Health Data Consulting

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The Role of Payers and Providers in Improving Healthcare Data

As today's healthcare moves into a changing world of healthcare reform, the importance of reliable, accurate and complete healthcare data has never been more critical. Historically the transactional data we rely on to understand the burden or illness of the population and the risk, complexity and severity of health conditions has been limited. In a recent article for ICD-10 Monitor (*ICD-10 Myths Part 2: Coding Specificity),* I reported on an analysis of 3 years of claims data representing of over 15 million professional claims. Based on this analysis, the primary diagnosis for 54% of all claims was "unspecified", "Other" or just "symptoms" or "signs". In looking at claims for cardiac rhythm disorders for example, in well over 50% of claims there was no way to determine the nature of the cardiac rhythm problem. In this example, if we try to look at this data to understand the cost of care or the number of cases of atrial fibrillation treated, we could be off by over 50%. There are few other industry segments where transactional data about what was done and why is as non-specific as the data we rely on to manage the healthcare of a population.

Will ICD-10 solve this problem?

While it would be great to believe that the implementation of ICD-10 will result in better data, those providers reporting claim transactional data can be just as vague in ICD-10 as they were in ICD-9. In many instance there are opportunities to be even less specific. ICD-10 provides an **opportunity** to be more specific, but this does not assure that we will take advantage of that opportunity. In another recent ICD-10 Monitor article *(ICD-10 Myths Part 2: Coding Specificity)* a more detailed discussion demonstrates some of the challenges in this areas. It was pointed out that in ICD-10 there are two valid codes for "Injury unspecified" and "Illness Unspecified" that in theory might be used to describe any condition. Although this is a rather extreme example, the reality is there are many codes that are very vague in ICD-10. While any provider treating a patient should document which side is being treated, ICD-10 allows for the coding of "unspecified side". ICD-10 has a code for "respiratory failure, unspecified" whereas in ICD-9 only "acute" and "chronic" respiratory failure are allowed. There is no doubt that ICD-10 has many more specific codes, but if these codes are not used appropriately, there will be no advantage to migration to ICD-10.

In many instances we have become so focused on the codes, that we have lost site of the fact that codes are just a vehicle for capturing important medical concepts. Without this connection, the codes are just a set of meaningless characters regardless of the code type.

The role of the clinician

The clinician is the source of all data about the clinical condition as it is represented in ICD-9 and ICD-10 codes. The data represented in these codes is entirely constrained by the observations and documentation of the clinician in the course of assessing the patient. Only the clinician is licensed to diagnose and treat. Unfortunately most clinicians do not see the value proposition for them in capturing more accurate data from the patient encounter. They feel that they know what they need to know to treat the patient and see additional documentation as a burden that takes away from good patient care. On the other side however, good documentation was an important part of what we were taught in medical school and residency. There is no doubt that poor documentation of the key parameters of the patient condition compromises healthcare quality as well as the continuity of care as patients are treated by many different providers. While I'm sure that many pilots feel that the required documentation and data capture for flying is burdensome and in many instances unnecessary from their perspectives, it is a key part of the aviation business and clearly is an important part of aviation safety. Most law enforcement professionals will tell you that they hate the paperwork and feel that it takes away from their job. But without that, documentation we could not convict a single criminal. Like it or not, being specific about the important medical concepts of the medical condition is what we signed up for as healthcare professionals.

The role of the payer

Payers in theory are responsible to assure that limited financial resources are used appropriately to assure good patient quality, broad access to needed services, patient safety and affordable healthcare coverage. To accomplish this goal, payers and other managers of healthcare for populations, must have accurate reliable data. Payers are also charged to assure that payment is fair and commensurate with the severity and complexity of the service. Unfortunately since the traditional focus has been more on service payment than the management of health conditions, there has been little focus on the quality of diagnosis based codes from the payer perspective. In some instances payers have encouraged providers to submit less than specific codes. Some payers have historically accepted "short codes" (which are not really valid codes) because their processing systems can only look at the first three characters. Some payers only process based on the primary codes and do not consider other codes that describe the patient condition. Some payers require the submission of a vague code for a range of conditions because it's easier to process and their system rules and logic are not sophisticated enough to utilize the greater level of detail. Payers should never tell providers which diagnosis code to use. Payers are not licensed to diagnose and treat. Without an assessment of the patient how can you know what code best represents the patient condition?

What's the solution?

There is little doubt that unless we understand the financial implications of clinical conditions and the clinical implications of financial decisions, healthcare delivery will not progress. Technology will not solve this dilemma. It's like thinking that the best word processing system will make you a great author. Healthcare

facts are technology independent and there is no amount of technology that can create facts that haven't been captured. Big data sounds great, but more garbage in just means more garbage out. It all comes down to incentives. How can we align incentives to make payers want better data about patient conditions? How do we make providers sees the value proposition to them and their patients in transactional data? While there is no magic bullet there are some key considerations:

- Payment should be aligned with the management of the patient condition rather than the count of services delivered.
- Providers should have open access to data that defines what they do and how they compare with their peers.
- We must apply judgement carefully to avoid assuming that variation equates poor performance. The best performers in healthcare are outliers as much as the worst performers. Expecting the norm may result in aspiring to mediocrity. Most data analysis raises more questions and seldom does any single report provide a final answer. A healthy dose of intellectual honesty must be applied to all data submitters and data consumers. We should not attempt to make data say something it cannot.
- Payers and provider alike should be held accountable for the quality and completeness of data about **what** was done for the patient and **why**.
- Electronic health records should be focused on collecting details important for patient care and less focused on driving clinicians to "cut and paste" to meet some pre-defined model that may not be relevant to the patient condition.
- Systems to capture data and find the appropriate codes should be as simple as most internet searches.
- EMR systems, cheat sheets, problem lists and super bills must avoid the temptation to cross walk from a short list of vague ICD-9 codes today to an equally vague short set of codes in ICD-10.
- "Decomplexification" is an important goal. There is lots of complexity in how we do things that is artificial and adds no value. To quote Albert Einstein: "Things should be as simple as possible, but no simpler"

Summary

The goal of moving to a new standard for the definition of the patient condition is clearly important but it will not happen automatically. The good news is that rapidly evolving payment models are leading to a greater focus on the detail of the patient condition, particularly on the hospital side. Without the clinicians fully understanding the value proposition for better documentation and better data however, and without payers providing incentives for good data and disincentives for bad data, we will not reach this goal.