

Vermont Explor Annual Meeting
April 29, 2003
Vermont Technical College, Randolph, VT

Summary of Presentations and Discussion

Dian Kahn, BISHCA

- BISHCA uses hospital discharge data for various purposes (reports to legislature, study of outmigration to New Hampshire, etc.)
- Thanks to hospitals for their hard work
- Good to see improvements in data quality and timeliness
- Looking into Emergency Room data grouping
- Studying shift from inpatient to outpatient care

Charles Bennett, Vermont Dept of Health

- Thank you to hospitals for making his work possible
- The data provide guidance for future action in public health
- Data uses in surveillance:
 - Healthy Vermonters 2010
 - Injury Report
 - Women's Health Status Report '02
 - Men's Health Status Report '02
 - Costs associated with hospitalizations (avg. and total annual charges)
- Examples from Healthy Vermonters 2010 goals: Hip fractures among women need to be halved; reduce visits to ER
- Coding of E-codes has improved dramatically to 97% complete
 - 38% include a location E-code
 - 5% include a perpetrator E-code
 - Suggestion: Add additional fields to data file to record location/perpetrator
 - Amanda Franklin (Brattleboro) responds: Communicate this to the physicians who fail to record the information necessary to generate these E-codes.
- Some current surveillance programs:
 - Asthma (rates of hospitalization have declined in past decade)
 - Diabetes (on the rise)
 - CHD (rate among men is much too high)

Pat Worcester, Vermont Dept of Health

- Compared outpatient data from 2000 and 2001, noted large increase in diagnostic GI procedures [due to expanded submission requirements]

- Analyzed ER data according to NYU's ED Classification System; 21% of visits were non-emergent, another 19% were emergent but could have been treated in a primary care setting; the conclusion is not that 40% of visits shouldn't happen, but that we should look for ways to improve primary care and access
 - Topic to study: Are there more "preventable" ER visits in areas lacking primary care doctors?
 - 36% of Vermont ER visits are for injuries

Ken Kuebler, HIDI (our data processor)

- [Please see the PowerPoint presentation at www.vtexplor.org/events.htm for a succinct summary of his presentation on unique personal identifiers]
- Audience responses to the idea of collecting Social Security Numbers:
 - Newborns don't have them
 - Ken said that in Missouri they do before discharge
 - Several people asserted that VDH would have to change the birth certificate system
 - Rich McCoy of VDH stated that VDH is implementing some changes in the next 8 months
 - Charles Bennett of VDH noted that the SSA has expressed interest in newborns getting SS#
 - Foreigners don't have them (many foreign students)
 - Patient privacy is crucial
 - Collecting SS# won't fix every coding issue we may want it to
 - Ken noted that 3 patient types lack SS# in his data: foreigners, children and refusers, but they account for only a few percent of records

Steve Reynolds, Porter Medical Center

- Steve spoke about the burden of correcting errors in submitted data. He asked that the decision makers pick an acceptable error rate (3%) and then not expect any further corrections to be made below that.
- 0% is unreasonable
- The hospital billing system is very complex; HIPAA only adds to that
- Billing rules change, causing errors – as perceived by Vermont Explor
- He would like to minimize the number of special situations that he has to deal with; the primary purpose of Porter's data system is to generate payable bills
- Amanda Franklin (Brattleboro) seconded his sentiments

Cheryl Hadden, Rutland Regional Medical Center

- Cheryl presented the problem with applying – or trying to apply – an E-code to every encounter a patient has with the hospital subsequent to an injury:

- It isn't correct coding practice
- After 6 months, "late effects" codes should be applied instead
- The medical record of a patient who shows up for therapy many months after an injury will probably not indicate the precise nature of the injury; the information isn't there to assign an E-code
- It's an additional work burden
- Coding should avoid fraud & abuse
- Billing needs to be timely

Angela Guyette, Fletcher Allen Health Care

We ran out of time for Angela to present, but she has provided the following information regarding CPT vs ICD-9 procedure codes for data analysis:

Factors influencing the use of coded data

- Basic coding guidelines for inpatient and outpatient differ – American Hospital Association guidelines vs. American Medical Association guidelines
- CMS payment methodologies differ – DRG vs APC vs other third party payer requirements
 - CPT-4 procedure codes are not reported on the UB-92 for inpatient visits.
- The coding systems differ – ICD-9 vs. CPT-4
 - CPT4 originated to capture physician charges for procedures performed and evaluation and management of patients.
 - ICD-9 originated through the World Health Organization as a standardized International Classification of Diseases and procedures for morbidity and mortality statistical reporting.
- Coding expertise from hospital to hospital may vary. While most hospitals now require their staff be certified in coding, the level of experience, exposure to simple vs complex procedures or severity of illness and human error may influence the accuracy of data. Do coders have access to reference data and coding tools
- Charge Master – must be updated and maintained with accuracy.
- Documentation practices vary from provider to provider. Coding accuracy is dependant upon clear and consistent documentation practices among all providers in relation to the coding guidelines.

What is the long-range intention of the use of data?

- Comparison of data between inpatient and outpatient procedures could only be performed by analysis of ICD-9 procedures since the CPT-4's are not submitted on inpatient claims. Financial information is not comparable due to the different payment methodologies. Apples to Oranges.
- If no comparison occurs between inpatient and outpatient, then an argument could be made that if only comparing outpatient to outpatient statistics, the

preferable codes would be the CPT-4 since CPT-4 are more precise and accurate in reflecting the detail of procedures performed.

For example: An outpatient procedure of a laceration/wound repair of the skin would always be coded to a single code in ICD-9 - 86.59; whereas there are a series of codes in CPT-4 that describe the length, location and extent of penetration of the wound repair in the range of codes in the 12001 series.

Or: Open and arthroscopic repairs of the knee are classified to “Other repair of knee” in ICD-9 whereas CPT-4 provides greater specificity with individualized codes.

- While use of CPT-4 codes for data analysis may provide more specificity, it may also be more troublesome due to the complexities of the process of coding as defined earlier, such as, non-standardization of documentation, process inconsistencies internal to a facility or in comparison between facilities, coding education level of staff, etc.
- AHIMA has written a position statement in support of ICD-10 with comments on the deficiencies of the current ICD-9 procedure coding system. “Although the Coordination and Maintenance Committee has attempted to make coding modifications to capture new technology, it has sometimes been difficult to achieve a reasonable result. Making needed changes to the ICD-9-CM procedural coding system has become increasingly difficult each year and involves making compromises that affect the precision of the coding. In fact, implementation of some meritorious code proposals has not been approved due to insufficient space to create a new code. ICD-9-CM procedure codes often fail to distinguish between significantly different technologies. It is difficult to track data on new procedures when they are classified to general, non-specific codes. Many of the terms used in the ICD-9-CM procedural coding system can have a variety of meanings and interpretations, resulting in difficulty and inconsistency in determining the most appropriate code.”
- CMS is planning to standardize a protocol for assignment of E/M levels for facility Emergency Room charges. Data analysts may find this standardization helpful in determining the level of care provided to patients based on the E/M level and diagnoses and/or procedure codes in the future.

Vermont hospital patient type classifications:

- VT Explor has grouped, by definition, patients into specific categories. However, each individual hospital has their own methodology for how they identify patient visits within their systems.
For example: FAHC has many patient types including but not limited to:
 - IP – inpatient
 - IPSYCH – inpatient psych admissions
 - IPREHAB – inpatient rehabilitation (grouped under CMG’s)
 - OPSURG – Outpatient surgery
 - OPOR – Outpatient surgery in OR with unit recovery charge

OPPROC – Outpatients with a procedure not in OR that requires a unit recovery

OPREC – Outpatient recurring

OP – Outpatient – lab, radiology, etc.

OPED – Emergency Room patients

Other hospitals may simply identify all their patients as either inpatient or outpatient. Does the VT Explor grouping provide enough specificity for accurate data comparison, especially among the outpatient population?

ICD-10

- 10th Revision of the International Classification of Disease. Standard Code Set that is an hierarchical structure, expandable, comprehensive, and relatively easy to use
- Intended to replace ICD-9 and CPT-4. Alphanumeric codes.
- ICD-10 is designed to provide a higher level of specificity
- Will require complete retraining of certified and non-certified coders as well as providers and all other users of coded data.
- Will require systems upgrades for hospitals, third party payers and all other data users.
- Requires new rules and regulations and coding guidelines.

ICD-10 may be the answer to the current issues addressed during discussion at the Annual Meeting in respect to reducing the complexity of existing coding processes, payer systems and information systems. For more information, please see the AHIMA web site: <http://www.ahima.org/dc/testimony.icd10pcs.cfm>.

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