Performance Work Group

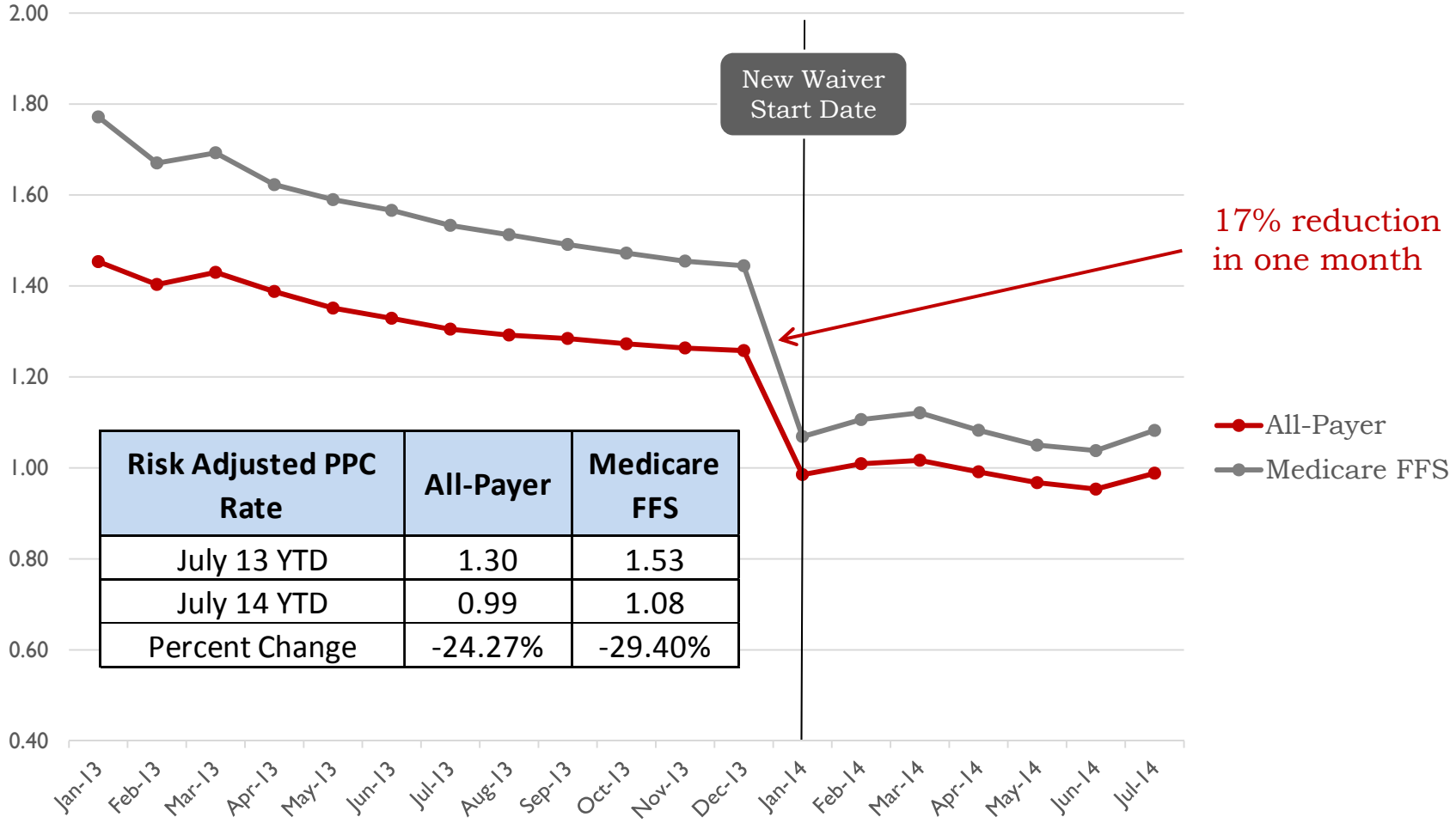
10/17/2015 Meeting

HSCRC
Health Services Cost Review Commission

PPC Performance Trends

Year-to-Date

Results: Risk-Adjusted PPC Rates YTD



Risk Adjusted PPC Rate	All-Payer	Medicare FFS
July 13 YTD	1.30	1.53
July 14 YTD	0.99	1.08
Percent Change	-24.27%	-29.40%

Note: Based on final data for January 2013 - June 2014 and preliminary data for July 2014.

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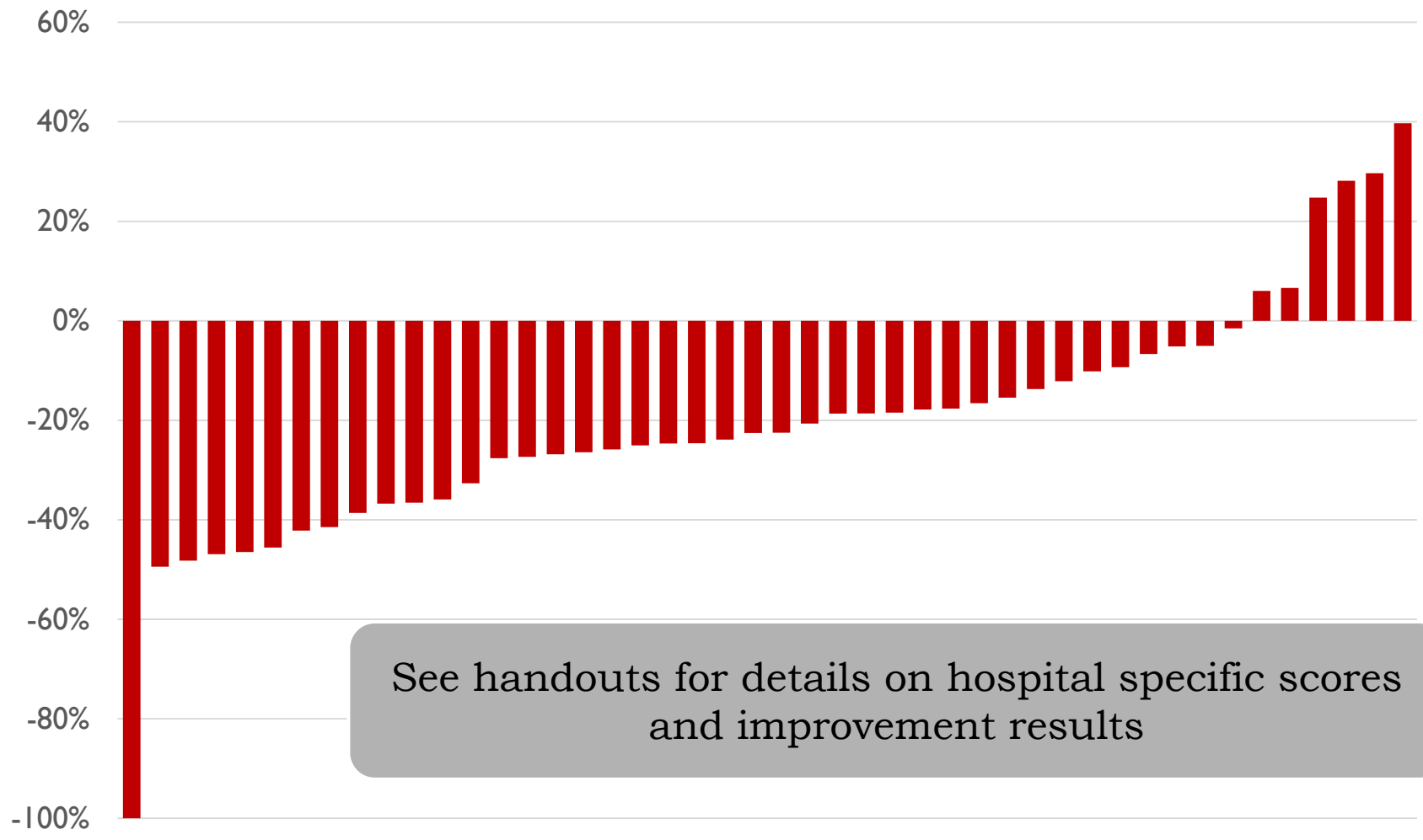
Improvements in All-Payer Risk-Adjusted PPC Rates YTD by Hospital



See handouts for details on hospital specific scores and improvement results

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Excel Sheet Tables

See Handouts

HSCRC Audit of Present on Admission Indicator

Presentation Contents

- Brief Overview of Present On Admission (POA)
  - General POA Reporting Requirements
- POA Coding Audit
  - Screens Developed by Michael Pine and Associates (MPA)
  - FY 2014 Hospital Audit
- Workgroup Discussion

Overview: POA Definition and Timeline

- POA Definition
  - Defined as being present at the time the order for inpatient admission occurs
  - Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA.

- Beginning with October 2007 discharges, CMS required the POA indicator on all claims for Medicare inpatient admissions to general IPPS acute care hospitals or other facilities.

- Maryland hospitals were required to submit POA by HSCRC beginning with July 2007 discharges, and by CMS beginning with October 2013 discharges.

Overview: General Reporting Requirements

- The POA indicator is assigned to the principal and all secondary diagnoses
  - Defined in Section II of the "ICD-9-CM Official Guidelines for Coding and Reporting" ("Official Guidelines") located at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm on the Centers for Disease Control and Prevention (CDC) website.
  - Providers must resolve issues related to inconsistent, missing, conflicting, or unclear documentation.
- Coding
  - The "UB-04 Data Specifications Manual" and "Official Guidelines" can help with assigning the POA indicator for each "principal" diagnosis and "other" ICD-9-CM diagnosis codes reported on the UB-04. For more information about the "UB-04 Data Specifications Manual," visit http://www.nubc.org/subscriber on the National Uniform Billing Committee website.
  - As stated in the Introduction to the "Official Guidelines," a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting diagnoses and procedures.
- Documentation
  - The importance of consistent, complete documentation in the medical record cannot be overemphasized.
  - Medical record documentation from any provider involved in the care and treatment of the patient may be used to determine whether a condition is POA. In the context of the "Official Guidelines," a "provider" is a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

General POA Reporting Requirements

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

- POA "E" for exempt may also be coded. The list of ICD-9-CM codes on the POA exempt list may be found in the "ICD-9-CM Official Guidelines for Coding and Reporting" ("Official Guidelines") on the Centers for Disease Control and Prevention (CDC) website. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

POA Coding Audit Overview

- The purpose of POA auditing is to identify potential systemic errors in coding practice within a facility. The aim is to flag potential problems when observed rates exceed reasonable thresholds for certain coding practices.
- For all cases reviewed, HSCRC's independent auditor reviews all ICD9 diagnosis codes in the HSCRC discharge data compared with the chart documentation, and including POA.
- In order to further assess the quality of POA coding, a subset of cases were audited that met criteria for several proprietary screening algorithms (i.e., screens) developed by MPA.

Examples of POA Coding Audit Screens Developed by MPA

- Diagnosis codes exempt from POA reporting that were assigned an invalid POA modifiers (Y, N, U or W) or non-exempt assigned an invalid POA modifier (blank)
- Principal diagnosis codes that by definition are present on admission and not exempt from POA reporting that were incorrectly assigned a POA of N or W.
- Improper POA coding of ICD-9-CM diagnosis codes for chronic conditions.
- Secondary diagnosis codes for conditions that frequently are hospital-acquired complications in medical patients but POA coded as N
- Inpatient mortality rates associated with selected secondary diagnoses when they are acquired in the hospital compared to mortality rates for the same diagnoses when they are present at the time of admission.
- Secondary diagnosis codes with POA=Y for conditions that are relative contraindications for elective surgical procedures
- Elective surgical cases with no coded complication but a longer than expected length of stay
- Diagnosis codes for conditions usually present at admission when women are hospitalized for labor and delivery that were coded as POA=N

Overview of Coding Audit Results

- HSCRC's independent auditor reports back to hospitals the results of their audits
- Hospitals' coding accuracy rate is calculated as the number of coding changes divided by the total number of codes reviewed.
- Pine screens have picked up higher proportion of inaccuracies for POA
- Hospitals have met the AHIMA published national benchmark for coding accuracy of 95% for APR DRG and POA coding.

POA Summary From Audit Report

POA Summary by Case

Case Type	# of Cases w/ POA Issues	Total Cases	% of Cases
POA Quality	21	65	32.3%
Coding Audit	6	165	3.6%
All Cases	**27**	**230**	**11.7%**

POA Summary by Codes

Reported POA	# of Cases w/ POA Changes	# of POA Changes	# of Codes	% of POAs Changed
POA Quality		**39**	**820**	**4.8%**
Y	13	20	619	3.2%
E		0	136	0.0%
N	8	19	64	29.7%
W		0	1	0.0%
Coding Audit		**7**	**2280**	**0.3%**
Y	5	5	1801	0.3%
E		0	330	0.0%
N	1	2	145	1.4%
W		0	4	0.0%
All Codes		**46**	**3100**	**1.5%**
Y	18	25	2420	1.0%
E		0	466	0.0%
N	9	21	209	10.0%
W		0	5	0.0%

FY 2014 Hospital Audits

- For FY 2014, the HSCRC is primarily focusing on auditing 10 hospitals that have had significant improvements in PPC rates.
- Cases selected for audit (N = 230)
  - 50% random sample for ICD-9 Audits
  - 50% for POA audits (used to be 30%) ; New Method: select from a file of discharges at-risk for PPC's with large improvements and those where the PPC status changed between the preliminary and final data submission. Increase in the hospice cases is additional topic for the audit.
- Other hospital selection factors: hospital size, date of last audit (not auditing in 2013 or 2014), percent change between preliminary and final data submission.

MHAC Modeling for FY 2017

Using Current Performance Data

CMS Hospital Acquired Conditions Case Number Requirements

CMS Domain 1&2 Inclusion Rules

- Complete data for the AHRQ PSI-90 composite measure (HAC Domain 1) means the hospital has three or more eligible discharges for at least one component indicator.
  - If a hospital does not have "complete data" for the PSI-90 composite measure, a Domain 1 score is not calculated for that hospital.
  - If a hospital has "complete data" for at least one indicator for the AHRQ PSI-90 composite measure, CMS will calculate a Domain 1 score.
- The calculation of the Standardized Infection Ratio for the CDC measures (HAC Domain 2) requires that the facility have a ≥1 predicted HAI event.
  - The predicted number of events is calculated using the national HAI rate and the denominator counts.
- In the event the SIR cannot be calculated for any Domain 2 measures because the facility has <1 predicted infection for each measure, Domain 1 scores exclusively will be used to calculate a HAC score.

Statewide Improvement Targets

Statewide Annual PPC Change

Potentially Preventable Complication (PPC) Rates in Maryland- State FY2010-FY2014														
	PPC RATES (FY2010 NORMS, vs. 30)				PPC RATES (CY2013 NORMS, vs. 31)			Annual Change (FY2010 Norms, vs. 30)			Change (CY2013 Norms, vs. 31)		FY 2010-FY 2014 Change	
	FY10	FY11	FY12	FY13	FY13	FY14		FY11	FY12	FY13	FY14		Average Annual Change	Total Change
TOTAL NUMBER OF COMPLICATIONS	53,494	48,416	42,118	34,200	34,143	26,900		-9.5%	-13.0%	-18.8%	-21.2%		**-15.6%**	-49.7%
COMPLICATION RATE PER 1,000 AT	1.92	1.82	1.65	1.41	1.40	1.16		-5.2%	-9.3%	-14.5%	-17.1%		**-11.6%**	-39.6%
COMPLICATION RATE PER 1,000 AT RISK CASES	1.92	1.77	1.58	1.30	1.40	1.13		-7.8%	-10.7%	-17.7%	-19.3%		**-13.9%**	TBD