Data User Group

Subcommittee/Working Group-Charge and Recommendations

May 2014

The working group will address the issues identified in the MHDO Data User Feedback Summary Table as reference numbers 11, 12 and 21.

1. Reference # 11- Define records clearly as Inpatient Facility, Outpatient Facility, and Professional.
2. Reference #12- Define “stays” where a patient is in one given facility for several days. (Transfer case is a different stay.)
3. Reference # 21- Have DRG and version information on all inpatient records

**Background:**

1. **Reference # 11**-There are two fields specific to this issue that health plans are required to provide (validation threshold is set at 100%) and that we in turn release:

|  |  |  |
| --- | --- | --- |
| Data Element | Column Name | Description |
| MC036 | Billtype | Required on institutional claims  |
| MC037 | Factype | Required on professional claims |

In reviewing a recent internal report that provides the threshold and the actual % it appears that 99.99% of the time the health plans are providing this information. We are in the process of running a report for CY 2012 and 2013 to verify that one of the other of the two fields was populated. **See information below:**

**Population of MC036 or MC037, CY 2012 & 2013**

|  |  |
| --- | --- |
| **Payer Type** | **Percent of Records with Valid and Correct Population of MC036 and MC037** |
| Total Commercial | 99.4% |
| MaineCare | 96.2% |
| Medicare | 100.0% |

**Deliverable:**

1. Articulate why the data elements MC036 and MC037 are not sufficiently defining the records as inpatient, outpatient and professional.
2. Develop recommendations for meeting the objective.

**Summary:**

* There is no issue defining professional (MC037) and facility claims (MC036).
* Finding a common definition or logic for inpatient and outpatient records to be used by all data users is not feasible. Because of variation in reporting measures users may always need do their own work.
* MHDO and HSRI currently identify inpatient records as those with 11, 12, 18, 41, 65, 66, 86 in MC036. Others use bill type alone or in combination with room and board revenue codes.

**Recommendation:**

* Refer users to commonly used definitions and logic in an FAQ or in the metadata.
	+ HealthPartners Total Cost of Care (TCOC) and Total Care Relative Resources Values (TCRRVs). Defines outpatient and inpatient (acute and non-acute). See the Data Preparation section (as of 2/11/2014 version on page 5) [https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev\_057642.pdf](https://www.healthpartners.com/ucm/groups/public/%40hp/%40public/documents/documents/dev_057642.pdf)
	+ HEDIS Technical Specifications (by purchase only). Defines outpatient and inpatient in slightly different ways for different measures. <http://www.ncqa.org/PublicationsProducts/HEDIS.aspx#Vol_2>
	+ UB-04 Data Specifications Manual 2014, Version 8.00 July 2013, pp. 17-18 Type of Bill codes
1. **Reference #12-**

**Deliverable:**

1. Confirm that this issue is about providing something in the data that reflects an episode of care. If yes, Provide reaction to our thought of creating an episode of care table. If no,
2. Specify what the objective of the issue is and develop recommendations for meeting the objective.

**Summary:**

* This issue relies on the identification of inpatient and outpatient records. Defining a “stay” in a standard way for all users is not feasible. Because of variation in reporting measures users may always need do their own work.

**Recommendation:**

* Refer users to commonly used definitions and logic in an FAQ or in the metadata.
	+ Medicaid Medical Directors Learning Network <http://www.ahrq.gov/policymakers/measurement/quality-by-state/mmdln.html>
		- 2010 Data Documentation attached: MMDLN Readmissions Specifications, Readmission scenarios, Diagnosis Groups and Categories
1. **Reference # 21-** There are two fields specific to this issue that health plans are required to provide (validation threshold is set at 100% for inpatient for a valid DRG version MC072) and that we in turn release:

|  |  |  |
| --- | --- | --- |
| Data Element | Column Name | Description |
| MC071 | DRG | DRG |
| MC072 | DRGVER | Version number of DRG used |

In reviewing a recent internal report that provides the threshold and the actual % it appears that 68% of the time on inpatient claims the health plans are providing this information. We are in the process of running a report for CY 2102 and 2013 to verify that that these fields are populated. **See information below:**

**Population of MC071 and MC072 for Inpatient Claims, CY 2012 & 2013**

|  |  |  |
| --- | --- | --- |
| **Payer Type** | **Percent of Records with a  Valid MC071\_DRG** | **Percent of Records with  a Valid DRG which also have a****Valid MC072\_DRGVERSION** |
| Commercial | 66.1% | 47.5% |
| MaineCare | 42.9% | 0.0% |
| Medicare | 94.2% | 94.2% |

**Deliverable:**

1. Specify what is not currently working with data elements collected and released.
2. Specify what the objective is.
3. Develop recommendations for meeting objective.
4. Answer the question as to whether or not there is utility in the MHDO applying DRG weights?

**Summary:**

* It would be helpful to have standard calculation provided by MHDO in addition to the payer provided DRG.
* A cost benefit analysis would need to be done once more information about licensing restrictions (e.g. sharing of documentation) became available.

**Recommendation:**

* Collect more than one ICD-9/10 procedure code from payers so a DRG can be calculated.
* MHDO to purchase a grouper to calculate the DRG and provide additional fields for the new DRG and version. Provide a DRG lookup table as well.