

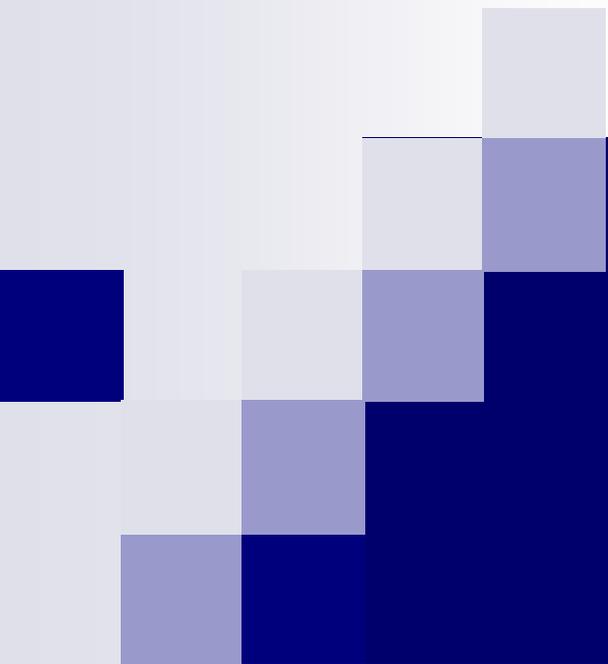
# Measuring Under-Utilization of Services

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# Introduction

- Community Health Network of Connecticut, Inc. (CHNCT) utilizes the LexisNexis Intelligent Investigator™ software to review claims and examine patterns of provider behavior.
- CHNCT will use this tool to identify potential under-utilization of services by providers in the Medicaid Quality Improvement and Shared Savings Program (QISSP) based on claims data.
  - The review criteria will be established by DSS in whole or in part based on the recommendations of the Equity and Access Council.
  - CHNCT's clinical staff will translate the review criteria into the appropriate coding.
- A detailed report is generated that will allow clinical and data informatics staff to conduct analysis by provider, provider group and member.
  - CHNCT will conduct a sampling of medical record reviews to validate the report findings.
- The presentation today will provide an overview of two modules:
  - Clinical History (This without That)
  - Ad-Hoc Query



# **Clinical History Module**

## **“This without That”**

# Identifying Potential Members with a Specific Diagnosis who haven't Received Certain Services

- The Clinical History module allows CHNCT to enter specific diagnosis codes, procedure codes, etc., which shows members with (“This”) criteria and then identify services by procedure and/or revenue center codes, reflecting what would be expected for a specific diagnosis (“That”).
- Timeframes can be entered that would allow CHNCT to view members with specific diagnosis code(s) that:
  - Have never received the associated procedure codes; **OR**
  - Have not received the associated procedure codes within a specified timeframe.

# Example 1: Members with a Diagnosis of Angina

- Based on the standard of care, members with a diagnosis of Angina should have:
  - One cardiographic procedure (e.g., ECG, Stress Test) or nuclear imaging procedure (e.g., SPECT scan); and
  - One consult or office visit with a cardiologist
- CHNCT will utilize the Clinical History module to identify members who have never received a cardiographic procedure.

# Example 1: Members with a Diagnosis of Angina: Entering Criteria (Testing)

The following diagnoses codes are entered under the “This” criteria:

- **413.0:** Angina Decubitus
- **413.1:** Prinzmetal Angina
- **413.9:** Other and unspecified Angina Pectoris

Timeframe: Never Received

Along with the following procedure codes under the “That” criteria:

- **93000-93018:** ECG/Stress Testing
- **93024:** Ergon. Provocation Test
- **93025:** Assess. Vent. Arrhythmias
- **93040-93042:** ECG
- **93224-93278:** Cardio. Monit. Services
- **93303-93352:** Echocardiogram
- **93451-93583:** Cardiac Cath
- **78452:** Spect Study

# Example 1: Members with a Diagnosis of Angina: Report Output

After criteria are entered and the user runs the report, the output will show all members with one of the Angina diagnosis codes entered who have not received one of the cardiographic procedure codes according to claims data.

The user will see the output on the screen in various fields, which includes the following information:

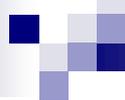
- Patient Demographics (ID Number, Name, Gender, Date of Birth, Program Name)
- Procedure Codes and Descriptions
- Revenue Codes and Descriptions
- Diagnoses Codes and Descriptions
- Modifier Codes
- Provider Information (Provider ID, Name, Specialty, Billing Provider ID, Tax ID, NPI, State and Zip Code)
- Claim Number
- Dates of Service
- Units of Service
- Payment Information (Charged Amount, Paid Amount, Processed Date, Check Date)

# Example 1: Members with a Diagnosis of Angina: Report Output (cont.)

- The user may also drill down further into certain fields, such as Member ID and Provider ID.
  - For example, by clicking on a member's ID number, a user is able to see detailed member demographics, the member's claim history and utilization by procedure or diagnosis code.
  - By clicking on a provider's ID, a user is able to see provider demographics, summary data on all claims submitted and provider transactions.



# Ad-Hoc Query Module



## Identifying Members who haven't Received Services from a Specific Provider Specialty

- The Ad-Hoc Query is a comprehensive tool that can be used to run a variety of different reports by entering specific criteria.
- For purposes related to monitoring under-utilization, CHNCT will use the Ad-Hoc Query to identify all members with a specific diagnosis who have not received services from a provider with a certain clinical specialty.

# Example 1: Members with a Diagnosis of Angina

- Based on the standard of care, members with a diagnosis of Angina should have:
  - One cardiographic procedure (e.g., ECG, Stress Test) or nuclear imaging procedure (e.g., SPECT scan); and
  - One consult or office visit with a cardiologist.
- In this example, CHNCT will utilize the Ad-Hoc query to identify members who have never received a consultation or office visit with a cardiologist.

# Example 1: Members with a Diagnosis of Angina: Entering Criteria (Consult/Visit)

Members with the following diagnoses codes:

- **413.0**: Angina Decubitus
- **413.1**: Prinzmetal Angina
- **413.9**: Other and unspecified Angina Pectoris

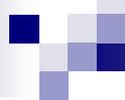
Timeframe: From dates of service January 1, 2012 - present

Who have not had one of the following procedure codes:

- **99241-99245**: Outpatient consultations
- **99201-99215**: Office visits

By one of the following provider specialty codes:

- **312**: Cardiology
- **313**: Cardiovascular Surgery
- **620**: Pediatric Cardiology



# Example 1: Members with a Diagnosis of Angina: Ad-Hoc Query Report Output

- After criteria are entered and the user runs the report, the output will show all members with one of the Angina diagnosis codes entered who have not received one of the consultation/visit procedure codes from a Cardiology specialist according to claims data.
- Similar to the Clinical History module, the user will see the output on the screen and can drill down further.

# Example 1: Members with a Diagnosis of Angina: Further Analysis

- The Clinical History and Ad-Hoc Query reports may also be exported into an Excel spreadsheet or other file formats for further analysis.
- For example, CHNCT may:
  - Profile providers by Primary Care setting: FQHC, PCMH, Community Practice, Hospital Clinic;
  - Profile members by race, ethnicity, gender, age;
  - Review medication history;
  - Identify trends by practice;
  - Determine member's attributed PCP; and
  - Select a sampling of members from a practice for chart reviews to validate the report findings.
- CHNCT's clinical staff will conduct provider site visits to review findings.



# Additional Examples

# Example 2: Members with a Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

- Based on the standard of care, members with a diagnosis of COPD should have:
  - One pulmonary function test; and
  - One consult or office visit with a Pulmonologist.
  
- CHNCT will:
  - Utilize the Clinical History module to identify members who have never received at least one pulmonary function test from any provider; and
  - Utilize the Ad-Hoc Query to identify members who have never had a consult/office visit with a Pulmonologist.

## Example 2: Members with a Diagnosis of COPD: Entering Criteria (Pulmonary Function Testing)

The following diagnoses codes are entered under the “This” criteria:

- **491.2X**: Obstruct. Chronic Bronchitis
- **492.X**: Emphysema

Along with the following procedure codes under the “That” criteria:

- **Pulmonary Function Tests:**  
94010-94450, 94620-94621,  
94680-94750, 94770

Timeframe: Never Received

## Example 2: Members with a Diagnosis of COPD: Report Output and Analysis

- After criteria are entered and the user runs the report, the output will show all members with one of the COPD diagnosis codes entered who have not received one of the pulmonary function test procedure codes according to claims data.
- Next, CHNCT will utilize the Ad Hoc Query to identify members who have never received at least one consult or office visit with a Pulmonologist.

# Example 2: Members with a Diagnosis of COPD: Entering Criteria (Consult/Visit)

Members with the following diagnoses codes:

- **491.2X**: Obstruct. Chronic Bronchitis
- **492.X**: Emphysema

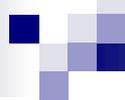
Timeframe: From dates of service  
January 1, 2012 - present

Who have not had one of the following procedure codes:

- **99241-99245**: Outpatient consultations
- **99201-99215**: Office visits

By one of the following provider specialty codes:

- **340**: Pulmonary Disease Specialist
- **629**: Pediatric Pulmonology



## Example 2: Members with a Diagnosis of COPD: Report Output

- After criteria are entered and the user runs the report, the output will show all members with one of the COPD diagnosis codes entered who have not received one of the consultation/visit procedure codes from a Pulmonary specialist according to claims data.

## Example 2: Members with a Diagnosis of \_\_\_\_\_

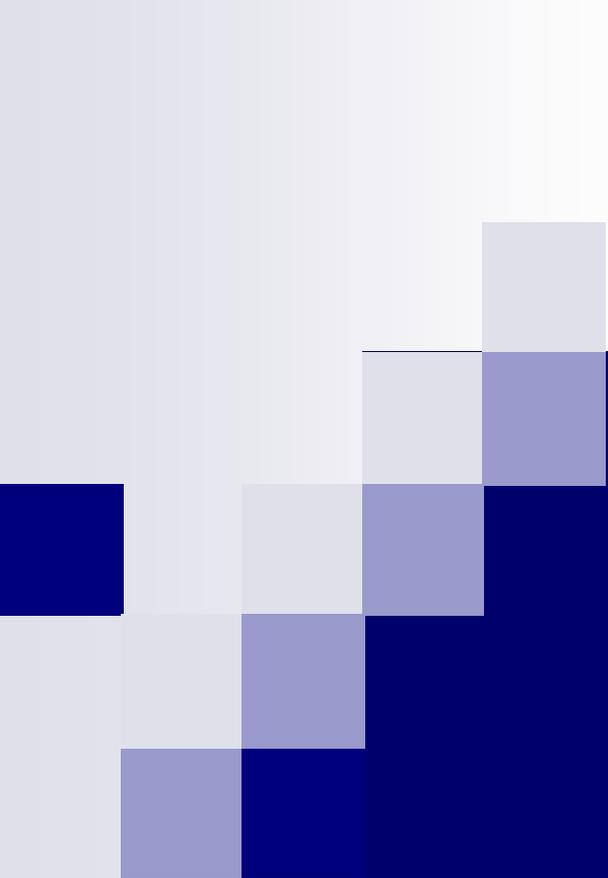
- Based on the standard of care, members with a diagnosis of \_\_\_\_\_ should have:
  - \_\_\_\_\_
  
- CHNCT will:
  - Utilize the \_\_\_\_\_ module to identify members who have never received \_\_\_\_\_



## **Example 3: Members with a Diagnosis of \_\_\_\_\_: Entering Criteria (\_\_\_\_\_)**

## Example 3: Members with a Diagnosis of \_\_\_\_\_: Report Output

- After criteria are entered and the user runs the report, the output will show all members with one of the \_\_\_\_\_ diagnosis codes entered who have not received one of the \_\_\_\_\_ procedure codes according to claims data.



# Questions