

A Health Data Consulting White Paper



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Managing Healthcare Policies

Transitioning policies for a new healthcare environment

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OVERVIEW

Every healthcare entity defines and uses policies to drive how they do business in a different way. There are however, common themes about how decisions are made and the rationale for actions that may be taken related to services and the conditions under which those services are provided. In particular, Payers must decide whether to take one of three actions when presented with a claim for payment for services:

- **Pay** - When the claim is received the service is paid at some defined level assuming appropriate conditions are met.
- **Pend** – Hold payment of the claim for some level of review or request for additional information
- **Deny** – Deny or disallow payment of the claim for any number of reasons that may be related to benefits, coverage limits, medical necessity, evidence of medical effectiveness, medical appropriateness or any number of other reasons that may or may not have to do with medical reasons.

Policies that drive the rules for these decisions may be defined at various levels of detail within the organization. There may be formal medical policies that guide processing decisions. There are other forms of documentation that define processing rules related to coverage, benefits of other processing drivers that may or may not include the rationale for those processing rules. Ideally any decisions about the payment of claims should have some policy or rationale for that decision that ends up in processing rules so that the “intent” of the organization is consistent with what actually happens.

For the purpose of this paper, “Policy” will be used in the broader meaning of the word to define any rationale and the instructions for what action is to be taken related to a claim request for payment. This may be a medical policy, a benefit rule, a coverage rule, or any number of other rules that define the conditions under which payment for claims is determined.

CURRENT CHALLENGES AND OPPORTUNITIES

In most organizations today, the process for defining the rationale and intent of a policy and assuring that the intent is actually implemented is not working as effectively as it should. Policies are made in different silos within the organizations, using varying definitions and standard for items that should be consistent. The level of documentation varies and the format for making the intent of the policy or rule clear is often inconsistent. Clarity of intent is frequently limited and there is the potential for considerable errors in interpretation of that intent by those defining the service, diagnosis and other codes within a claim that would represent that intent.

Figure 1. graphically illustrates the flow from the definition of the policy and the intent of the policy, to defining the codes that represent that intent, to configuring those codes in systems that will be processing claim data at some level.

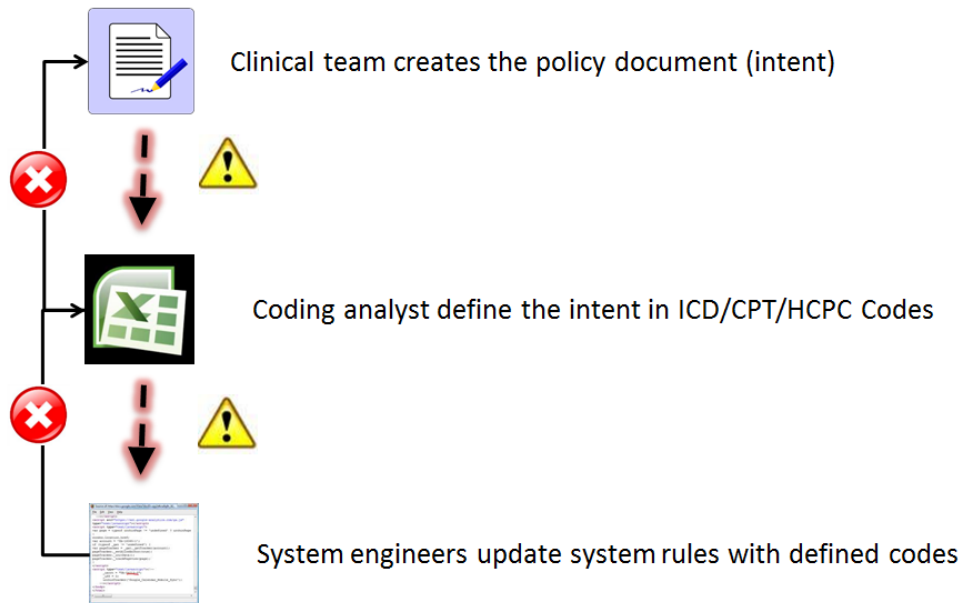


Fig. 1

For many organizations there is risk of miscommunication between these processes. There is also a deficiency in the feedback loop to review the implementation of policy intent. As a result, what is stated in policy is frequently not what is implemented in practice. This type of process is not only inefficient and labor intensive, but results in significant issues with translation and well as with synchronization of efforts as changes in policies, codes or systems occur. As a result, payment may be inconsistent, result in unanticipated payment or denials and in general erode both provider and consumer confidence and trust.

The transition to ICD-10 brings both challenges and opportunities.

Challenge:

- Because of the nature of the change in ICD-10-CM diagnostic and ICD-10-PCS institutional procedures codes, virtually all policies and rules that reference these diagnostic or procedural codes will require a major re-definition.
- Simply mapping current ICD-9 codes through GEM or some other crosswalk will not address the issue. Meeting the intent of the policy will require very different ICD-10 codes that go beyond just mapping to ICD-9. For example, a policy or rule that references the conditions of a “Median Nerve Injury” would contain 3 ICD-9 codes today. Mapping in both a forward and backward direction using GEM would come up with a total of 15 equivalent ICD-10 codes. However direct research would indicate that there are 33 ICD-10 codes that would meet the the intent of this rule. By not fully researching the ICD-10 codes that would define this intent, over half of the claims related to “Median Nerve Injury” might not be flagged or otherwise processed as intended.

- Because of the disconnect between processes, unintended codes may have occasionally been included in the original policy related code configuration. For example, on reviewing a payer policy related to “External Bone Growth Stimulators” it was noted that the policy was described the condition of “nonunion” of fractures, but the configuration for this policy included one code for “malunion”. “Malunion” is clearly not a condition that should be included as appropriate for payment, but some downstream interpretation resulted in the code being added in error. In ICD-10 the concept of “malunion” is now represented in 2909 different codes. Mapping the one wrong code in ICD-9 would obviously magnify the number of errors in ICD-10.

Opportunity:

- Since most policies will need to be re-evaluated to support ICD-10, there is an opportunity to relook at both the policies as well as the processes for defining and maintaining those policies.
- ICD-10 brings with it the ability to refine policies to leverage the details of ICD-10 as well as the ability to define risk, severity, comorbidities, complications, sequelae a number other parameters of health care conditions and procedures that was not possible in ICD-9. This can result in more rational and better targeted policies and rules that can enhance payment accuracy, timeliness and auto-adjudication rates.
- ICD-10 will allow the ability to have a clearer dialogue with providers around the documentation needed to support the codes as well as the rationale for how the policies are implemented.
- There is an opportunity to integrate the process of the definition of the policy intent, the coding of that intent and the configuration of systems to support that intent in a much more efficient way that is not only more accurate and consistent, but would also greatly lower the burden of current processes.

INTEGRATING THE PROCESS

Accomplishing the goal of establishing a consistent, efficient and maintainable process for policy definition and implementation requires an integration of the processes referenced in Fig.1 The following are considerations to address the requirement for this integration goal

1. Defining policy rationale and intent:

A free text document such as “Word” provides a great deal of freedom of expression, but does not provide a standardization of key components that would be necessary to accurately define the policy. The intent of the policy could be buried in the text of the document, and create opportunities for misinterpretation about what should happen downstream from a processing perspective. Some guides and constraints around the content of the policy are needed to assure that a diversity of authors can contribute in

a way that is consistent with the desired operation of the organization. There are several component areas where these guides and constraints will help assure a consistent and accurate approach to policy definition so that the intent is apparent.

- Metadata- This component of the policy defines information about the policy document itself and might include items like
 - Policy Name
 - Policy ID
 - Policy Author
 - Date Authored
 - Date Reviewed or approved
 - Who reviewed or approved the policy
 - Date if should be reviewed again

Numerous other items might be considered around the description of the documents as part of this “metadata”

- Rationale – A component that cites the reasons for the policy from a medical or some other perspective
- Glossary – A definition of key terms within the policy that are ideally derived from some more consistent enterprise wide definition of terms in order to assure consistent definition across policies for the same conditions or procedures.
- References – A list of reference citations that support the rationale for the policy and the intended actions based on the policy
- Alternative Treatment – Some policies may list a set of alternative treatments that might be considered. Generally this is used for educational purposes, but may be used as criteria for approval for pre-authorization in some instances.
- The Policy Intent – This component of the policy is the key driver for processing rules downstream. In effect, this policy component defines for any set of services, the conditions under which the claims will be paid, pending for review or not paid. This intent may be encompassed in one or more rules that define the set of services that should be considered in the conditional logic. In order for analysts to accurately reflect this intent in codes that can be identified on the claim, the intent must explicitly define what services are relevant and under what conditions claims should be paid, reviewed or not paid.

The development of these components can be standardized through a well-designed template or ideally through an application that can guide the process.

2. Defining codes that represent the intent:

Assuming the policy intent has been clearly articulated by the authors, the analyst must convert this intent in to a set of service codes that define the scope of one or more rules that will be required to process claims consistent with this intent. The analyst must represent this intent in sets of code that are related through some logic that defines the rule by answering the following:

- What are the various service codes that define the scope of the policy related rule?
- What are the diagnosis codes, or other data elements related conditions that are associated with the decision to 'pay', 'pend' or 'deny payment' for the claim?
- What is the 'AND', 'OR', 'AND NOT' logic between sets of codes that defines the appropriate action.

It is important that the analyst clearly communicates the codes and the logic and intended actions of the codes so that a system engineer or system configuration specialist can properly load the code table and/or logic in the system. Often this communication is through an excel template or some other document. Usually this communication is not in a "machine readable" format and therefore must go through another interpretive step.

3. Configuring the system:

The system engineer or configuration specialist must interpret the information provided by the analyst and create the tables, programming code or rules engine logic based on that communication. Ideally most of the code sets related to these configurations are referenced in tables, but there are occasions when codes values are "hard coded" in programming language. As policies are changed or new codes are added or deleted from existing code sets, each policy rule must be updated.

As can be seen in the description of these activities the potential for miscommunication, interpretive errors and lack of synchronization at each hand-off puts the intended actions based on the policies at risk. Careful process management, standards and end to end oversight is needed to address this risk. The effort to assure continuity is substantial without some tool that can help integrate definition of intent, identification of codes to meet that intent, and communication of those codes and associated logic to downstream systems in some machine readable format.

TESTING THE RESULT

Even with the best designed and implemented processes, unintended consequences may occur.

- The definition of the policy intent may be inaccurate or incorrect
- The definition of the codes that represent that policy may not be correct
- The configuration of the intent may not be correct
- All of the above may be correct, but the result of processing may bring unexpected results.

Testing provides a means to reduce the risk of errors or unanticipated results, but test cases must be developed specifically for each policy to reflect scenarios that would be impacted by those policies. Using the previously mentioned policy related to "external bone growth stimulators" testing would require the creation of several scenarios that would be established in test transactions to see if the policy resulted in expected

processing. Given this particular policy the following are examples of scenarios that will need be represented in test claims related to:

- External bone growth stimulators associated with
 - Fractures associated with nonunion
 - Fractures associated with malunion
 - Delayed or normal fracture healing
 - “Navicular” fractures of the wrist
 - Acute fractures other than “navicular” fractures
 - Other conditions not related to fractures
- Implantable bone stimulators or other devices or procedures not specifically defined as “external bone growth stimulators”
- Other claims where that might be denied or pended independent of the nature of the procedure or patient condition.

A careful design of these test cases for each policy will assure is needed reduce the risk of improper payment and loss of confidence with patient and providers.

MAINTENANCE

Healthcare is in a constant state of change, as are the standards that define conditions and the appropriateness of the services used to maintain or improve those conditions. Policies must change consistent with these overall changes in healthcare delivery and data standards in order to maintain relevancy and assure that necessary high quality care at a reasonable cost is delivered to members. Maintenance will be very difficult if the method for maintaining these codes does not address the ongoing challenges of integration and synchronization of the processes noted above. If an integrated process for defining policies from end to end is established appropriately, the same process will support efficient maintenance or editing of existing policies. If the processes for creating policies is disconnected then the process for maintaining policies will also be disconnected.

SUMMARY

Polices in the broadest since of the word provide the rationale for appropriate action designed to manage the quality and cost of healthcare delivery. For policies to be effective the intent of those policies must be clear and the steps to implement processing of claims consistent with that intent must be in synch. Reaching this goal requires the following:

1. Clear definition of the scope and intent of polices that is unambiguous to analysts defining relevant codes and logic
2. Accurate code definition to represent that intent accurately
3. Consistent configuration of defined codes and logic in system processes
4. Visibility from end to end to assure continuity
5. Testing to reduce the risk of errors of interpretation and unintended consequences

6. Ongoing maintenance to address changes in the standard codes that define service and conditions as well as the current state of healthcare knowledge of effectiveness and appropriateness.
7. A well-defined system to assure that these processes are standardized, continuous and verifiable and that the overall effort is as efficient as possible.