Washington State Health Care Authority

Technical Advisory Group (TAG)

December 11, 2013

Dr. Daniel Lessler, Chief Medical Officer

Preston Cody, Division Director, Health Care Services

OVERVIEW OF MCO CONTRACTS

Questions?

Improving Medical Care for Injured Workers:

L&I Updates

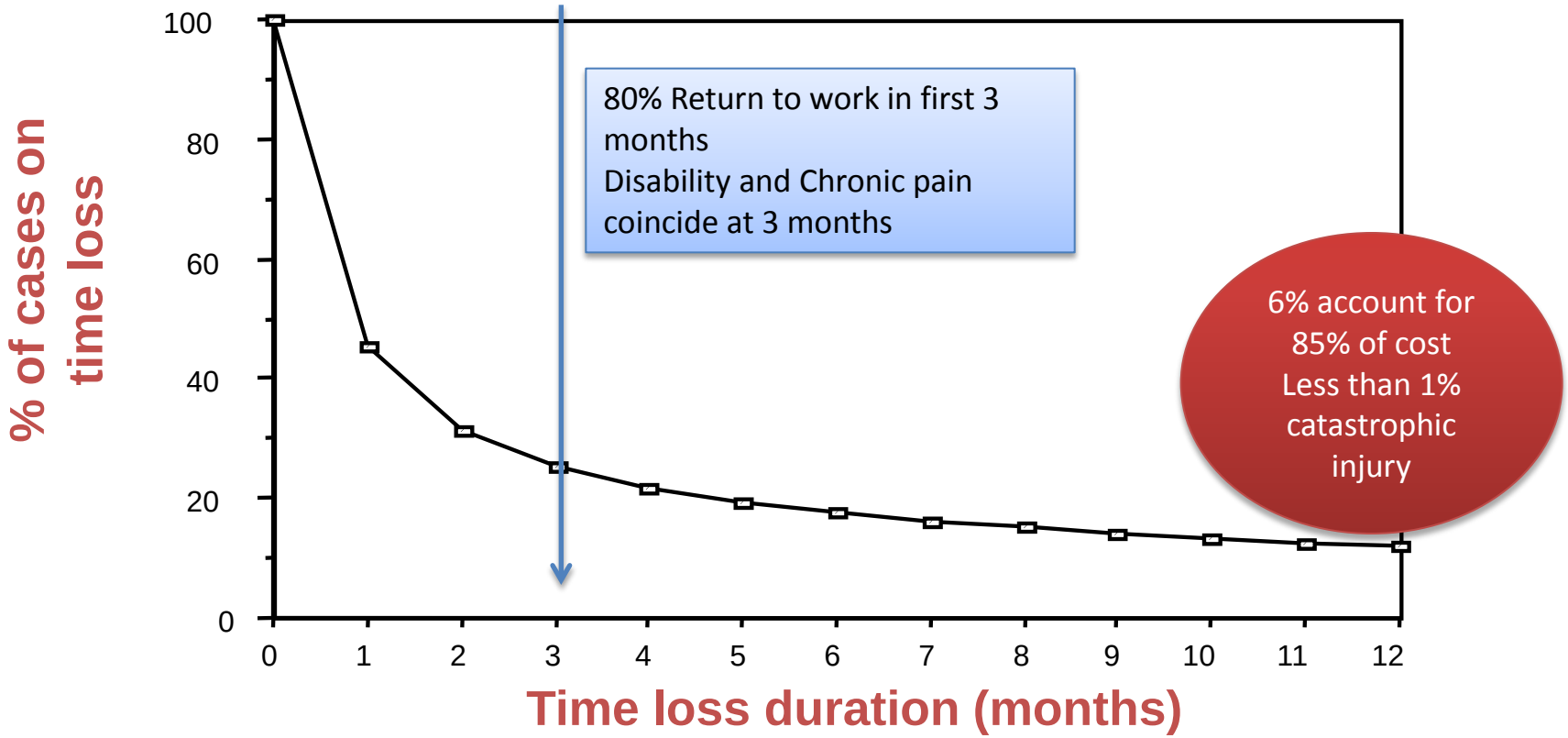
December 2013

Leah Hole-Marshall, Medical Administrator
Erik Landaas, Manager Healthcare Policy & Payments

Highlight of L&I Quality Efforts 2013

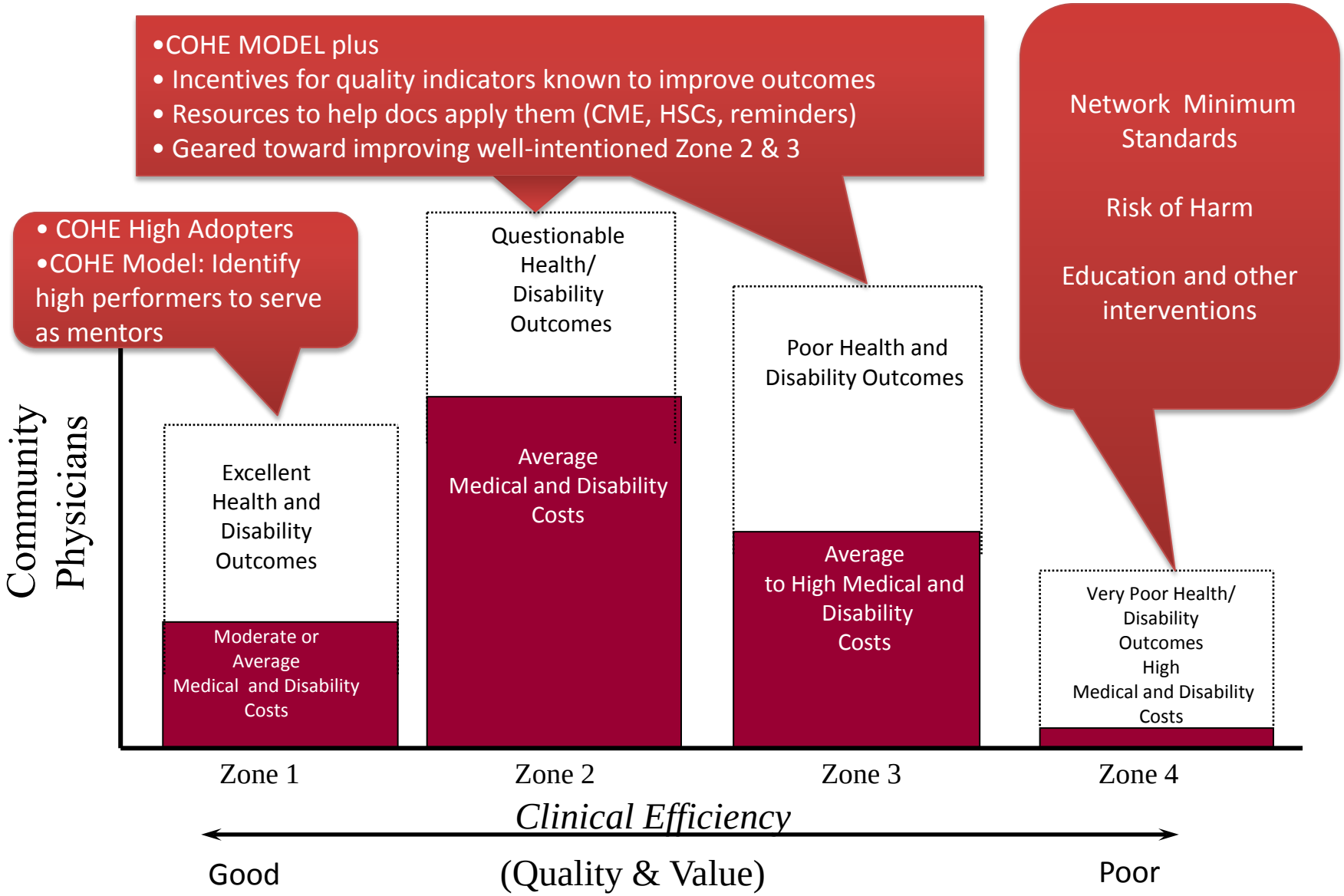
- 2011 Worker's Compensation Reform
  - Medical Provider Network
  - Risk of Harm
  - Top Tier
  - COHE Expansion and Best Practice Pilots
- Bree Collaborative
  - Spine Report; Joint Replacement Warranty Report
- Guidelines
  - Workers on Chronic Opioids
  - Shoulder Surgery
- ICD Conversion

Disability Prevention is the Key Health Policy Issue



Adapted from Cheadle et al. Am J Public Health 1994; 84:190–196.

Distribution of Quality of Care



2011 Workers Comp Reform Legislation: Substitute Senate Bill 5801

Background on Reform

Goals:

- Reduce disability by providing higher quality medical care
- Promote occupational health best practices
- Improve worker outcomes

Substitute Senate Bill 5801: Key Provisions

The new law directs L&I to:

- Create a statewide medical provider network for workers covered by L&I and self-insured employers
- Define criteria for terminating a provider from the network (including “risk of harm”)
- Designate a “top tier” and provide incentives for network providers who demonstrate best practices
- Expand Centers of Occupational Health & Education (COHEs)
- Create a tracking system for occupational-health best practices in COHE and Top Tier
- Identify and pilot emerging best practices

NETWORK MANAGEMENT AND STATUS

Phase-In by Provider Type

Beginning **January 1, 2013,** the following Washington State providers can treat for the initial visit *only* unless they are in the network:

- Physicians (medical and osteopathic)
- Chiropractors
- Naturopathic Physicians
- Podiatric Physicians
- Advanced Registered Nurse Practitioners
- Physician Assistants
- Dentists
- Optometrists

"Initial visit" = the visit when the physician fills out the first accident report on the injury claim.

Application Processing Status

Network Enrollment (as of Dec 2, 2013):

Status	Number of providers
Approved	18,718
Provisional	513*
Nonprovisional: Applied before Jan. 1	256
Nonprovisional: Applied after Jan. 1	598
TOTAL APPROVED OR PENDING DECISION	20,680

***Includes providers who applied both *before* and *after* Jan. 1st who meet criteria for provisional enrollment in WAC 296-20-01020.**
All Provisional providers can currently bill and be paid for ongoing care for injured workers, as can others who applied before Jan. 1st and have applications still pending.

Status of denied applications – through November 13, 2013

	Providers
Providers Initially Denied*	**101**
Providers Approved on Reconsideration	**28**
TOTAL PROVIDERS WITH FINAL OR PENDING DENIAL	**73**
Denial Final & Implemented	**51**
Denial Pending or in Reconsideration	**22**
TOTAL PROVIDERS WITH FINAL OR PENDING DENIALS	**73**

** Excludes 27 applications withdrawn after initial denial.*

NOTE: Proportionate additional denials are expected as more applications are reviewed. **The overall denial rate is currently 0.3%.**

Purpose and Goals

RISK OF HARM

Quality Oversight: Risk of Harm

L&I's new rules establish a clearer standard for when a provider may be removed from the network due to quality of care issues. Three criteria must be met. There must be:

–A pattern

–Low quality care

– Risk to the patient of physical or psychiatric harm

- Purpose
  - To protect injured workers from physical or psychiatric harm due to low quality care
- Goals
  - To develop methods to identify potential outlier providers
  - To establish an internal process of action

Example 1: Death as A Harm

- Harm: Death
- Low quality care: various*
  - Overuse of treatment intervention (*e.g.* high dose and long term prescription of opioids)
  - Poor prescribing patterns (*e.g.* opioids + sedatives)
- Pattern(s):
  - Two or more deaths
  - or one death + a life-threatening event(s);
  - or one death + very high doses in other patients (risk of harm)

*Some patterns of low quality care (very high doses of opioids) constitute risk of harm

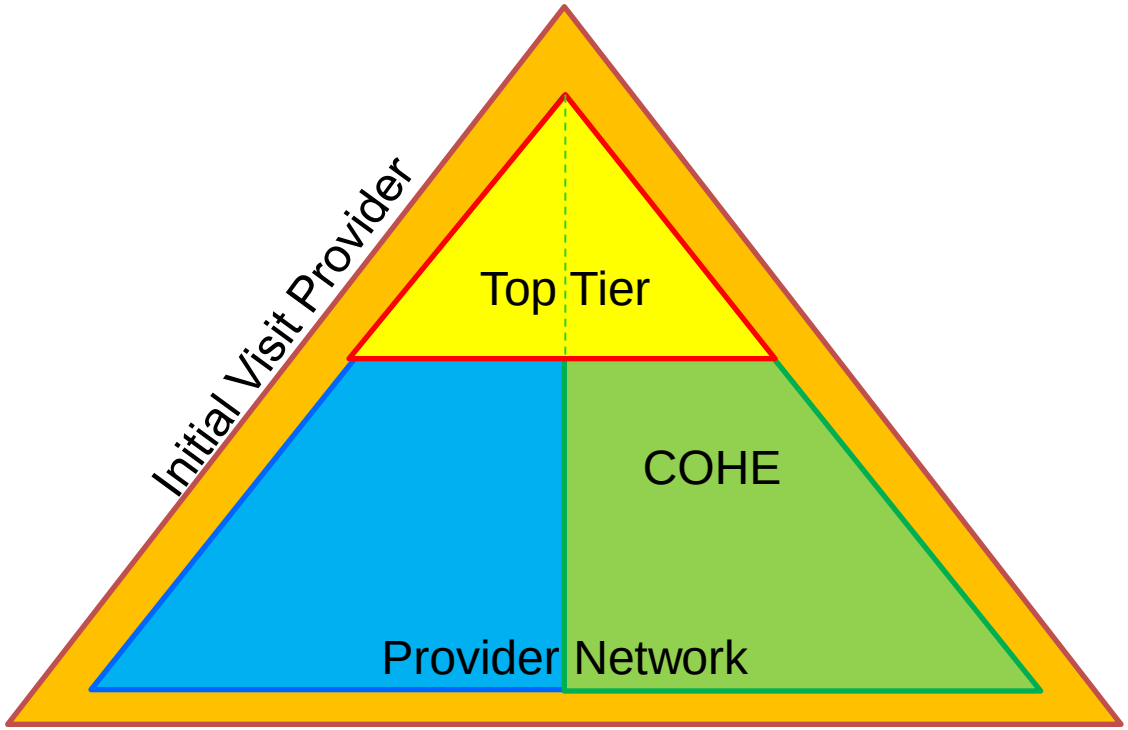
Example 2: High Rate of Repeat Surgery Following Lumbar Fusion as Low Quality Care

- Low quality care
  - High re-operation (repeat surgery) rate following lumbar fusion
- Pattern(s)
  - A provider's cases are at/or below the tenth percentile
  - A provider's adverse event rates are at least twenty percent above the expected rate
- Harm: various
  - Decreased function or increased disability
  - Increased pain
  - Worsening of condition(s) - *e.g.*, failed back surgery syndrome or arachnoiditis

Purpose and Goals

TOP TIER

Top Tier Visual



TOP TIER

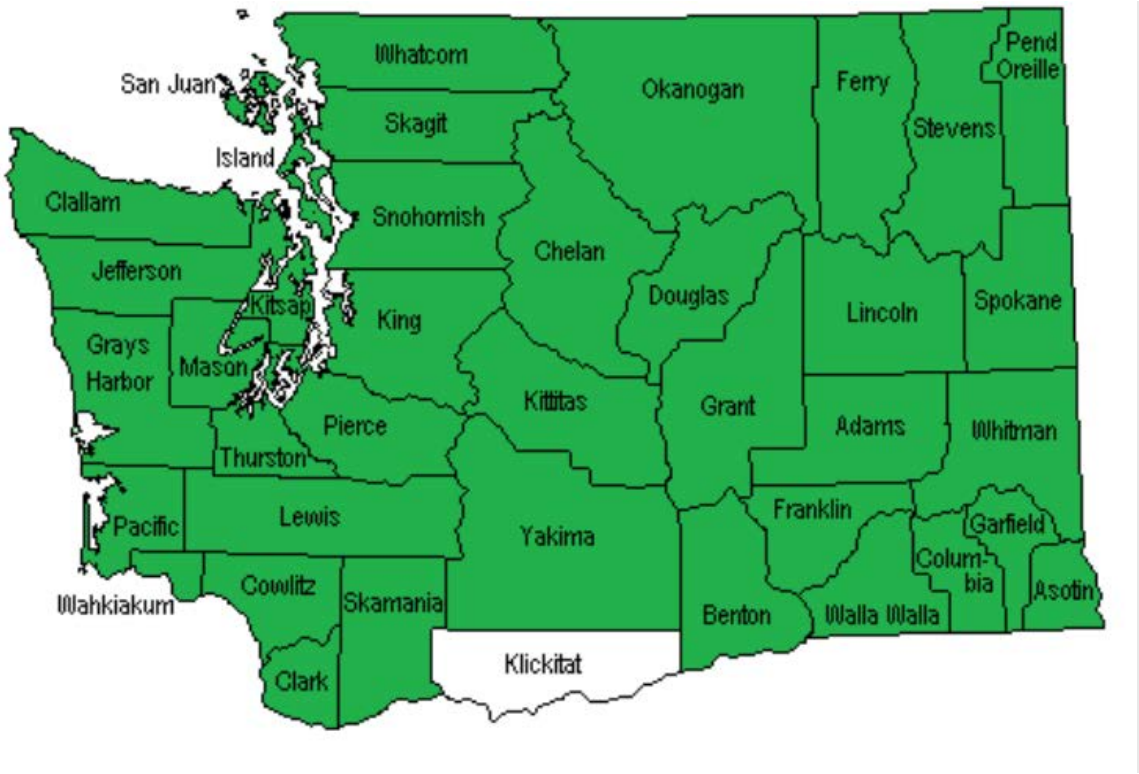
- Provide Financial and Non-financial incentives to providers for demonstrated use of best practices
- **Top Tier Goals**
  - Increase the use of best practices
  - Achieve positive outcomes for injured workers
  - Be simple for providers to understand and L&I to administer
  - Align with other incentive programs (such as COHE)
- **Advisory Group (ACHIEVE) Items for Dissions**
  - Top Tier Timing
  - Top Tier Eligibility
  - Top Tier Incentives
  - Top Tier Administration

Purpose and Goals

COHE Expansion and New Best Practices

Expanding Access to COHE Services

The 6 current COHEs will serve 38 counties :



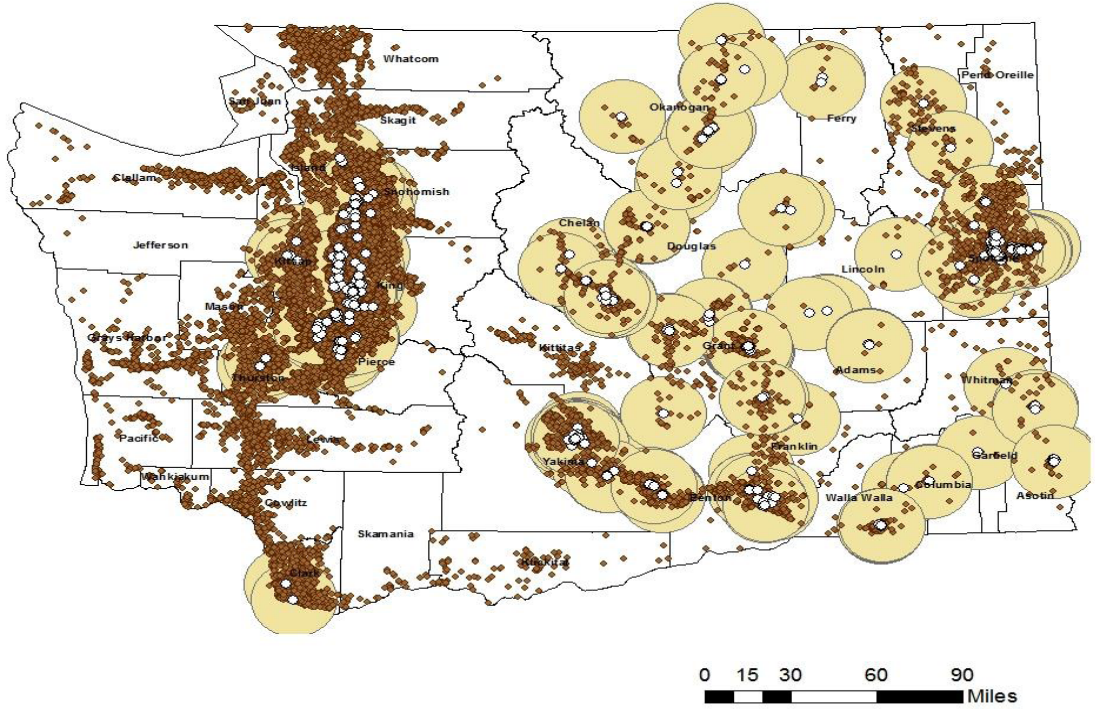
Expanding Access to COHE Services

COHE Enrollment -- as of November 21, 2013

Current # of Enrolled Providers	Proposed # of Enrolled Providers	COHE Name
1,149	1,451	Eastern Washington COHE at SLRI/INHS
220	230	The Everett Clinic COHE
36	70	Group Health Cooperative COHE
181	233	Harborview Medical Center COHE
265	300	Renton COHE at Valley Medical Center
109	1,208	Western Washington COHE at Franciscan Health System
1,960	**3,492**	**TOTAL**

Expanding Access to COHE Services

Centers of Occupational Health & Education (COHE)
COHE providers as of September 8, 2013
and Injured Workers Population as of September 1, 2013



N
W E
S

- COHE Providers
- Injured Workers September 1 2013
- 15 mile radius from COHE providers

Expanding Access to COHE Services

% IWs with 5 or more COHE Providers within 15 mile radius as of September, 2013

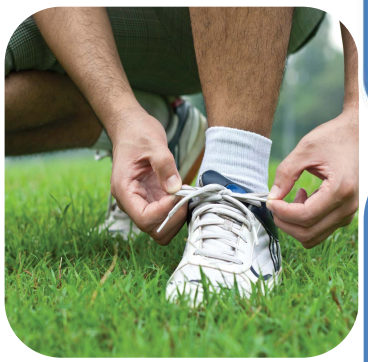
Report prepared September 12, 2013	SELF-INSURED Current total count of IWs	SELF-INSURED Current COHE Provider	STATE FUND Current total count of IWs	STATE FUND Current COHE Provider
State	**38,098**	**82%**	**47,256**	**75%**
Adams	132	96%	199	93%
Asotin	42	100%	81	98%
Benton	1,072	100%	1,289	99%
Chelan	353	96%	629	99%
Clallam	325	0%	676	0%
Clark	1,374	0%	1,536	0%
Columbia	13	92%	38	97%
Cowlitz	641	0%	654	0%
Douglas	211	98%	297	99%
Ferry	47	38%	37	43%
Franklin	568	95%	824	92%
Garfield	7	0%	14	7%
Grant	493	94%	913	75%
Grays Harbor	342	0%	788	0%
Island	303	69%	440	56%
Jefferson	72	4%	180	11%
King	11,031	99%	10,349	99%
Kitsap	974	98%	1,357	98%
Kittitas	184	1%	347	0%
Klickitat	61	0%	127	0%
Lewis	429	0%	807	0%
Lincoln	33	61%	92	63%
Mason	256	4%	509	4%
Okanogan	154	95%	388	83%
Pacific	95	0%	167	0%
Pend Oreille	37	22%	89	15%
Pierce	5,792	98%	6,513	98%
San Juan	16	0%	112	0%
Skagit	522	40%	1,398	41%
Skamania	34	0%	69	0%
Snohomish	6,323	98%	6,296	96%
Spokane	2,445	100%	3,184	100%
Stevens	213	59%	274	54%
Thurston	1,154	1%	1,900	1%
Wahkiakum	15	0%	36	0%
Walla Walla	264	91%	379	94%
Whatcom	749	0%	1,534	0%
Whitman	63	68%	187	67%
Yakima	1,259	99%	2,547	99%

Emerging Best Practices: Current Pilots

Activity Coaching

Model: Progressive Goal Attainment Program (PGAP)

Coaches encourage and track structured activities for injured workers



A provider in E. Washington said:

- **"This patient had 22 'red flags' when I referred him to PGAP. At the next visit he was a completely different person."**

Workers have said:

- **"It gives you a reason to get out of bed and how to be in control of your life again."**
- **"It teaches you how to relearn to manage your pain and life."**

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#2

Emerging Best Practices: Current Pilots

Functional Recovery

- Functional Recovery Questionnaire (FRQ)
  - Early identification of potentially "at risk" workers
- Functional Recovery Interventions (FRI)
  - Providers incorporate interventions to enhance recovery in addition to 4 the COHE Best Practices

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#3

Emerging Best Practices: Upcoming Pilot

Emerging Surgical Best Practices

Four best practices selected from the literature by a focus group of attending providers & surgeons related to:

- Transition of Care
- Return to Work

Creation of a Surgical Health Services Coordinator to:

- Coordinate care and transitions
- Help providers with complicated cases

http://www.lni.wa.gov/ClaimsIns/Providers/Reforms/EmergingBP/#4

Purpose and Goals

BREE Collaborative

BREE COLLABORATIVE

Bree Collaborative: is a statewide public/private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which **public and private health care stakeholders** can **work together to improve quality**, health outcomes, and cost effectiveness of care in Washington State."

- Members are appointed by the Governor and include representatives from public and private health care purchasers, employers, health plans, providers, and quality improvement organizations.
- The Bree identifies **up to three areas annually** where there is **substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes**. After the Bree selects a topic area, it appoints an expert workgroup to develop evidence-based recommendations for improving quality and reducing waste in the health care system.
- Recommendations sent to Health Care Authority. Collaborative model does not include mandate to require implementation
- Bree Website: http://www.hca.wa.gov/bree/Pages/index.aspx

BREE COLLABORATIVE

BREE Topics to date:

Topic	Recommendation Status	L& I Implement
Obstetric care	Best Practices for hospitals on Induction and C-Section. August 2012	Support. No further action
Cardiology	Make SCOAP appropriateness of percutaneous coronary interventions transparent and increase reporting. January 2013	Support. No further action
Avoidable Readmissions	Currently ongoing	
Accountable Payment Models	Final warranty for total knee and total hip replacement surgery. July 2013	Support. In Review
Spine Care	Final recommendation to participate in Spine SCOAP. November 2012 Draft Report on best practices to prevent low back pain transition to chronic. November 2013	Support. No further action In review

BREE COLLABORATIVE

Accountable Payment Models -

Warranty for total knee and total hip replacement surgery completed in July 2013.
http://www.hca.wa.gov/bree/Documents/bree_warranty_tkr_thr.pdf

Spine Care

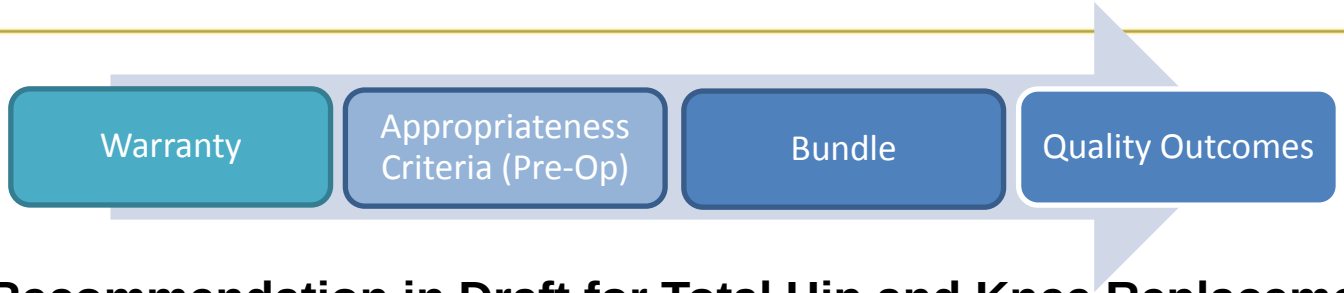
1- The Collaborative establishes participation in Spine SCOAP as a community standard, starting with hospitals performing spine surgery.

http://www.hca.wa.gov/bree/Documents/spine_scoap_recommendation.pdf

2 - Low Back Pain – Best practices recommendations to prevent Transition to Chronic

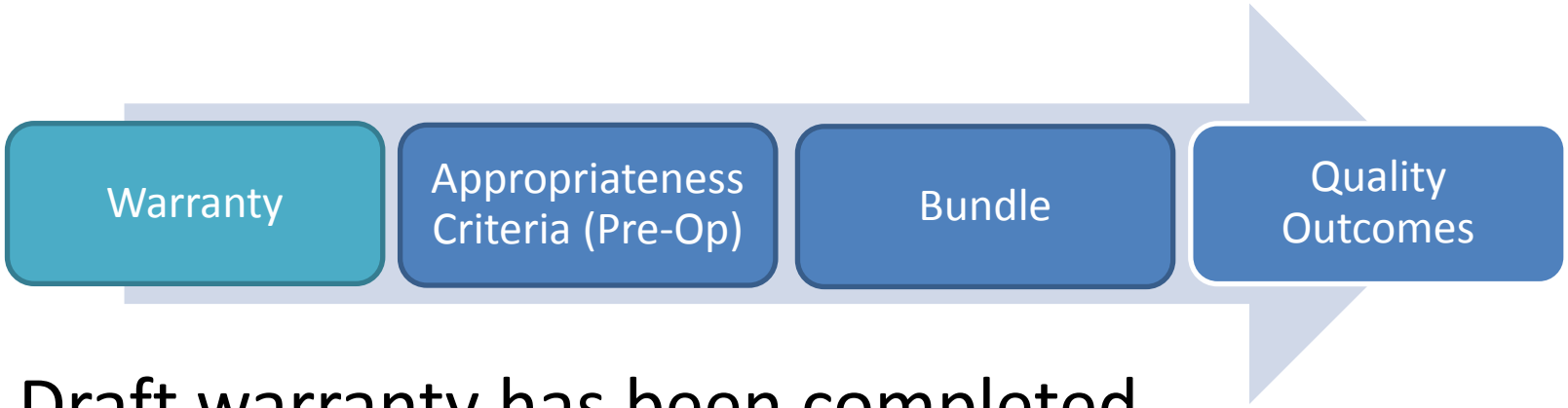
http://www.hca.wa.gov/bree/Documents/spine_report_draft_1010.pdf

BREE COLLABORATIVE: Accountable Payment



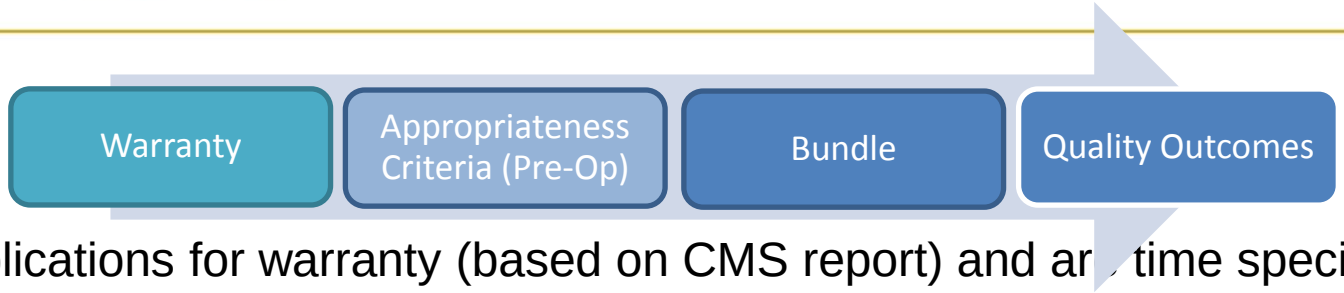
First Recommendation in Draft for Total Hip and Knee Replacement

- The primary intent is to set a high priority on patient safety. It is also intended to balance financial gain for providers and institutions performing TKR and THR surgery with financial accountability for complications attributable to these procedures.
- Appropriateness criteria of the TKR/THR
  - Documented Disability: reduced function and pain due to osteoarthritis despite conservative therapy
  - Fitness for surgery: patient engagement and physical preparation
- Bundle Components: include standards for surgery and rehab function of the that must be included in the bundle
  - Repair of the osteoarthritic joint
  - Recovery from surgery and return to function



- Draft warranty has been completed
- 4 Components
  - Diagnostic code for osteoarthritis (excludes trauma, cancer and congenital malformation)
  - Procedural codes for TKR and THR
  - Age limits
  - Definition of complications (and codes) excluded from additional reimbursement
  - Definition of warranty period

BREE COLLABORATIVE: Warranty Complication



Complications for warranty (based on CMS report) and are time specific:

Within 7 Days

- Acute myocardial infarction
- Pneumonia
- Sepsis/septicem

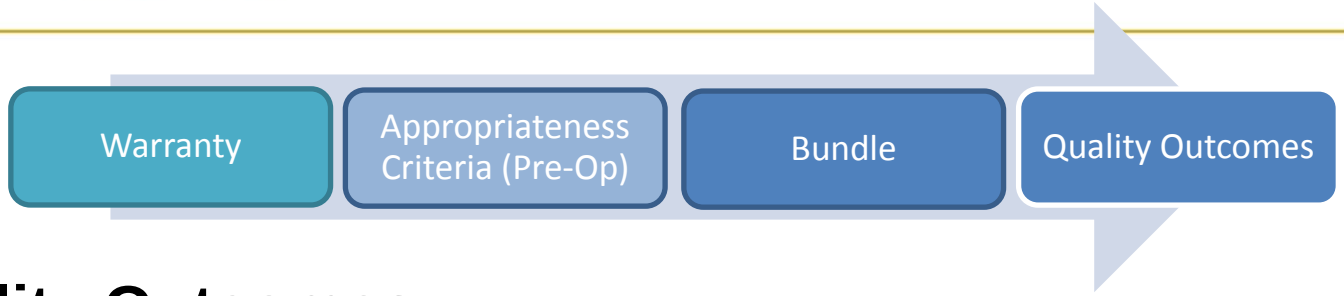
Within 30 Days

- Death
- Surgical site bleeding
- Wound infection
- Pulmonary Embolism

Within 90 days

- Mechanical Complications
- Periprosthetic joint Infection

BREE COLLABORATIVE: Accountable Payment



Quality Outcomes

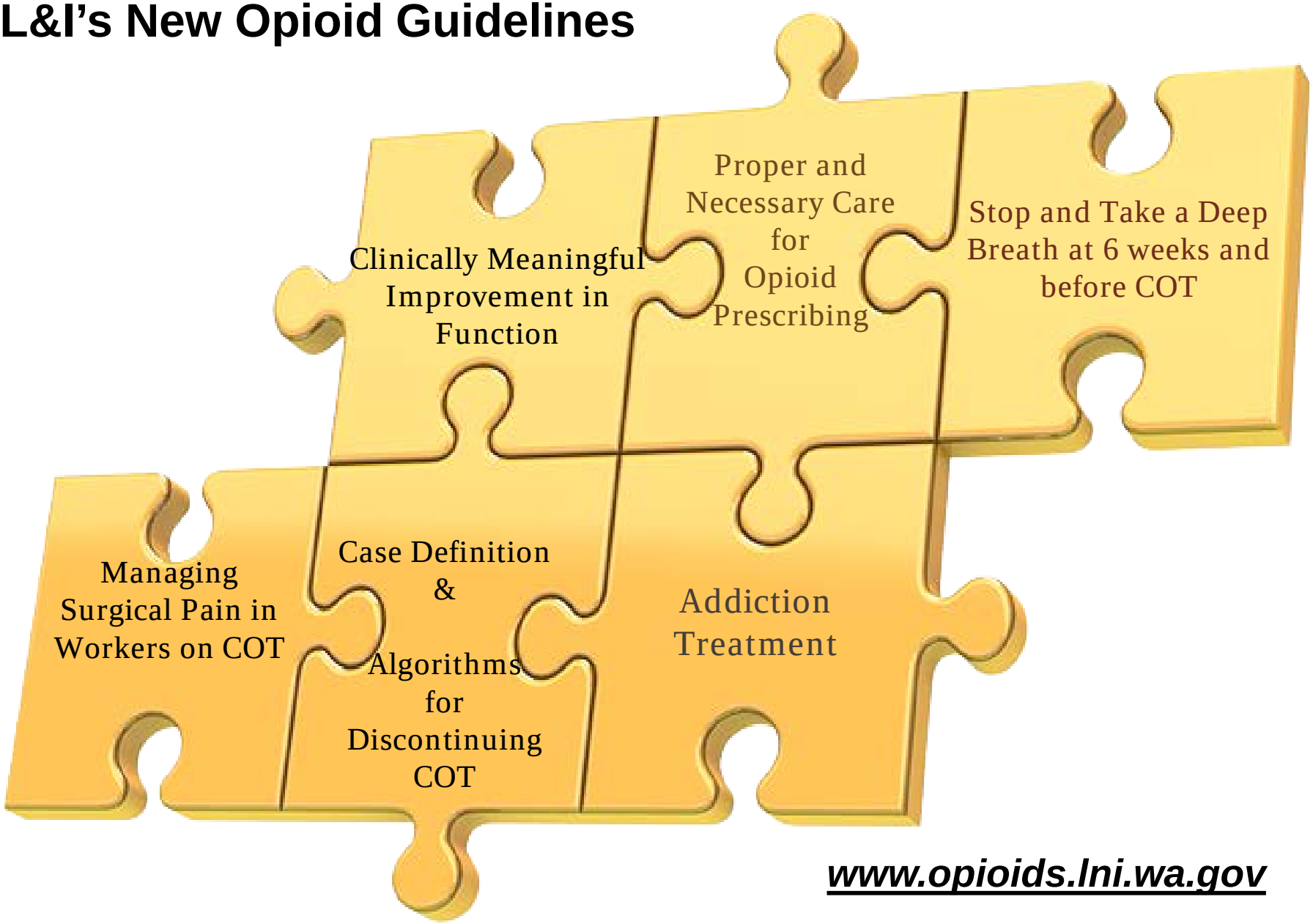
5 Broad Categories of Measures

1. Evidence-based Care
2. Functional Improvement (Pre and post operation)
3. Patient Satisfaction
4. Readmissions
5. Other, e.g., Reduction in time out of work

Purpose and Goals

NEW GUIDELINES

L&I's New Opioid Guidelines



www.opioids.lni.wa.gov

Old Shoulder Guideline

Medical Treatment Guidelines

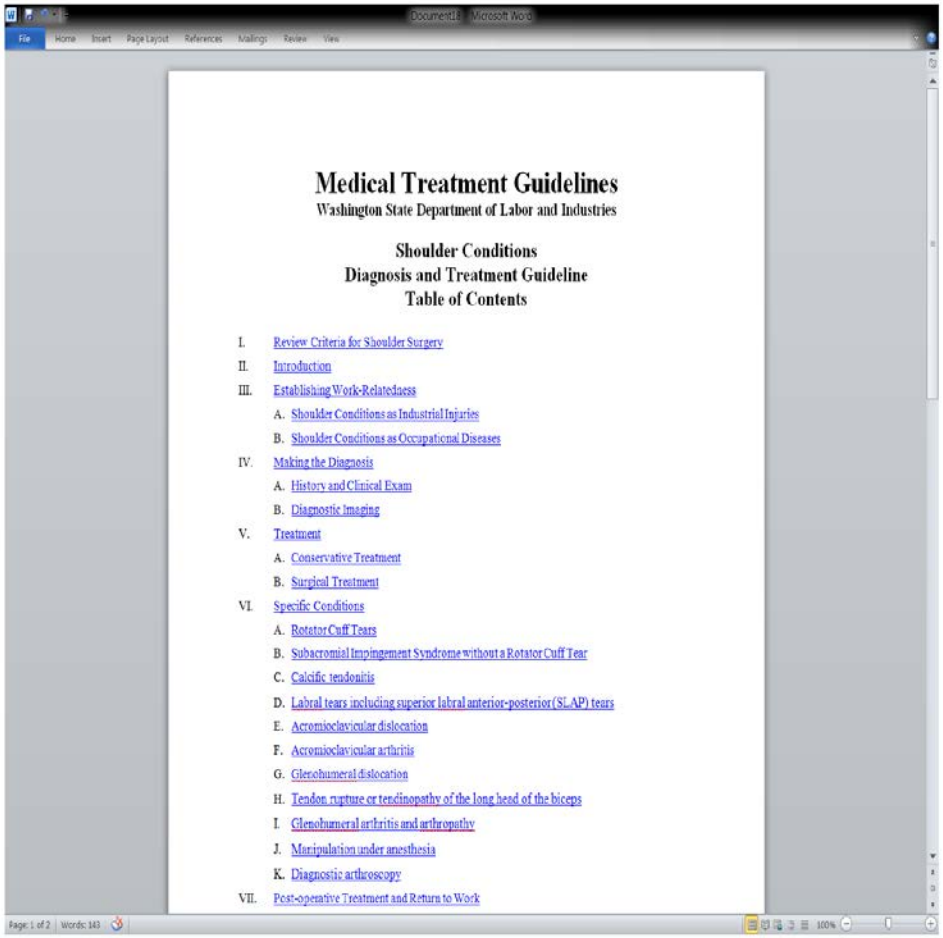
Washington State Department of Labor and Industries

Criteria for shoulder surgery

A request may be appropriate for ↓	If the patient has ↓	AND the diagnosis is supported by ↓	↓	↓	AND this has been done (if recommended) ↓
Surgical procedure	**Diagnosis**	**Clinical findings**			**Conservative care**
		Subjective	**Objective**	**Imaging**	
Rotator cuff repair (CPT 23410, 23412, 23420).	**Full thickness rotator cuff tear** **AND** Cervical pathology and frozen shoulder syndrome have been ruled out.	Shoulder pain and inability to elevate the arm; Tenderness over the greater tuberosity is common in acute cases.	Patient may have weakness with abduction testing; May also demonstrate atrophy of shoulder musculature; Usually has full passive range of motion.	Conventional x-rays, AP, and true lateral or axillary view **AND** Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.	Not required.
Rotator cuff repair CPT 23410, 23412, or 23420) **OR** **Anterior acromioplasty** [1] (CPT 23130	**Partial thickness rotator cuff repair** **OR** **Acromial Impingement Syndrome** (80% of these	Pain with active arc motion 90-130 ° **AND** Pain at night; Tenderness over the greater tuberosity is common in acute	Weak or absent abduction. May also demonstrate atrophy **AND** Tenderness over rotator cuff or anterior acromial area	Conventional x-rays, AP, and true lateral or axillary view **AND** Gadolinium MRI, Ultrasound, or Arthrogram shows positive evidence of	Recommend 3-6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent.

- 2001
- 2 pages
- 9 procedures
- No content on work-relatedness; little on non-operative treatment
- Gadolinium (contrast) MRI often required

New Shoulder Guideline



Medical Treatment Guidelines
Washington State Department of Labor and Industries

Shoulder Conditions
Diagnosis and Treatment Guideline
Table of Contents

- 29 pages
- 14 procedures
- Imaging Updates
- Narrative section covering;
  - Work-relatedness
  - Diagnosis and Criteria
  - Conservative treatment
  - Post-op and return to work

Approved by IIMAC and Final, Posted to Web, review criteria to start Jan 1

http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALguidelineShoulderConditionsOct242013.pdf

ICD 10 Conversion

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD)

Washington State Department of
Labor & Industries

L&I will convert from ICD-9 to ICD-10 effective October 1, 2014

- Although worker's compensation is technically exempt, L&I is converting to ICD-10 to align with industry standards. Doing so will:
  - Minimize the administrative burden to medical providers by not requiring them to maintain a separate billing system using ICD-9 codes
  - Result in the allowance of more accurate diagnoses on claims
  - Result in more precise data collection by L&I

Washington State Department of
Labor & Industries

Key dates for State Fund conversion

- September 1, 2013
  - ICD-10 end to end testing with trading partners begins
- March 1, 2014
  - L&I begins testing internal ICD-9 to ICD-10 conversion process
- April 1, 2014
  - All State Fund bills must be submitted in the 5010 format.
- October 1, 2014
  - Compliance date for ICD-10 CM

ICD-10 Online Resources

- onehealthport.com
  - See what other payers are doing to implement ICD-10 conversion
- CMS.gov
  - Information about HIPAA, 5010 billing format, and GEMS crosswalk tool
- AAPC.com
  - Resources for medical coding staff including training and certification

Questions?

Centers for Medicare and Medicaid Updates

WA State Health Care Authority

Technical Advisory Group (TAG)

December 11, 2013

Nancy L. Fisher, MD, MPH

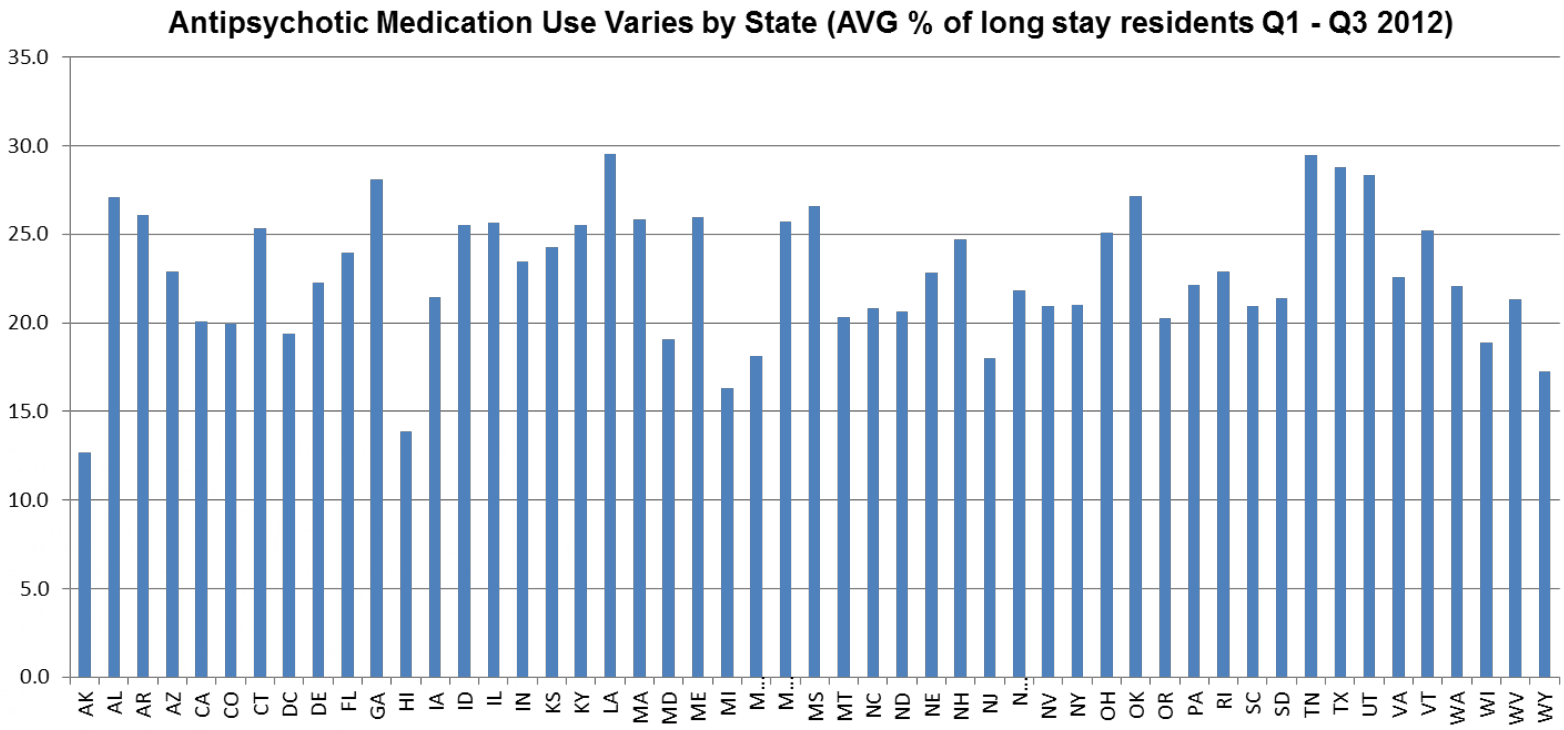
Chief Medical Officer

Region X

Updates

- Donut Hole
- ESRD
- Medicare Advantage
- Incarcerated Beneficiary Claim Denials
- Home Health Payments for 2014
- Health Insurance Marketplace
- National Partnership to Improve Dementia Care
- Meaningful Use
- ICD-10

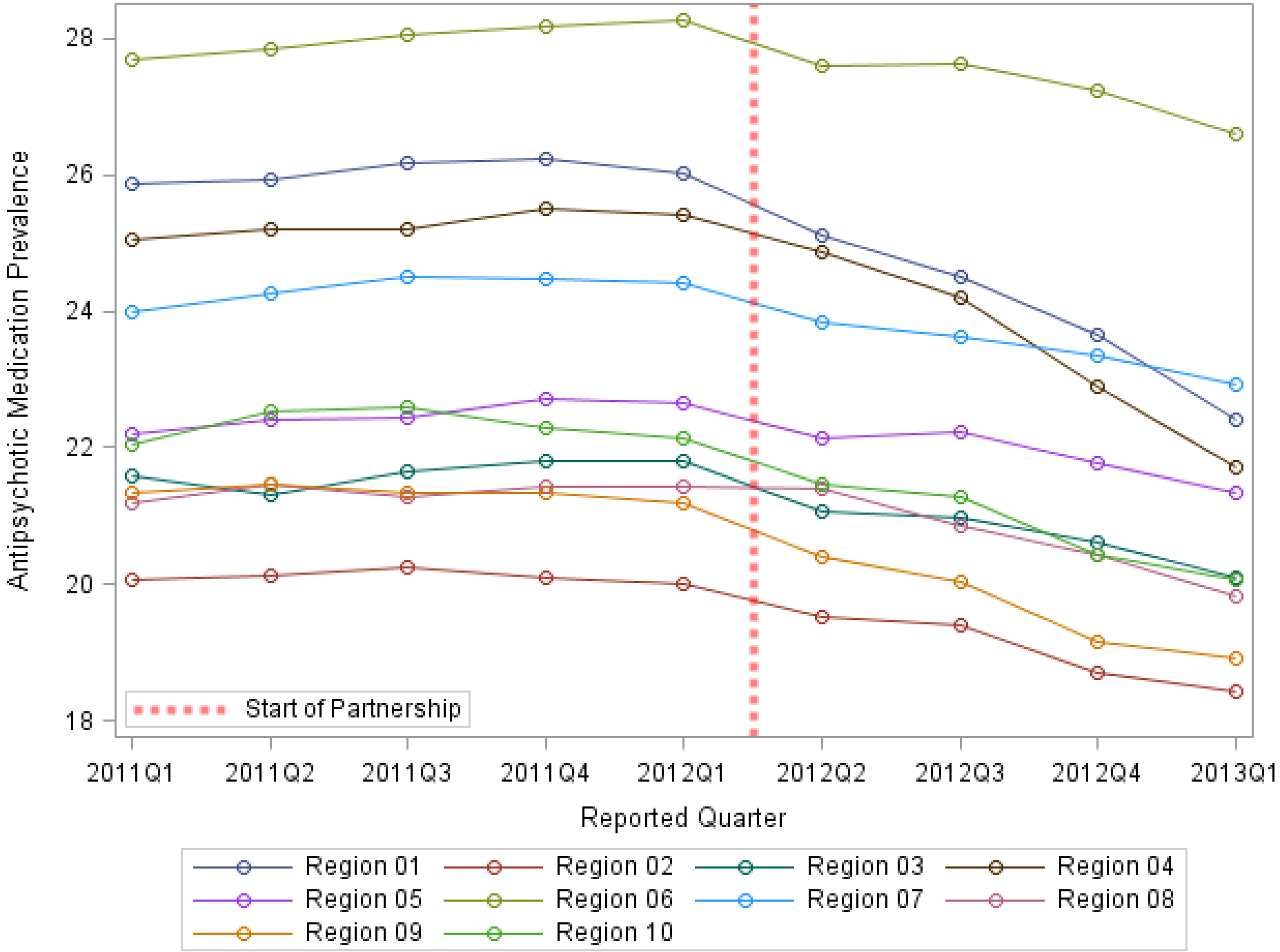
Antipsychotic Medication Use in Nursing Homes Varies by State



Antipsychotic Use by CMS Region and Quarter

- Percent of long-stay residents receiving an antipsychotic medication

Region	2011Q1	2011Q2	2011Q3	2011Q4	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	Percentage point difference (2011Q4to2013Q1)	Percent change
National	23.50	23.64	23.74	23.87	23.82	23.21	22.98	22.33	21.71	-2.16	-9.06%
Region 01	25.88	25.94	26.16	26.22	26.02	25.10	24.49	23.66	22.41	-3.82	-14.55%
Region 02	20.07	20.12	20.27	20.10	20.00	19.52	19.42	18.71	18.44	-1.66	-8.24%
Region 03	21.60	21.31	21.64	21.81	21.80	21.08	20.98	20.62	20.10	-1.71	-7.84%
Region 04	25.05	25.20	25.21	25.51	25.42	24.88	24.20	22.90	21.70	-3.81	-14.92%
Region 05	22.19	22.40	22.45	22.71	22.65	22.14	22.22	21.78	21.34	-1.37	-6.05%
Region 06	27.69	27.83	28.05	28.19	28.27	27.59	27.62	27.22	26.61	-1.58	-5.60%
Region 07	23.98	24.27	24.50	24.47	24.42	23.82	23.62	23.36	22.93	-1.53	-6.27%
Region 08	21.20	21.47	21.30	21.44	21.45	21.40	20.87	20.45	19.84	-1.61	-7.50%
Region 09	21.33	21.48	21.36	21.34	21.19	20.40	20.05	19.16	18.92	-2.42	-11.33%
Region 10	22.03	22.54	22.60	22.30	22.14	21.47	21.28	20.44	20.07	-2.23	-9.99%


Antipsychotic Medication Prevalence
28
26
24
22
20
18
Start of Partnership
2011Q1
2011Q2
2011Q3
2011Q4
2012Q1
2012Q2
2012Q3
2012Q4
2013Q1
Reported Quarter
Region 01
Region 02
Region 03
Region 04
Region 05
Region 06
Region 07
Region 08
Region 09
Region 10

ICD-9 CM

IS

OUTDATED !

ICD-10 Compliance Date

- The compliance deadline for ICD-10-CM and PCS is **October 1, 2014**

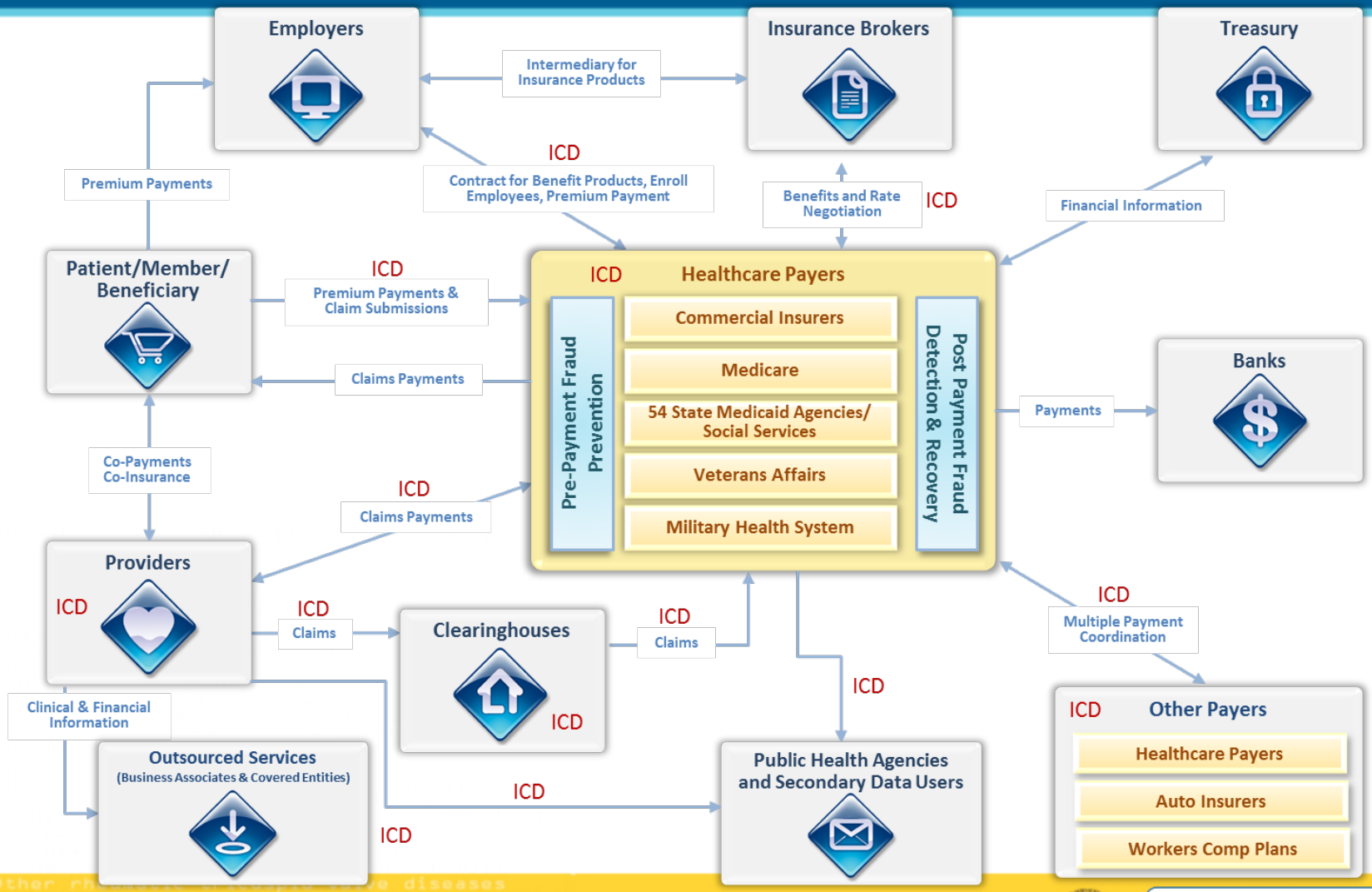
ICD-10 DEADLINE

Oct 1, 2014

Claims Submission

- ICD-9 codes no longer accepted on claims **after** October 1, 2014
- ICD-10 codes will not be recognized/accepted on claims **before** October 1, 2014
- Claims cannot contain **both** ICD-9 codes and ICD-10 codes
- Institutional Claims – Return to Provider (RTP)
- Professional/Supplier Claims—Return as Unprocessable

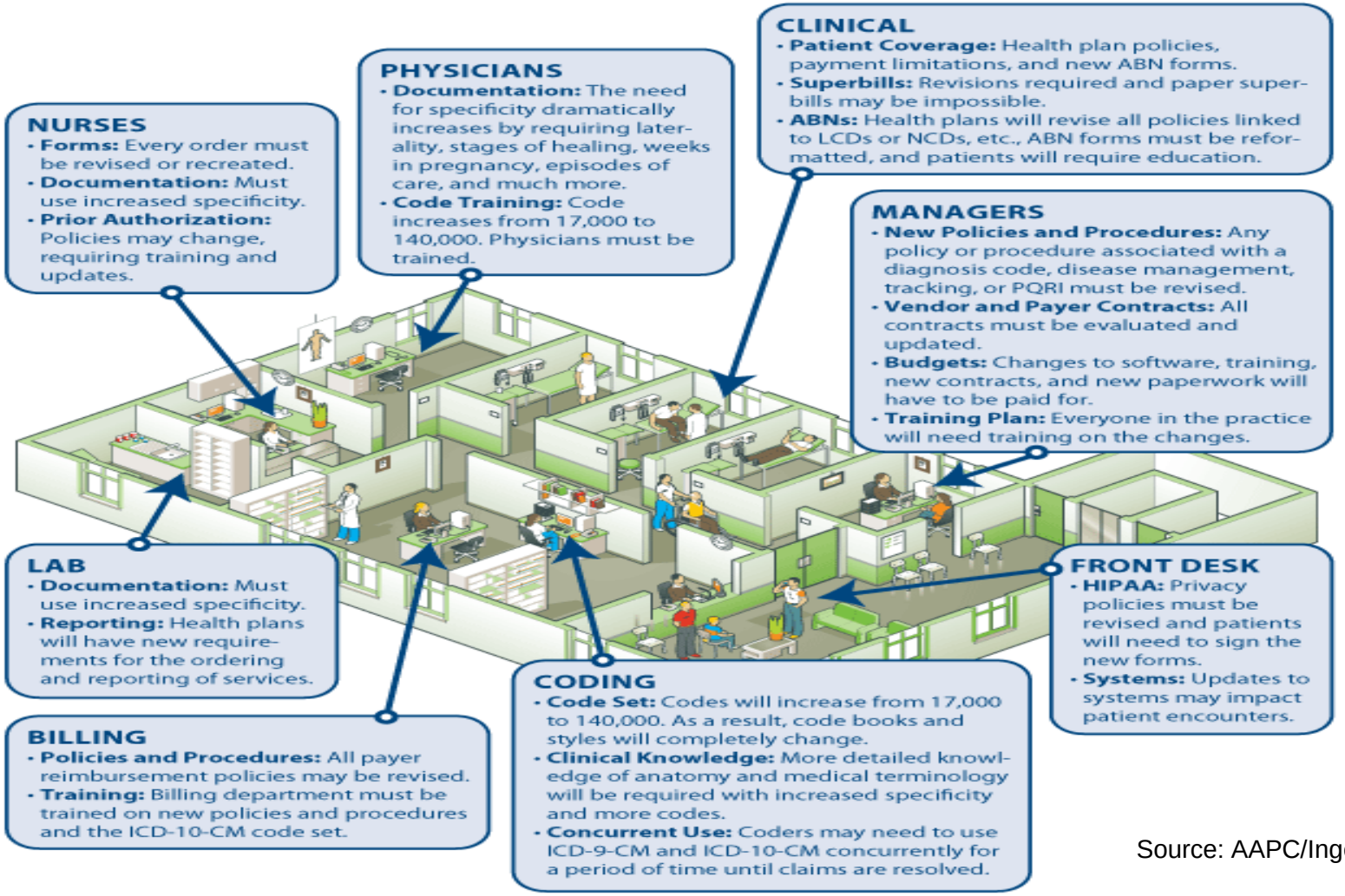
ICD-10 Impact Across the Industry



078 Other rheumatic heart diseases
079 Rheumatic tricuspid valve disease, unspecified
080 Rheumatic disorders of both mitral and aortic valves
081 Rheumatic disorders of both mitral and tricuspid valves
082 Rheumatic disorders of both aortic and tricuspid valves
083 Combined rheumatic disorders of mitral, aortic and tricuspid valves

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

ICD-10 and Physician Practices



Source: AAPC/Ingenix

078 Other rheumatic tricuspid valve diseases
079 Rheumatic tricuspid valve disease, unspecified
080 Rheumatic disorders of both mitral and aortic valves
081 Rheumatic disorders of both mitral and tricuspid valves
082 Rheumatic disorders of both aortic and tricuspid valves
083 Combined rheumatic disorders of mitral, aortic and tricuspid valves

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

ICD-9/ICD-10

ICD-9 Diagnosis

- 3-5 digits
- E and V characters
- No place holders
- Approx. 14,000 codes
- Severity parameters limited
- No laterality
- Combination codes limited
- Terminology
- Index/Tabular system
- Coding guidelines

ICD-10 CM

- 7 digits
- Alpha/numeric for any code
- Place holder “x”
- Approx. 69,000 codes
- Extensive severity parameters
- Right vs. left
- Combination codes common
- Similar
- Similar
- Somewhat similar

Coding Changes

ICD-9 procedure codes

- 3-4 digits
- Not structured
- Approx. 4,000 codes
- Chapter 3 of ICD-9 CM
- Diagnosis included
- NOS and NEC common
- Use of eponyms and named procedures
- Uses “combination” codes

ICD-10 PCS

- 7 digits
- Structured (complex)
- Approx. 72,000 codes
- Managed separately
- Diagnosis excluded
- NOS and NEC uncommon
- Avoids eponyms and named procedures
- Avoids “combination codes

Placeholder "X"

- Addition of dummy placeholder "X" (or "x") is used in certain codes to:
  - Allow for future expansion
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies

- When placeholder character applies, it must be used in order for the code to be valid

Unspecified Codes

- Each healthcare encounter should be coded to the level of certainty known for that encounter
- Unspecified codes should need to be selected less often due to greater number of code choices in ICD-10-CM
- Unspecified codes should be reported when they most accurately reflect what is known about the patient's condition at the time of that particular encounter

Terminology Changes

ICD-9

- Bunionectomy
- Amputation
- Arthroscopy, Cystoscopy…
- Incision
- Closed reduction

- Radical Mastectomy
- Subtotal Mastectomy
- Cesarean Section

- Debridement

ICD-10

- Resection of Metatarsal
- Detachment
- Inspection…endoscopic approach
- No term
- Reposition(+repair) of (Right or Left), (endoscopic, external, percutaneous)
- Resection (right, left, or bilateral)
- Excision
- Extraction of the products of conception
- Excision, extraction, irrigation, extirpation

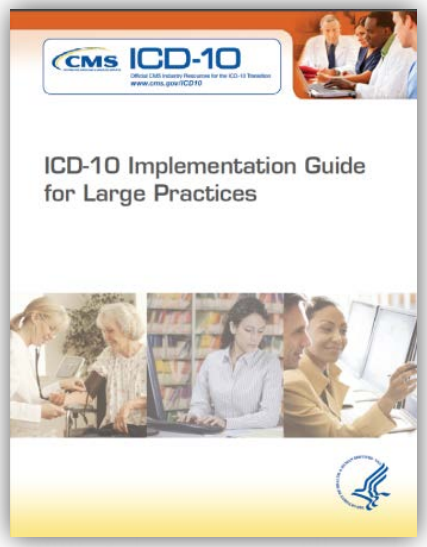
External Causes of Morbidity

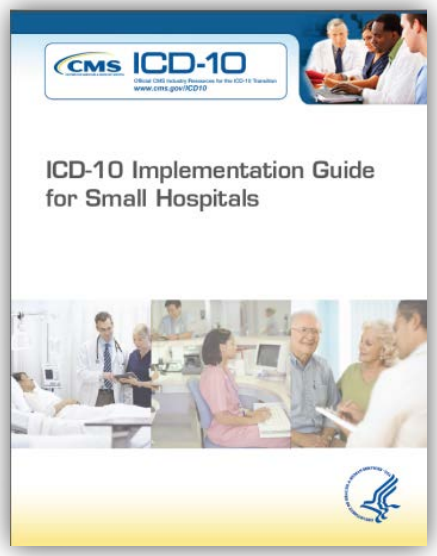
- **No national requirement for mandatory ICD-10-CM external cause code reporting**
- Reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is only required for providers subject to a state-based external cause code reporting mandate or payer requirement
- In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes

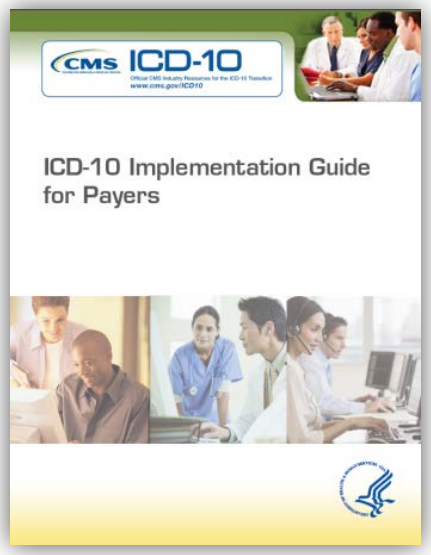
Using General Equivalence and Reimbursement Mappings

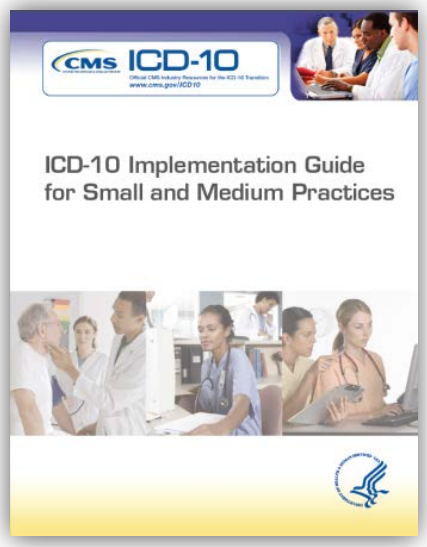
- General Equivalence Mappings (GEMs) are designed to aid in converting applications and systems from ICD-9-CM to ICD-10-CM/PCS
- Reimbursement Mappings are temporary mechanism for mapping claims containing ICD-10-CM/PCS codes to "reimbursement equivalent" ICD-9-CM codes

Implementation Guides









Questions?

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