

Reports

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WSMA foundation sponsor of project

To improve quality, thousands of physicians to receive patient-specific reports

BY JEAN COLLEY

WSMA regularly promotes and publicizes efforts to improve the quality of care in the state of Washington, and WSMA leaders have strongly supported the movement toward more evidence-based cost-effective medicine.

THE WSMA’S NEW logo includes the phrase “Physician Driven - Patient Focused.” The association’s number one priority for the year is “making Washington a better place to practice medicine and to receive care.” Through its foundation, the Washington State Medical Education and Research Foundation (WSM-ERF), a new project that exemplifies these goals is being launched.

This past year, Art Sprenkle, MD, WSM-ERF project medical director, and John Arveson, WSMA director of professional affairs and WSM-ERF vice president, applied for a grant from the Physicians’ Foundation for Health Systems Excellence. (The foundation was created out of the Aetna racketeering settlement with physicians.) WSM-ERF received a two-year \$1 million grant for the project, the Washington State Quality Improvement Initiative. “Its ultimate purpose,” said Arveson, “is to improve the quality of care delivered by primary care physicians and have a positive impact on the health status of patients in Washington state with chronic health conditions.”

In brief, the project hopes to accomplish two interrelated tasks, both involving numerous physician stakeholders: one,

reach agreement on use of selected clinical guidelines and two, distribute physician-specific, patient-specific reports to physicians on how those patients are faring relative to the guidelines.

Dr. Sprenkle will make presentations across the state in coming months to acquaint physicians with the project. He will also oversee meetings with primary care physician leaders regarding guideline development.

By late fall, nearly all primary care physicians in Washington state will receive reports on specific patients in their practices with diabetes, heart disease, asthma and antibiotic use, along with patients who should be screened for cervical and breast cancer. These patients will have been identified as “belonging” to a particular physician, based on past insurance claims data.

Physicians to receive registries

The reports will include “registries”—patients’ names, the conditions for which they are being treated and when treatment is needed. The reports will also compare a physician’s practice to guidelines representing best practices and peers. The registries should prove useful to all medical practices, but particularly to small medical practices

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without the resources to develop their own registries. “The registries are a way for physicians, whether they practice solo, in a five-person group or in a large multispecialty clinic, to see how they individually are doing with specific patients,” said Dr. Sprenkle. “If the patient isn’t ‘theirs,’ they will be able to let us know. If the patient is theirs but has not come in for needed care or treatment, they will be encouraged to track the person down.”

The reports will be based on pharmacy and claims data pooled from the major health insurers, ideally covering most of Washington’s publicly and privately insured population. Health insurers are issuing report cards on physician practices, but this project will combine data from all the major insurers—ensuring a much more realistic snapshot of an individual physician’s practice. “Our project is not just another report card,” said Dr. Peter Dunbar, WSMA president and WSM-ERF vice chair. “We are providing physicians with information they can actually use to improve care with specific individual patients.”

Under-use of care a quality issue

Widely cited RAND* quality of care studies of 2003 and 2004 showed under-use of care more of a problem than over-use among patients with chronic conditions. Less than one-quarter of people with diabetes had their average blood sugar levels measured regularly. Patients with hypertension received less than 65 percent of recommended care.

“There are a wide range of quality of care studies available but none tell physicians which patients are not receiving recommended care,” said Arveson. “Nor do they suggest why patients might not be receiving appropriate care. The physician-specific and patient-specific information this project will provide could prove hugely valuable in improving the delivery of care

* See http://www.rand.org/pubs/research_briefs/RB9053-1/index1.html for highlights of the RAND studies as well as where they were originally published.

to chronically ill patients.”

Added Dr. Sprenkle, “Our reports won’t just be saying you are 40 or 60 or 80% in compliance with best practices. Most physicians don’t have a way to track what happens to patients who don’t come in for follow-up care. They may not know what other physicians the patient is seeing.” Some 90% of insured patients in Washington state are in fee-for-service plans where patients are not required to obtain care through a primary care physician.

Physicians will receive pharmacy data

The project’s pharmacy data will tell physicians whether a patient is taking medications the physician has prescribed. “Right now, physicians really don’t know if a patient has filled the prescription,” said Dr. Sprenkle.

Washington State Quality Improvement Initiative over next few months

OVER THE NEXT several months, Art Sprenkle, MD, project director for the Washington State Quality Improvement Initiative, will be traveling the state to educate primary care physicians about the Washington State Quality Improvement Initiative. (See cover story, page 1.)

At the same time physicians representing WSMA, specialty societies and medical groups and others will be invited (or volunteer) to participate in reaching agreement on practice and prescribing guidelines for diabetes, heart disease and asthma along with screening for cervical and breast cancer. They will give feedback on the tools to validate the reports. “The aim is to get unanimous agreement among the stakeholders on one set of guidelines for the chronic conditions under study,” said Dr. Sprenkle. “There are little nuances in different health plans’ guidelines that can confuse physicians. We need to have the same guidelines, regardless of health plan.”

The project will combine data from all the major insurers—ensuring a much more realistic snapshot of an individual physician’s practice.

“And the number one breakdown in quality is not following through on physicians’ recommendations.”

Many patients with chronic conditions find long-term compliance difficult, particularly with diseases like diabetes where lifestyle changes are recommended. “Patients being seen on a regular basis are getting excellent care,” he said. “The problem comes with those who slip through the cracks—both patients and physicians. Physicians typically haven’t tried to get patients to come back in. A significant

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In the reports physicians will receive patient information only on aspects of care—so-called metrics—that are measurable through pharmacy and claims data. For example, the reports will reveal whether and how often a diabetic patient has received a hemoglobin A1c test, rather than the actual value.

To avoid overwhelming medical practices, the project will provide registries of patients who have incurred a medical or pharmacy claim in the last two years. The reports will be delivered to practices electronically. The project expects to issue reports quarterly.

Integration Management, Inc., an experienced information management company, will collect the data from the insurers and generate the reports.

During the project’s second year, reports will be refined and patient registries will be available.

Anyone who would like to comment or participate in the project should contact Dr. Sprenkle at (425) 891-0502 or asprenkle@myexcel.com or John Arveson at the WSMA, (206) 441-9762, 1 (800) 552-0612 or jva@wsma.org. ♦

Office of the Inspector General and consultations

In March, the federal Office of the Inspector General publicly expressed its concern over inaccurate and inappropriate use of consultation codes. The OIG estimated that in 2001, of the \$3.3 billion in Medicare Part B consultations, it overpaid by \$1.1 billion. It attributed that result to miscoding services that were not actually consultations and to “over-coding” the service to the wrong level of consultation (www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf). By 2004, Medicare’s payments for consultations grew to \$4.1 billion, and the OIG was critical of CMS for not having acted to address the perceived problem.

Physicians and staff are strongly encouraged to review the Noridian Medicare B News, Issue 227, April 4, 2006, which revised their September 7, 2005 article on the correct coding of consultations. (<http://bbnor.noridian.com/bulletinboard/main.asp>).

Looming change to diagnostic coding

The structure of diagnostic coding may be poised to change in the not-too-distant future. The ICD-9-CM manual physicians use to report diagnostic data is being squeezed out in favor of ICD-10. The House of Representatives this summer is expected to begin marking up HR 4157, a health information technology bill that the Senate passed last November. It includes a provision to force compliance with ICD-10 in 2009.

Organizations like the American Health Information Management Association are vigorously advocating for ICD-10’s rapid adoption, but the WSMA and other members of the Washington Healthcare Forum are urging the Washington congressional delegation to delay implementation. The AMA and other medical organizations are urging lawmakers to delay implementation to 2012 and do a pilot test of what promises to have a hugely negative impact on physicians’ practices.

Why does that change pose such a problem? Complexity. ICD-10 will

inflict absurdly pointless levels of reporting “granularity” on physicians’ practices and hospitals. Consider this:

ICD-9 diagnosis codes (inpatient and outpatient) number 13,000. ICD-10 will raise that to 120,000.

ICD-9 procedure codes (only used by inpatient facilities) number 11,000. ICD-10 will raise that to 87,000.

The current ICD-9 E-code (external causes) for “asphyxiation and strangulation” would be replaced by 39 ICD-10 codes.

The current single ICD-9 E-code for “striking against or struck accidentally in sports without subsequent fall” will be replaced by 24 ICD-10 codes (to distinguish among strikes by baseball bats, tennis rackets, golf clubs, ice hockey sticks and ice hockey pucks).

Neither physicians’ practices nor health insurers are ready to take on the burden of moving to ICD-10. Their resources are already spread thin. More pressing is the need for practices to continue to adopt electronic claim submission and move away from costly and labor-intensive paper claims. For most physicians’ practices, the idea of using electronic remittance advices and electronic eligibility verifications is still far in the future. The grand vision of electronic communications, enacted by HIPAA in 1996, is a decade old and still we struggle with its implementation. ICD-10 will only harm those more important efforts.

Physicians are strongly encouraged to visit the WSMA’s Grassroots Action Center (www.wsma.org) and contact their congressional representatives, advising them that physicians’ practices are not prepared, through the use of technology, to support using the more refined codes, and that the huge investment will not produce the much-anticipated clinical information. In reality, the inability of physicians to traverse this dense list of codes in busy practice settings will likely result in less accurate data being gathered as inevitable shortcuts are taken. ♦

number of patients think I’m their doc, but I haven’t seen them in a while. And there are clearly outlier physicians.”

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THE INSURANCE DATA that will support the project has become available only recently. In 2004, the health insurers agreed to supply claims and pharmacy data to the Puget Sound Health Alliance (an organization of employers with more than 700,000 covered individuals) for the purpose of improving quality and reducing costs. The new project expects to cooperate closely with the alliance in obtaining the data and issuing the resulting reports to physicians.

Impact on practice

How good a job the reports will do in changing physician practice is an unknown right now. But reports on specific patients, along with guidelines, will be an improvement on guidelines alone. Said Dr. Sprenkle, “You do have to agree on what you are measuring, but guidelines are just a footer in the structure.”

In the not too distant future, Medicare and other insurers are expected to begin rewarding physicians for measurably higher quality of care. At the same time, more resources to help physicians develop better systems to track care are expected to become available. In a demonstration project Medicare is currently assisting a number of small medical practices by paying for development and implementation of in-office computer systems to track the quality of care and generate reminders.

“We’re excited by this project,” said Dr. Dunbar. “We see it as a vehicle to provide physicians much needed information they have been asking for, and it will also help medical practices retool or remodel the way their practice delivers care.” ♦