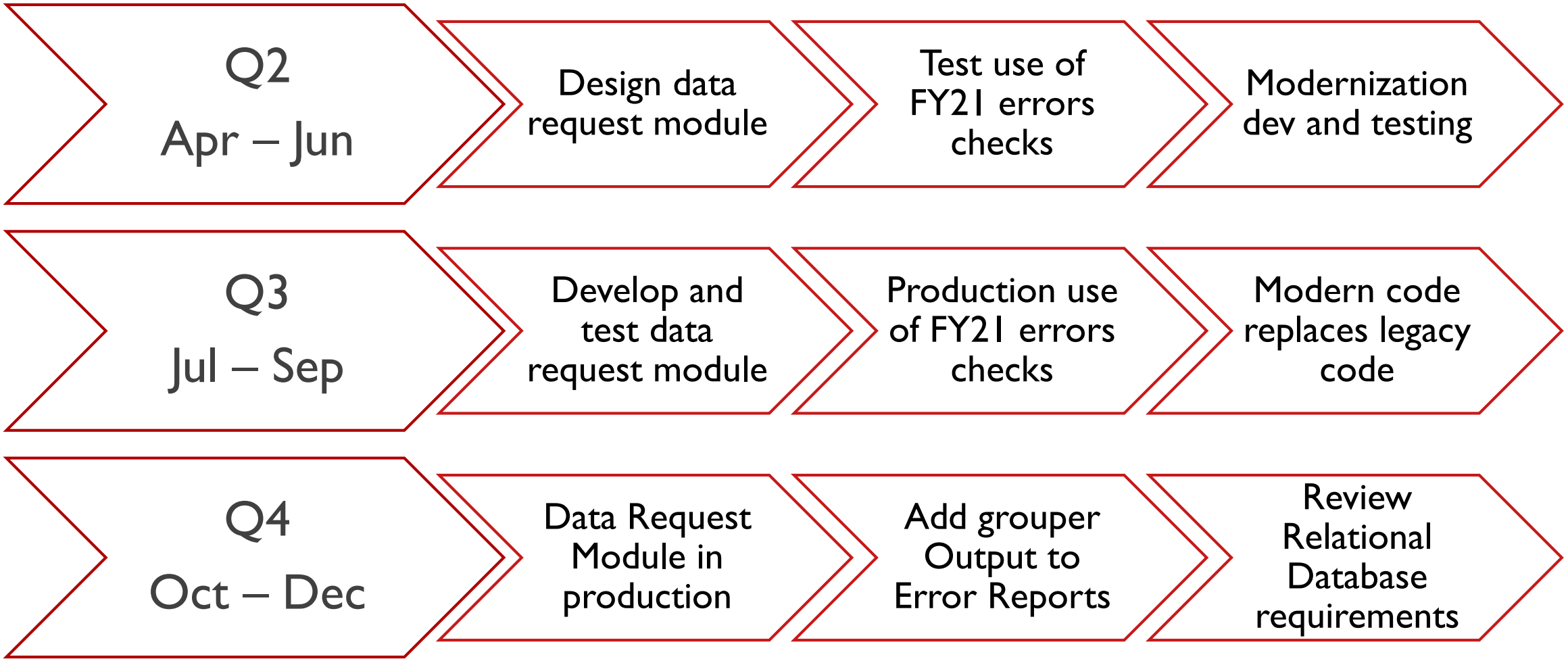
Data Processing Updates and Status

- Reminders
  - Data submittal forms are no longer required
  - Only submissions to HSCRCIP, HSCRCOP, and HSCRC-Psych will be processed
- Modernization of the processing pipeline in progress
  - Stable, configurable platform
  - Minor updates to the Error Report
  - Reduction of processing time
- Test site available for Hospitals on July 1, 2020
  - FY21 Data Submission Rules

Changes to Error Reports

- Retiring tabs
  - Unedited Data Codes
    - Record Count
    - Valid Discharge Count
    - Data File Load Errors
    - Mismatched Cases
    - Total Charges Submitted
    - Total Charges for Valid Case
    - Relevant information will be moved to the HSCRC Letter tab
  - Data Fields
    - Summary of look up values

CY 2020 Roadmap for Continuous Improvements to DAVE



Case Mix Data Audit Findings

Case Mix Audit Findings

- Advanta Government Services, LLC (AGS) is the case mix audit vendor
- Under this contract, 18 hospitals have been reviewed
- Results from the first 10 will be presented. AGS reviewed data from FY 2018 (APR v34/EAPG v3.12/PPC v35)

Inpatient Discharge Disposition

- Verify hospital system discharge disposition dictionary includes all discharge disposition responses from the current data submission regulations
- Test mapping of responses from abstracting system to submission file
- Home (01) Discharge Disposition

Outpatient Discharge Disposition

- Verify hospital system discharge disposition dictionary includes all discharge disposition responses from the current data submission regulations
- Test mapping of responses from abstracting system to submission file
- “Series” or recurring patient disposition is 00

Observation Services

- The primary purpose of the observation service is to determine whether the patient is to be admitted as an inpatient or discharged.
- This service **must be ordered** and documented in writing as to time and method (fax, phone, etc.) given, by a medical staff practitioner.
- Observation services may be provided in the emergency department or another area of the hospital.
- Observation RVUs are based on "**clock time**" and not clinical care time (CCT).
  - Clock time begins at the time when a valid physician order for observation is documented.
  - Clock time ends at the time when a valid physician order to cease observation is documented. This service usually does not exceed one day.
- The minimum observation time is one hour. After 1 hour, round up or down to the nearest full hour.
  - 31 to 60 minutes = round up
  - 1 to 30 minutes = round down

Drug Units

- Hospitals are required to report all drug CPT/HCPCS codes in the outpatient case mix data in accordance with the HSCRC Data Submission Requirements.
- Example - patient received Zofran 4mg
  - J2405 Zofran 1mg
  - Units = 4

Excision Lesion

- Procedure Type - verify that an excision is being performed and not a biopsy, debridement or shave removal.
- Size - operative note should include the lesion size.
- Review Pathology Report - CPT codes require the distinction between benign or malignant for accurate coding.
- Location - identify the specific location of the lesion.
- Separately Code - each lesion is coded separately. If there are multiple excisions in the same location a modifier 59 should be added to the second and any subsequent procedures.

Repair (Closure) Definitions

- Simple repair is used when the wound is superficial (involving primarily epidermis or dermis, or subcutaneous tissue without significant involvement of deeper structures). Wound closure involves closing one layer, including local anesthesia, and chemical or electro-cauterization of wounds not closed.
- Intermediate repair requires layered closure of one or more of the deeper layers of subcutaneous tissue **and** in which superficial (non-muscle) fascia is required in addition to the skin (epidural and dermal) closure. Intermediate repair includes limited undermining, which is defined as a distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect. Intermediate repair may also be reported for single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter.
- Complex repair includes the repair of wounds that, in addition to the requirements for intermediate repair, require at least one of the following: a) exposure of bone, cartilage, tendon or named neurovascular structure; b) debridement of wound edges (e.g., traumatic lacerations or avulsions); c) extensive undermining (defined as a distance greater than or equal to the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect); d) involvement of free margins of the helical rim, vermilion border, or nostril rim; or e) placement of retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions

Data Issues Discussion

- COVID-19 Coding and Quality Reporting Update
- Discontinuing MedChi and SPCC Provider Numbers
- OP Bundling of SDS cases with IP Rehab

Covid-19 Diagnosis Coding

New Code for COVID-19 Effective April 1, 2020

- Assign code U07.1 for all confirmed cases.
- Use additional codes for other manifestations and secondary diagnoses (e.g. other viral pneumonia J12.89, acute bronchitis J20.8 or acute respiratory distress syndrome J80).
- Intended to be used for all patient types as first-listed or principal diagnosis except in the case of obstetrics.
- Covid-19 infection that progresses to sepsis follow the sepsis guidelines in Section I.C.1.d of the Official Coding Guidelines.
- If Covid-19 does not meet the definition of principal or first-listed diagnosis (e.g. develops after admission) then code U07.1 should be a secondary diagnosis.

Presumptive Cases

A presumptive test result means that the sample has tested positive for the virus at the state or local level, but has not yet been confirmed by the CDC.

- Presumptive cases should be coded as a confirmed diagnosis of COVID-19.
- Documentation that states "suspected, possible, or probable" COVID-19
  - Assign a code(s) explaining the reason for encounter.

Exposure to COVID-19

Patient with exposure to someone who is confirmed or suspected to have COVID-19 and their own COVID-19 test is negative or unknown

- Symptomatic
  - Code signs and symptoms and Z20.828
- Signs and Symptoms -Where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms.
  - R05 Cough
  - R06.02 Shortness of Breath
  - R50.9 Fever, unspecified
- Asymptomatic
  - Z20.828 Contact with (suspected) exposure to other viral communicable diseases

Exposure to COVID-19

Asymptomatic Patients Possible Exposure Ruled Out

- Code Z03.818 for encounter for observation for suspected exposure to other biological agents ruled out.

Screening for COVID-19

For patients who are asymptomatic and are being screened for COVID-19 and have no known exposure and the test results are either negative or unknown, use code Z11.59 for encounter for screening for other viral diseases.

Laboratory Codes

Developed	CPT/HCPCS Code	Description
February 4,2020	U0001	CDC developed test kit
February 4,2020	U0002	Test kit that is not the CDC developed test kit
March 13, 2020	87635	*Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique*
April 10, 2020	86318	Revised description *Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip)*

Laboratory Codes

Developed	CPT/HCPCS Code	Description
April 10, 2020	86328	New code: *severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])*
April 10, 2020	86769	New code: *Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])*
April 14, 2020	U0003	*Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.*
April 14, 2020	U0004	*2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.*

References

1. https://hscrc.state.md.us/Pages/hsp_info1.aspx
2. https://hscrc.maryland.gov/Pages/hdr_compliance.aspx
3. https://www.cms.gov/newsroom/press-releases/cms-develops-additional-code-coronavirus-lab-tests
4. https://www.cdc.gov/nchs/icd/icd10cm.htm
5. CPT Assistant September 2018 p.7
6. CPT Assistant November 2019 p.3
7. https://journal.ahima.org/ahima-and-aha-faq-on-icd-10-cm-coding-for-covid-19/

Contact Information:

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HSCRC COVID-19 Quality Update

HSCRC will not use claims-based data for the following quality programs/measures for the January-June 2020 timeframe, consistent with CMS:

- Quality Based Reimbursement (QBR)- inpatient mortality
- Readmission Reduction Incentive Program (RRIP)- readmission rates
- Maryland Hospital Acquired Conditions (MHAC)- complication rates
- Potentially Avoidable Utilization (PAU)- PQI rates

HSCRC COVID-19 Quality Update

- For the QBR HCAHPS and NHSN Infection Measures:
  - Hospitals can choose to submit, or not, data to CMS for October 19-June 2020.
  - For hospitals that choose to submit, HSCRC has a 6/16/20 meeting with CMMI to discuss whether hospitals would need to submit an exception request consistent with the Hospital Value-Based Purchasing (VBP) Program's Extraordinary Circumstances Exceptions (ECE) policy.
  - HSCRC goal: To reach agreement with CMMI to not require an exception form even if hospitals submit the HCAHPS and NHSN data, as we intend not to use the data if submitted.
- For more information
  - HSCRC COVID Page,
  - HSCRC 4/10 COVID Quality Memo
  - CMS-HSCRC Quality data correspondence

Why we collect MedChi Number?

HSCRC Statutory Law Section 19-2018 states:

(a) In general. -- The Commission shall require each facility to give the Commission information that:

(4) Includes physician information sufficient to identify practice patterns of individual physicians across all facilities.

(b) Confidentiality. -- The names of individual physicians are confidential and are not discoverable or admissible in evidence in a civil or criminal proceeding, and may only be disclosed to the following:

(1) The utilization review committee of a Maryland hospital;

(2) The Medical and Chirurgical Faculty of the State of Maryland; or

(3) The State Board of Physicians.

MedChi Number vs National Provider ID

Staff is looking into whether we need to continue to collect MedChi and only use NPI.

MedChi Number:

- Confidential variable– only ghost ID provided publically
- Assigned by MedChi
- Updates monthly
- Issue: Data lag for assigned MedChi numbers

National Provider ID (NPI):

- Can be shared in PUF
- Publically available online (assigned by CMS)
- Updated monthly
- Download file from website for validation
- No known issues, but testing is needed for OP (non-OBS) providers

Discontinuing SPCC Provider ID

- 2 Digit provider ID assigned by the St Paul Group
- Used to keep Provider IDs the same when hospitals change their 6 digit Medicare provider number.
  - At the time, it was the best way to not 'lose' the new hospital in all of the old COBOLT programs that referenced an old Medicare Provider number
  - Removed the need to update historical data with the new Medicare provider numbers
- This is no longer an issue with updates to the processing programs
- No longer included in Public Use Files
- Phase out variable in FY 2021 for data requests processed by hMetrix
  - A crosswalk between the SPCC and Medicare ID number will be available upon request
  - SPG will continue to populate and provide this to anyone who wishes to continue receiving it in the datasets.

Discussion of OP Bundling of SDS cases with IP Rehab

Next Meeting Date

September 11, 2020 @ 10:00