maryland
health services
cost review commission

FY 2021 Quarter 2 Data Forum

December 11, 2020

Agenda

- Announcements
  - Case Mix Weights and Grouper Transition Update (Prudence/Andi)
  - Quality Update (Dianne/Andi)
  - Transfer from or Discharge to Designated Disaster Alternate Care Sites (Claudine)
  - Financial Data Update (Amanda/Claudine)
  - Ambulance Run Number Format Change (Oscar)
  - Edits and Error Threshold Implementation Timeline (Oscar)
  - Errors Effective January 1, 2021 (Oscar)
  - Invalid Look-up Values Effective January 1, 2021 (Claudine)
  - Deferring Edits: Revenue Codes without CPTs (Oscar)
  - REMINDER: Data Forum Survey (Oscar)
- Data Processing Vendor Update (Mary)
- Repository Vendor Update (John)
- Case Mix Review Discussion (Brenda)
- Next Steps & Next Meeting
  - Upcoming workgroups (Oscar)
  - Next Meeting (Oscar)

Announcements

Grouper Transition: Case Mix Weights

Rate Year	RY2022
APR/EAPG Version	IP Weights: 37.1* OP Weights: 3.15
Data Period Used	CY 2019
Implementation Date	July 2021

*Updated from version 37 to incorporate ICD-10 codes for coronavirus)

Grouper Transition: Market Shift

Rate Year	RY2022	
	Temporary Market Shift (Jan – Jun)	**Permanent Market Shift (Jan – Dec)**
APR/EAPG Version	CANCELLED DUE TO COVID EMERGENCY	37.1*/3.15
Timeline		Base Year: January – December 2019 Performance Year: January – December 2020
Implementation Date		July 2021

*Updated from version 37 to incorporate ICD-10 codes for coronavirus

Grouper Transition: MHAC, RRIP, QBR for **CY 2021**

Rate Year	RY2023
APR/PPC Version	38 (Updated from version 37.1 to incorporate annual 3M updates)
Timeline	Base Year: • MHAC: CYs 2018-2019 • QBR-Mortality: CY 2019 • RRIP: CY 2018 Performance Year: • All Programs: CY 2021 (longer timeframe for MHAC for small hospitals TBD) RY 2023 and COVID: Current policy is still being finalized – please see individual draft/final policies in Commission Meetings. For the latest on COVID, please visit https://hscrc.maryland.gov/Pages/COVID-19.aspx
Implementation Date	RY 2023 policies begin Jan 1, 2021 in most cases. Look for base period and performance period updates in the coming months.

Quality Update: Interim Final Rule Addressing COVID-19 Public Health Emergency – NO UPDATES

- CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted
- CMS is still reserving the right to suspend application of revenue adjustments for all programs at a future date in 2021; changes will be communicated through memos ahead of IPPS rules.
- We do not know at this time if Maryland has flexibility in suspending our programs and we have to make those decisions prior to CMS making their decisions.
- CMS modified the SNF VBP program performance period to use earlier time periods and then the July-September 2020 to ensure one full year of data
  - 6 months data might be inadequate.
  - Provides an option for duplicating use of 2019 data in combination with last 6 months of 2020.

RY 2022 and COVID-19 Public Health Emergency

Data Concerns	Options
RY 2022 (CY 2020): Only 6 months of data for CY 2020 may be used: 1. Is 6-months data reliable? Consider fall 2020 surge of COVID-19 cases 1. What about seasonality?	• Use 6-months data, adjust base as needed for seasonality concerns • Merge 2019 and 2020 data together to create 12-month performance period • Use 2019 data or revenue adjustments
Clinical concerns over inclusion of COVID patients (e.g., assignment of respiratory failure as an in-hospital complication)	• Remove COVID patients from all measures of quality in CY 2020 derived from case mix data
Case-mix adjustment concerns: 1. Inclusion of COVID patients when not in normative values 2. Impacts on other DRG/SOI of COVID PHE	• Remove COVID patients from all measures of quality in CY 2020 derived from case mix data • Use 2019 data or revenue adjustments

RY 2023 and COVID-19 Public Health Emergency

Data Concerns	Potential Options
RY 2023 (CY 2021) How do we understand fall/winter 2020/2021 surge of COVID-19 cases and impacts of such issues as: 1. Seasonality 2. Reliability/Validity of smaller volume of eligible discharges? 3. Vaccine and promise of post-COVID?	• Use 6-months data, adjust base as needed for seasonality concerns • Merge pre- or post-COVID time periods together to create 12-month performance period • Use previous revenue adjustments?
Clinical concerns over inclusion of COVID patients – Some have been addressed by 3M; others remain, e.g., increased HAI rates.	• Consider ongoing exclusion in CY 2021 or partial re-integration into quality programs
Case-mix adjustment concerns: 1. Inclusion of COVID patients when not in normative values 2. Impacts on other DRG/SOI of COVID PHE	• Consider applying RY 2022 decision regarding case-mix adjustment

Quality Update: Palliative Care – Z515, in PPC Grouper V 38

- In RY 2022 MHAC Policy, palliative care patients were included back into the program.
  - They had previously been removed as they were not identified in the base period. This is no longer a concern due to data runout.
  - At the time, analysis showed that palliative care patients were only assigned PPC 45 – Post-Procedure Foreign Body due to logic within the 3M PPC Grouper.
  - There was no material impact to this policy change, and it was approved.
- In RY 2023 MHAC Policy, this inclusion was carried forward.
  - hMetrix has identified, and 3M has confirmed, that under v38 of the PPC grouper Z515 must now be present-on-admission (POA) in order to be considered a blanket exclusion from PPC assignation.
  - The material impact of palliative care cases being included in the RY 2023 MHAC program is currently being assessed.
- Next Steps: HSCRC Quality Staff will work with the stakeholder workgroup (PMWG) to assess impact and recommend next steps

Quality Update: Review of Secondary Dx in Case Mix Data

- In current Quality programs, up to 29 secondary dx (30 dx total) are incorporated when grouping case-mix data submissions
- Beginning FY 2019, HSCRC understood many hospitals to say they were enabled to collect up to 99 secondary dx (100 dx total)
  - HSCRC Quality truncates at 30 total dx codes to align base and performance periods.
- Present state – hMetrix is studying the impact of additional secondary dx codes
  - APR-DRG grouper will incorporate up to 50 dx codes (1 primary, 49 secondary); EAPG grouper will incorporate up to 25 dx codes (1 primary, 24 secondary).
  - Further study is needed to understand impact if we were to expand the number of secondary dx codes under analysis.

Quality Update: Date of Death

- Quality team is working to develop a 30 day all diagnoses, all cause mortality measure
- Maryland regulations this year direct Vital Statistics to provide the death dates to CRISP to add to the hospitalization case files
- CRISP will add the date of death when it is within 90 days of hospitalization to the HSCRC Case Mix data in January 2021 beginning with discharges from October 2019
- Hospitals will be provided updated quarterly reports on deaths for hospitalizations during CY 2021 through the CRISP CRS portal

Transfer from or Discharge to Designated Disaster Alternate Care Sites

- Effective July 1, 2020 (FY 2021)
  - New Point of Origin (Source of Admission) Code:
    G =TRANSFER FROM A DESIGNATED DISASTER ALTERNATE CARE SITE
  - New Patient Discharge Disposition:
    69 = DISCHARGED/TRANSFERRED TO A DESIGNATED DISASTER ALTERNATE CARE SITE
- Applicable to transfers from or discharges to Designated Disaster Alternative Care Sites
  - Adventist Tacoma Park (Reporting under White Oak Hospital ID 210016)
  - UM Laurel (Reporting under Laurel Hospital ID 210055)
  - Lord Baltimore Hotel (Reporting under UMMC (210002)
  - Baltimore Convention Center (Reporting under 210068)
  - Washington Convention Center (?)
  - Others?

Transfer from or Discharge to Designated Disaster Alternate Care Sites, cont.

- Reserve Flag “A”
  - Used to identify Alternative Clinical Sites where the patient was not discharged or transferred from another hospital. For example, COVID testing at a temporary clinic site at Pimlico Racetrack
  - As a reminder, an **Alternative Clinical Site is defined as “an area, building or structure that is not located on the hospital campus that is being used to provide clinical services during the COVID-19 emergency.”**

Financial Data Update

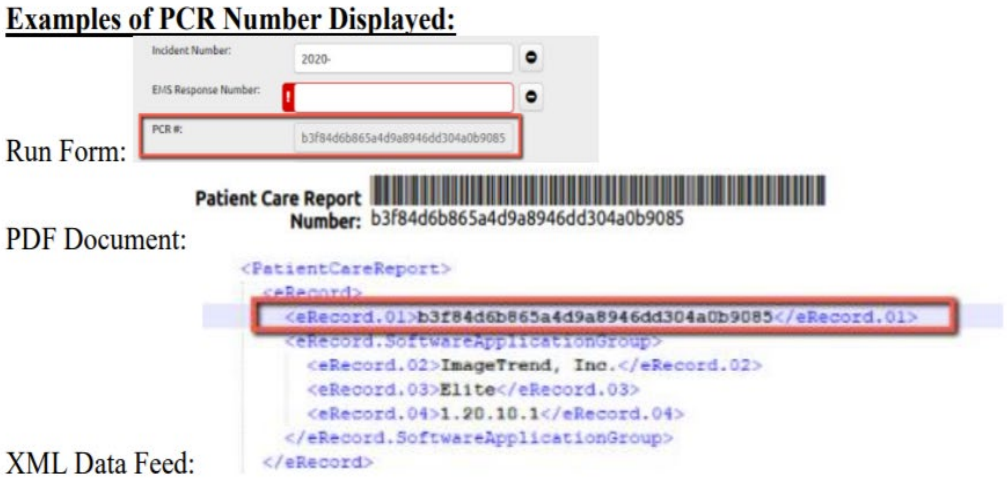
- COVID Emergency Reporting
  - Reinstated bi-weekly volume and revenue reporting to support COVID 19 activities
    - First reporting period: December 1 – December 13
    - Due Date: **December 18**
  - Quarterly reports delayed
    - **Denials and UCC quarterly reports** delayed until further notice. Data will be due once the reports are reinstated.
    - **Reconciliations** will be provided to hospitals but will be for informational purposes only. Staff will be reviewing the data internally for any data issues and will contact hospitals if need be.
- Annual Cost Report Model
  - First iteration of the new cost report model was released for the FY 2020 Annual Filing
  - Use of new model was not mandatory for FY 2020, however all schedules had to be submitted electronically
  - Use of new model will be mandatory for FY2021 Cost Report. The model will be updated and released after review of this year's reports.

Financial Data Update, cont.

- Reconciliation reports through DAVE
  - HSCRC is working with hMetrix to incorporate the Financial vs Case Mix Reconciliation reports
  - The reporting timeline will be the same (per the HSCRC production schedule)
  - Hospitals would be able to receive the Financial portion of the Reconciliation 20 days after submission of quarterly preliminary data. The lag is due to the timing of monthly financial data.
  - More to come at the next Data Forum Meeting

New Format for Ambulance Run Number

- Starting January 1, 2021, MIEMSS is changing the numbering format of the auto-generated, Patient Care Report Number [eRecord.01] within an eMEDS® report.
  - **Current: E**leven (11)-digit format,
  - **New:** Thirty-two (32) alphanumeric character string - Globally Unique Identifier (GUID).
  - The new format will be effective in the DSR for discharges on and after January 1, 2021
  - For questions, please contact Jason Cantera, MIEMSS EMS Applications Coordinator, at jcantera@miemss.org.



Edits and Error Threshold Implementation Timeline

July 2020
- DAVE sandbox available;
- New edits are flagged as warnings

Oct 1, 2020
- New edits displayed as warnings in production

Jan 1, 2021
- New edits will switch from warnings to errors

April 2021
- 5% error threshold will be in effect for FY 2021 Q3 Final and subsequent final quarters

Errors Effective January 1, 2021

Field Name	Error Type	Rule	IP	OP	PS	Jan 1, 2021 Update
Patient Account Number	**Fatal Error**	**If value is missing, invalid (alpha or special characters), all 9's or all 0's**		**X**	**X**	**Error -> Fatal Error**
Newborn Birth weight	Error	If value is not between 150g and 9000g	X			Warning -> Error
Newborn Birth weight	Cross Edit Error	If value is missing and Nature of Admission = 2	X			Warning -> Error
Date of Birth	Error	If calculated age => 125 years	X			Warning -> Error
Date of Birth	Error	If value is missing	X			Warning -> Error
Date of Birth	Cross Edit Error	If value > Admission Date	X			Warning -> Error
Marital Status of the Patient	Error	If value is not "1 - Single" or "9 - Unknown" and age based on DOB < 14	X			Warning -> Error
Patient County of Residence	**Fatal Error**	**If value is missing**	**X**	**X**	**X**	**Error -> Fatal Error**
Residence Zip Code	**Fatal Error**	**If value is missing**	**X**	**X**	**X**	**Error -> Fatal Error**
Point of Origin (Source of Admit)	Cross Edit Error	If value is invalid for the reported Discharge Disposition (see Prop Prov List v3 for valid ID numbers). If hospitals want to code the providers (i.e., SNF), the provider ID must be valid).	X	X	X	Warning -> Error
Nature of admission	Cross Edit Error	If value =2 and Major Service not in {4, 5}	X			Warning -> Error
Nature of admission	Cross Edit Error	If charges for Rate Center 16 > $0 then value should be 08 (Rehab)	X			Warning -> Error

Errors Effective January 1, 2021 (contd.)

Field Name	Error Type	Rule	IP	OP	PS	Jan 1, 2021 Update
Disposition of the Patient	**Fatal Error**	**If value is missing**	**X**	**X**	**X**	**Error -> Fatal Error**
Disposition of the Patient	Cross Edit Error	If Total Charges for Unknown Disposition records > .5% of Total IP Hospital Charge	X	X	X	Warning -> Error
Disposition of the Patient	Cross Edit Error	If value in {02, 05, 43, 62, 63, 65} then Provider Specific Discharge Destination must = appropriate Provider ID (see Prop Prov List v3 for valid ID numbers).	X	X	X	Warning -> Error
Principal Diagnosis	**Fatal Error**	**If value is missing**	**X**		**X**	**Error -> Fatal Error**
Charges	**Fatal Error**	**If value < 0 (negative charges)**	**X**	**X**	**X**	**Error -> Fatal Error**
Rate Center	Error	If value is not "00" when associated Revenue Code is = "0001"	X	X	X	Warning -> Error
Units of Service	Error	If value is not "000000" when associated Revenue Code is reported as "0001" (Total Charge)	X	X	X	Warning -> Error
Date of Service	Cross Edit Error	If value is +/- 2 days from Thru and From Date		X		Warning -> Error
Data Populated after Total Charges	Error	If revenue codes after the Total (“0001”) have any data populated	X	X	X	Warning -> Error

Invalid Lookup Values Effective January 1, 2021

Lookup Name	Value	Comments
Provider Specific Admission Source	777777	Not Applicable - leave provided blank if not applicable
Provider Specific Discharge Destination	777777	Not Applicable - leave provided blank if not applicable
Point of Origin (Source of Admission)	NB	No longer valid for Newborn (Patient born at the hospital) includes babies born anywhere in the hospital, including the ED
Disposition of the Patient	61	To a hospital-based Medicare-approved swing bed (same hospital)
Expected Primary Health Plan Payer	33	Coventry Health Care of Delaware, Inc. Do Not Use
	38	Evergreen Health Cooperative, Inc. Do Not Use
	46	BEACON (formerly VALUE OPTIONS) DO NOT USE
	59	Informed Do Not Use
	63	Medstar Medicare Choice (includes Choice Dual Advantage & Care Advantage) Do Not Use
	75	National Capital PPO (NCPPO) CareFirst Administrators LLC / National Capital Administrative Services Do Not Use
	84	CareFirst PPO Behavioral Health Do Not Use
	91	Value Options Do Not Use
	93	MD Health Insurance Plan (MHIP) EPO Do Not Use
	94	MD Health Insurance Plan (MHIP) PPO Do Not Use

Deferred Edits: Revenue Codes Requiring CPT Codes

- Initial edit required a CPT code for every revenue code except Total Charge
  - During testing, discovered valid revenue codes that do not require CPT
- Working on refining the edits related revenue codes that require or do not require a CPT codes
  - HSCRC to convene workgroup to review edits for FY 2021

Reminder: Complete the Data Forum Survey!

- Opportunity to provide feedback on
  - Meeting logistics (meeting notice, registration, ease of participation)
  - Topics covered during the prior meeting
  - Topics for discussion for future meetings
- After this Data Forum, participants will receive a link to a survey via Survey Monkey
- Questions about the survey: contact hscrcteam@hmetrix.com

Data Processing Vendor Update

Points of Contact

HSCRC	hMetrix / Burton Policy
Claudine Williams Phone: (410) 764-2561 Email: claudine.williams@maryland.gov	**Maria Manavalan** (Primary PoC) Phone: (610) 595-9979 Email: maria@hmetrix.com
Oscar Ibarra Phone: (410) 764-2566 Email: oscar.ibarra@maryland.gov	**Mary Pohl** (Hospital Support) Phone: (410) 274-3926 Email: marypohl@burtonpolicy.com
	Team Email: hscrcteam@hmetrix.com

Data Processing Updates and Status

- Reminders
  - Submit Production files to
    - HSCRCIP, HSCRCOP, and HSCRC-Psych distribution lists
  - Submit Test files (available all the time for testing) to
    - TESTIP, TESTOP, and TESTPSY distribution lists
  - Use DAVE to notify HSCRC & hMetrix if you want to use the Preliminary submission for the quarterly Final
- Production site updates
  - December 1, 2020
    - Display content of the Revenue Group in the Error Detail tab to assist in debugging
  - January 1, 2021
    - New edits (FY21) will be switched to errors
    - System level error reports available for download

Display Content of the Revenue Group in the Error Detail Tab

- **Line #** from submission
- **Contents** – Revenue code, Rate Center code, Units of Service, Charges
- **Explanation** – Revenue group number with missing data
- Available for submissions after December 1, 2020

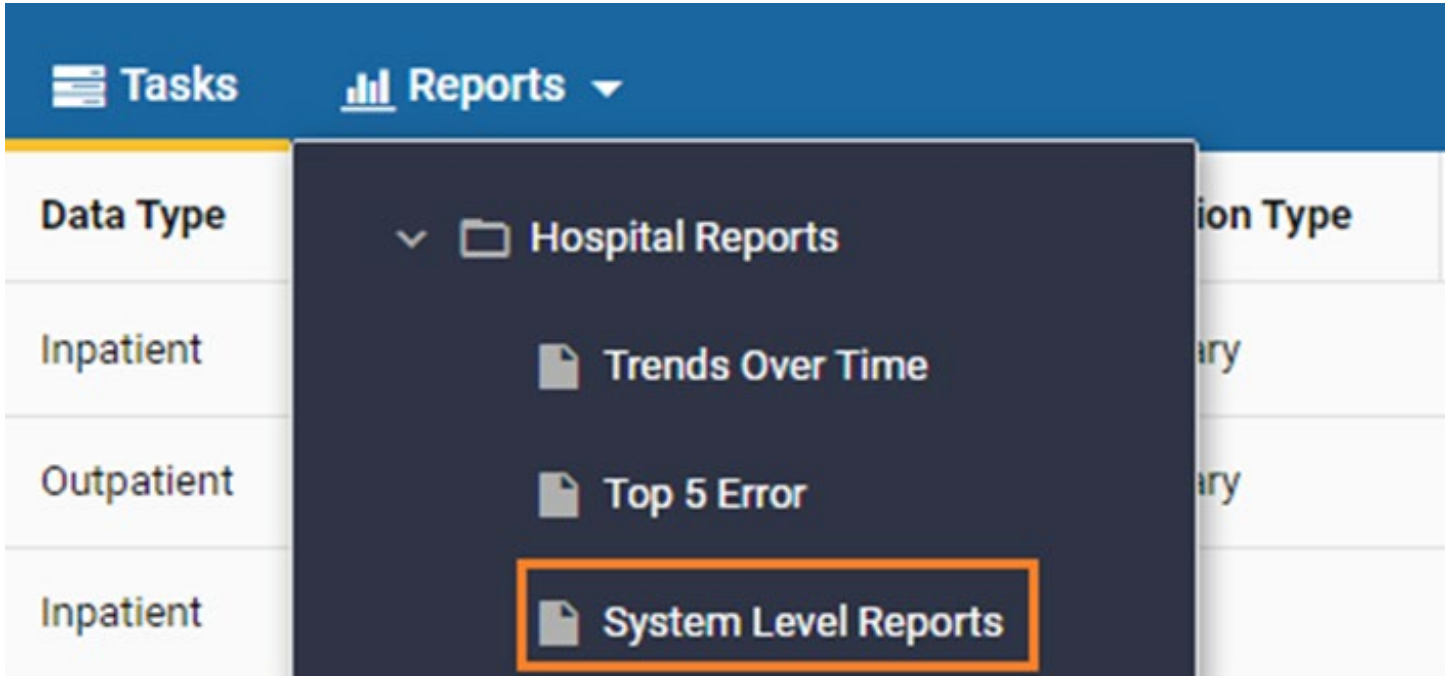
LINE #	CONTENTS	EXPLANATION
159	2	Patient Disposition does not have valid Provider Specific Discharge Destination
567	K210	Other Diagnosis 22 is invalid
1113	REVCODE: 300 / RCTCODE: 42 / UNTSVC: -10 / CHARGE: -24.46	Units of Service 6 is invalid
4165	REVCODE: 300 / RCTCODE: 42 / UNTSVC: -10 / CHARGE: -24.46	Units of Service 9 is invalid

System Level Error Report Available

- System level error report contains
  - All hospitals that the user has access to
  - Details for all errors in submission
- Available as:
  - CSV file
  - Excel workbook
- Download from DAVE as required
- For submissions after Jan 1, 2021

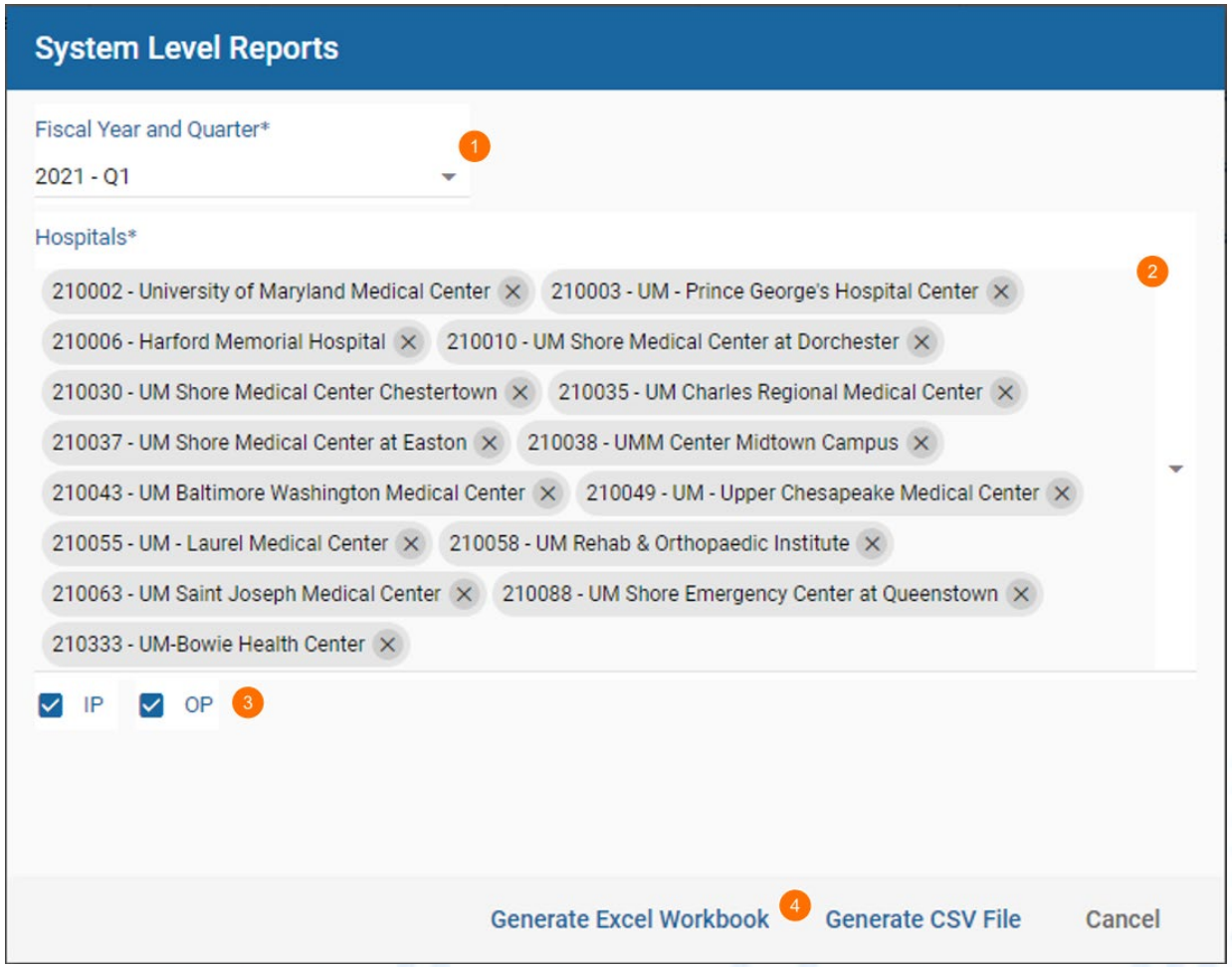
- Columns in the report
  - Provider ID
  - Claim Type – IP, OP or PS
  - Issue Type – Fatal, Error or Warning
  - Medical Account Number
  - Patient Account Number
  - Admit Date/ From Date
  - Discharge Date/ Thru Date
  - Error Number
  - Error Line
    - Line number in the input file with an error
  - Error Contents
    - Contents of the field that has the error
  - Error Explanation
    - Details regarding the error

System Level Error Report – Location in DAVE



System Level Error Report - Interface

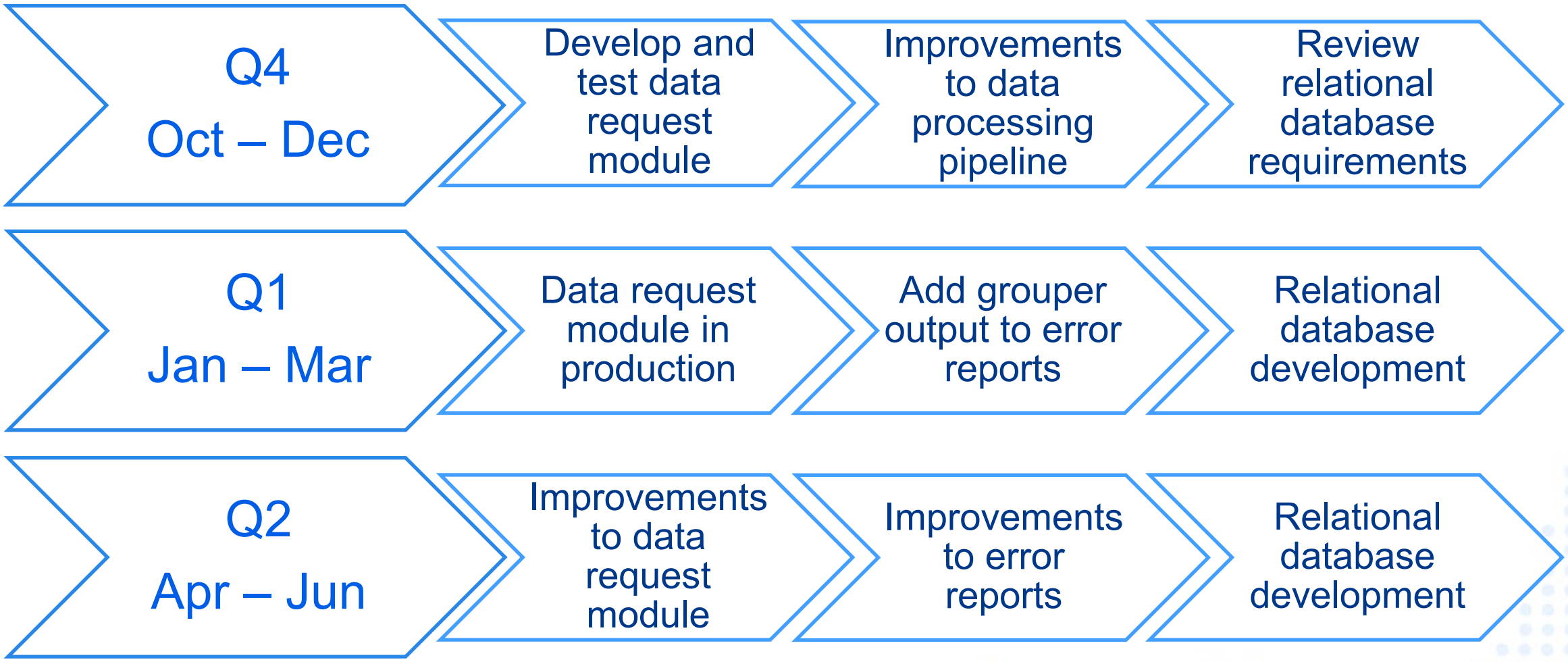
1. Choose submission period
2. Confirm the list of hospitals
3. Choose the data type
4. Download the report



ECMAD Datasets Added to PUF

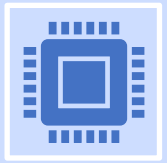
- IP ECMAD dataset
  - All IP non-confidential fields
  - HSCRC assigned DRGs for Chronic and Rehab cases
  - OP Observations greater than or equal to 24 hours added
  - OP records for high weight EAPG 47
  - HSCRC weights
- OP Per Visit ECMAD dataset
  - All OP non-confidential fields
  - Key to join with OP ECMAD data
- OP ECMAD dataset
  - HSCRC Service Line
  - Preliminary Service Line
  - High EAPG type
  - High EAPG
  - High CPT
  - ECMAD weight
  - Zip code or County using MSA logic
  - Sequence based on date of service
  - Key to join with OP per visit ECMAD data

CY 2020 Roadmap for Continuous Improvements to DAVE



Data Repository Vendor Update: Secure File Transfer

Reason for the Change:



Current software package is stringent and built on top of older technology. It requires us to work within its framework with little room to scale or improve.

Current software vendor was acquired.

Current software has reached end of support from the vendor.

New Software: St. Paul Group SFT (Secure File Transfer)

A system developed in house to meet present and future goals, not a software package

Standards based

Improved web user interface that does not rely on a particular brand or version of browser

Future Improvements:

Better internal automated processes:

Drag and drop files to/from folder as you would another shared network folder

Ability to transfer larger files

Timeline:

PILOTING TO BEGIN WITH A SMALL USER COMMUNITY JUST AFTER THE NEW YEAR

PLANNED FULL ROLL OUT BY THE END OF CY21Q1

Contact Information:

Jen Vogel	John Hartlove
Director of Operations	President
Jen.Vogel@thestpaulgroup.com	John.Hartlove@thestpaulgroup.com
443-749-5450	443-749-5445

Case Mix Review Discussion

Case Mix Review Results: Year 1 and 2

FY18 and FY19 Comparison of Hospital Inpatient Performance

- There were statistically significant improvements ($p < .01$) in inpatient performance scores for all five measures.

Inpatient Category	Year 1 Hospitals										Year 2 Hospitals										AT				
All Samples	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16	#17	#18	#19	#20	50th	75th	90th	SO↓	PB
Random & Focused	76	87	71	78	74	73	84	81	93	72	75	85	73	91	93	73	83	91	82	85	82	87	93	88	95
APR-DRG	86	94	93	95	91	95	98	96	96	97	97	96	92	96	96	98	97	96	98	97	96	97	98	92	95
Disposition of Patient	96	98	86	97	83	78	89	93	99	76	94	92	88	98	99	90	91	96	91	97	93	97	99	88	95
Prov. Specific DD	99	98	86	97	83	78	90	92	100	98	91	97	93	99	100	86	100	97	94	96	97	99	100	89	95
Weight	80	90	87	93	88	94	95	94	94	95	96	94	89	94	95	97	94	96	97	95	94	95	97	91	95

Red is >1, Yellow is <= 1 standard deviation from the PB, Green is at or above the PB.

AT = Achievement Threshold representing the 50th (median), 75th and 90th percentile of hospital performance.
SO↓ = Statistical Outlier representing one standard deviation from the PB.
PB = Performance Benchmark frame of reference for expected case-level accuracy regarding payment impact.

FY18 and FY19 Comparison of Hospital Outpatient Performance

- Average outpatient performance scores were significantly lower ($p < .01$) in four of the five measures.
  - Random and focused
  - CPT
  - Units
  - Disposition of Patient
- Average performance score for Modifiers was significantly higher ($p < .01$).

Outpatient Category	Year 1 Hospitals										Year 2 Hospitals										AT				
All Samples	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15	#16	#17	#18	#19	#20	50th	75th	90th	SO↓	PB
Random & Focused	88	82	53	76	77	86	90	85	86	83	55	72	60	85	71	65	71	47	65	42	74	85	88	81	95
CPT	96	94	72	87	93	81	91	89	88	84	90	95	73	94	89	87	93	61	83	81	89	93	95	86	95
Units	92	90	88	93	100	100	99	100	100	100	65	95	91	98	99	90	91	76	80	58	93	100	100	83	95
Modifiers	98	97	83	96	94	95	99	95	96	97	97	98	97	95	98	95	99	97	100	99	97	98	99	91	95
Disposition of Patient	100	100	97	99	91	100	100	100	100	100	96	84	92	94	82	90	81	100	92	97	97	100	100	89	95

Red is >1, Yellow is <= 1 standard deviation from the PB, Green is at or above the PB.

AT = Achievement Threshold representing the 50th (median), 75th and 90th percentile of hospital performance.
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Reporting Attending Physician in the Case Mix Data

Reporting Attending Physician: HSCRC Definition

In the HSCRC DSR, there definition for reporting Attending Physician is as follows:

> *"The attending physician is the physician who is responsible for the longest portion of the patient's total length of stay. If two or more physicians are responsible for equal number of days of the length of stay, the attending physician is the physician most associated with the principal diagnosis."*

The valid values are (for NPI or MedChi #)

- 6-digit numeric field for **physician or physician group** [emphasis added],
- 6 number 9's for unknown
- blank for not applicable.

Reporting Attending Physician: Medicare Definition

- The Medicare Claims Processing Manual Chapter 25 - Completing and Processing the Form CMS-1450 Data Set, (which can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf), replaces Attending Physician, with Attending Provider and defines it as follows in FL 76: **"The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter."**
- Chapter 12, Section 30.6.9.2 of the Medicare Claims Processing Manual defines **Attending Physician in the context of the party who may report discharge day management services, which oftentimes includes generation of the discharge summary**. It also distinguishes between the attending physician and physicians other than the attending who have been managing concurrent health are problems not primarily managed by the attending physician and who are not acting on behalf of the attending physician.
  - "B. Hospital Discharge Day Management Service Hospital Discharge Day Management Services…between the attending physician and the patient. The …discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient per hospital stay. Only the attending physician of record reports the discharge day management service.[emphasis added]" Physicians … other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (CPT code range 99231 - 99233) for a final visit…" (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Reporting Attending Physician: Challenges with HSCRC Definition

- HSCRC definition is ambiguous
  - Attending physician is the physician who is responsible for the longest portion of the patient's length of stay, but then adds a sentence inferring that the longest portion would be determined by counting the number of days and defaulting to the physician most associated with the principal diagnosis only when there is an equal number of days among two or more physicians who cared for the patient
- Hospital interpretation of the definition varies
  - Select by counting days, if the same, select the physician aligned to the principal diagnosis
  - Select the surgeon regardless how many days they saw the patient
  - Select based upon who supervised and provided discharge day management services
  - Select physician who completes the discharge summary
  - Select based on what unit patient was admitted to

Reporting Attending Physician: Scenario #1

A patient is admitted for surgery and after surgery is managed by the Hospital Medicine practice (hospitalists) for medical management. The surgeon sees the patient 3 of 8 days, the hospitalists one day in consultation then assume the care of the patient for 6 of the other days. The principal diagnosis is related to the reason for surgery. The hospitalists care for medical complications from the surgery as well as other chronic medical issues. Among the hospitalists, three different physicians provide care, the first for 3 days, followed by two other hospitals, seeing the patients each for 2 days. One of the hospitalists who saw the patient 2 days discharges the patient.

Under the current HSCRC definition, the surgeon would be considered the Attending Physician. He saw the patient an equal number of days as one of the hospitalists and the principal diagnosis was in line with the care managed by the surgeon.

Reporting Attending Physician: Scenario #2

The patient was admitted for surgery performed on day 1, a PA sees the patient on behalf of the surgeon on days 2 and 3, the surgeon returns day 4 to check up on the patient's status and asks for medical management of the patient to be covered by Hospital Medicine for the remaining days of care, days 5 through 10, at which time the patient is discharged and sent to a nursing home. One hospitalists sees the patient for on day 5 and another hospitalists sees the patient on day 6 through 10 when he discharges the patient.

Under the current HSCRC definition, the last hospitalist who saw the patient on days 6 through 10 would be the Attending Physician.

If the PA actively saw the patient on days 2 through 10, and the surgeon returned to examine the patient at discharge (as one of his 3 days), in one interpretation, the attending physician would be the surgeon (because the PA worked under the supervision of the attending even if the attending did not see the patient face-to-face); under a different interpretation, the hospitalist who saw the patient on days 6 through 10 and prepared the discharge summary would be considered the attending physician.

Reporting Attending Physician: Scenario #3

A patient is admitted by a hospitalist then sent to the ICU where pulmonary medicine is called in to manage the patient's respiratory condition for 5 days and nephrology is called in to treat the patient's nephrology condition for 7 days (5 of which are in the ICU and the other 2 days when the patient steps down from the ICU. For the remaining 4 days of hospitalization, the patient is seen by the same hospitalist who also discharges the patient. The hospitalist who admitted the patient saw the patient 1 day, another hospitalist saw the patient for 3 of the 5 days while the patient was in the ICU, another hospitalist saw the patient for 2 days after the patient left the ICU, and the last hospitalist who saw and discharged the patient did so for a total of 4 days.

Under the current HSCRC definition, the nephrologist would be considered the attending physician because he saw the patient the most days. The hospitalist group saw the patient for a total of 10 days and discharged the patient, but no single physician saw the patient more than the nephrologist who saw the patient for 7 days (or the pulmonologist who saw the patient for 5 days).

Reporting Attending Physician: Scenario #4

A teaching hospital has residents who work under the supervision of a teaching physician from the same clinical practice for the entire admission. The total length of stay is 10 days. One teaching physician sees the patient on admission and the following 5 days. Another teaching physician sees the patient days 7 through 10 and provides discharge day management supervision.

Under the current HSCRC definition, the first teaching physician would be considered the Attending Physician because he saw the patient the most days.

If the same fellow saw the patient every day, and the supervising teaching physician saw the patient 3 of the 10 days and a consulting physician from infectious diseases aw the patient for 6 of the 10 days, under the current HSCRC definition, the Attending Physician would be the consulting physician.

Reporting Attending Physician: Discussion

- Does the hospital have the latitude of establishing policies where it determines how it will define Attending Physician? If yes, are there any restrictive elements to the policy?
- Under the current HSCRC definition, does it make sense designating the Attending Physician as the physician who saw the patient and provided discharge day management services regardless of the number of days the discharging physician saw the patient?
- Under the current HSCRC definition, if the primary service of the patient was orthopedic surgery and hospitalists were called in consultation to address and then manage medical matters, but the orthopedic surgeon saw the patient for fewer days but discharged the patient, could the orthopedic surgeon considered to be the Attending Physician?

Workgroups and Next Meeting

Upcoming Workgroups

- Data Edits Review Workgroup
  - Purpose: To review and update the IP and OP edits for FY 2022
  - Duration: 2 – 3 meetings (via Google Meet)
  - Membership: 6 – 8 members
  - Timing: February – March 2021
- Data Submission Requirements Review Workgroup
  - Purpose: To review and edit the final FY DSR for accuracy and consistency
  - Duration: 1 – 2 meetings (via Google Meet)
  - Membership: 4 – 5 members
  - Timing: March – May 2021
- Email Oscar.Ibarra@maryland.gov to volunteer for these workgroups

Notes and slides will be posted to the HSCRC website:

https://hscrc.maryland.gov/Pages/hsp_info1.aspx

Next Meeting
FY 2021 Q3
March 12, 2021