Data Blind Spots: Identifying Palliative Care

CAPC Webinar July 20, 2023

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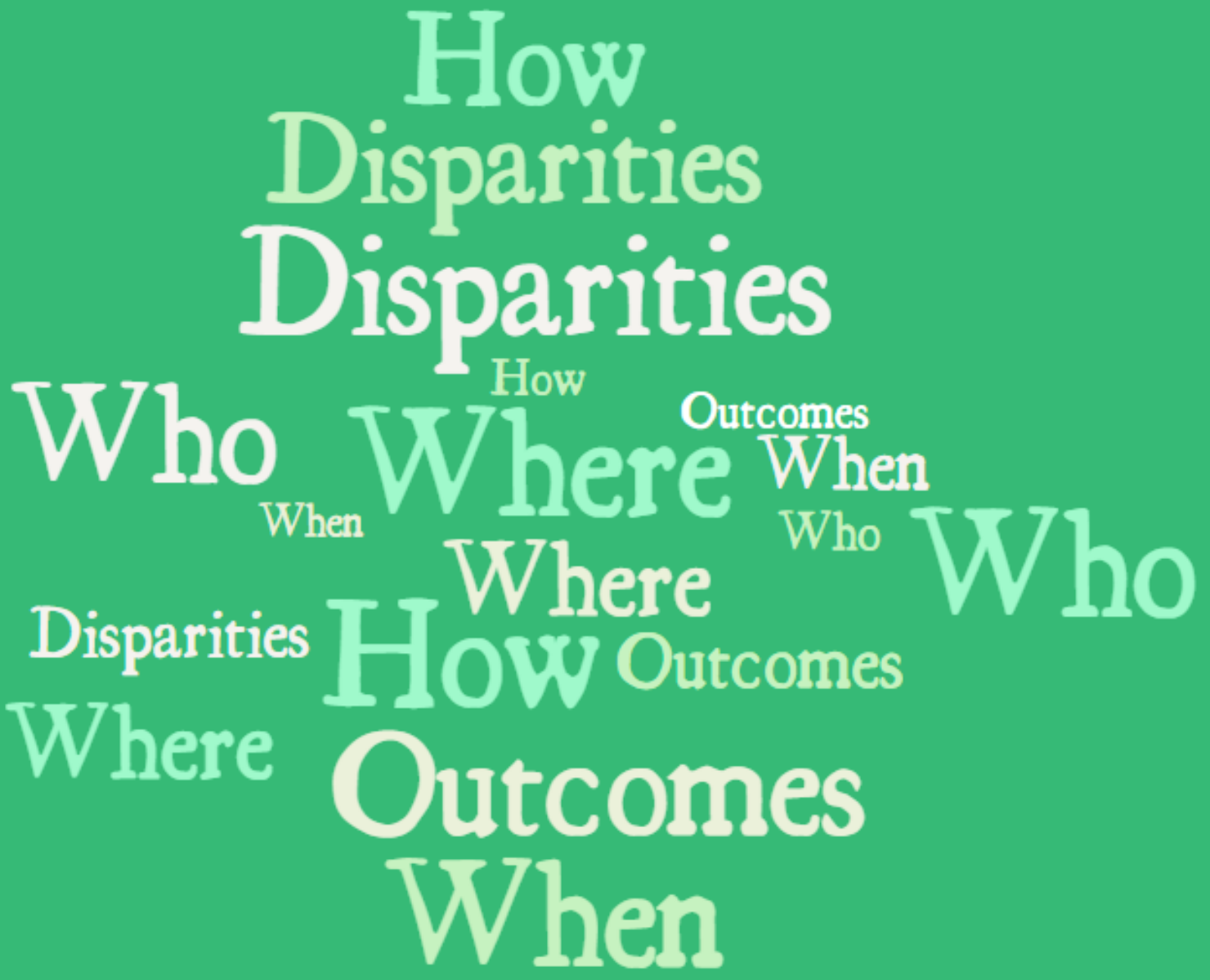
Payers, policymakers, health system leaders, and researchers all want to know



But Getting Answers Isn't So Easy . . .

→ No federal certification for programs

→ No state licensure for programs

→ Not a distinct service for hospital licensure

→ No primary specialty designation

→ No distinct CPT code for palliative care services

→ Patients span thousands of diagnostic codes

What We'll Cover

- ❑ Existing Approaches to Identifying Programs/Specialists
- ❑ Existing Approaches to Identifying Patient Encounters
- ❑ Implications of These Existing Approaches:
  - Research Implications
  - Policy Implications
  - Payment Implications
- ❑ Recommendations

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How specialty palliative care is currently identified: Programs

- No single dataset
- American Hospital Association Annual Survey Database
  - Hospitals only, voluntary, self-report, and averages 80% participation
  - Two questions: palliative care program or palliative care unit
- No national survey for community palliative care programs
- Directories:
  - GetPalliativeCare.org – open to all programs, self-report
  - NHPCO – includes programs that are NHPCO members
  - State-level directories, when available
- Palliative Care Program Certification
  - TJC (hospital [73] and community [77]), ACHC [7], CHAP [53], DNV [4]

How specialty palliative care is currently identified: Clinicians

- No single dataset
- Medicine: *Hospice & Palliative Medicine* is a sub-specialty with board certification
  - ABMS 2021-2022 Report: 7,523 board-certified physicians
- Nursing: certification reports through the Hospice and Palliative Credentialing Center: ACHPN [2,458], CHPLN [453], CHPN [7,469], CHPNA [1,663], CHPPN [222]
- Social Work: certification reports through the Hospice and Palliative Credentialing Center: APHSW-C [809]
- Chaplaincy: two certifications; reports not readily available

Identifying Patient Encounters with the Palliative Care Team

ICD-9	ICD-10
V66.7	Z51.5
Encounter for Palliative Care	

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Validating V66.7 for Specialty Palliative Care Encounters

Feder (2018)

- Sample: 100 heart failure patients in the VA Health System
- Sensitivity: 84.0%; Specificity: 98.0%

Hua (2017)

- Sample: 100,910 patients in one academic medical center
- Sensitivity: 49.9%; Specificity: 99.1%
- Specificity decreased to 75.1% for patients who died in hospital

O'Keefe (2021)

- Sample: 4,670 pediatric ICU patients in one children's hospital
- Sensitivity: 11.0%; Specificity: 99.8%

There is risk of misclassification when using these codes to identify specialty encounters

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"In the ICD-10-CM the term/word "Comfort Care" and "Hospice" are not in the alphabetic index . . . With direction to see code Z51.5 Encounter for Palliative Care in the tabular."

--"Z Codes: Understanding Palliative Care and Related Z Codes" *ICD10monitor* 10/10/2022

Some Hospitals Use Z51.5 to Improve Mortality Reporting

Per J Brian Cassel “Update on Hospital Mortality Measures and Their Implications” CAPC Webinar recorded 2/11/20:

→ Z51.5 is a factor in risk-adjustment for Healthgrades computation of mortality for 16 conditions

→ Z51.5 is a variable in the IBM Watson/Truven “100 Top Hospitals” risk-adjustment process

→ Premier and Vizient include Z51.5 in some risk-adjustment models if present on admission; when present, they carry a ‘large weight’

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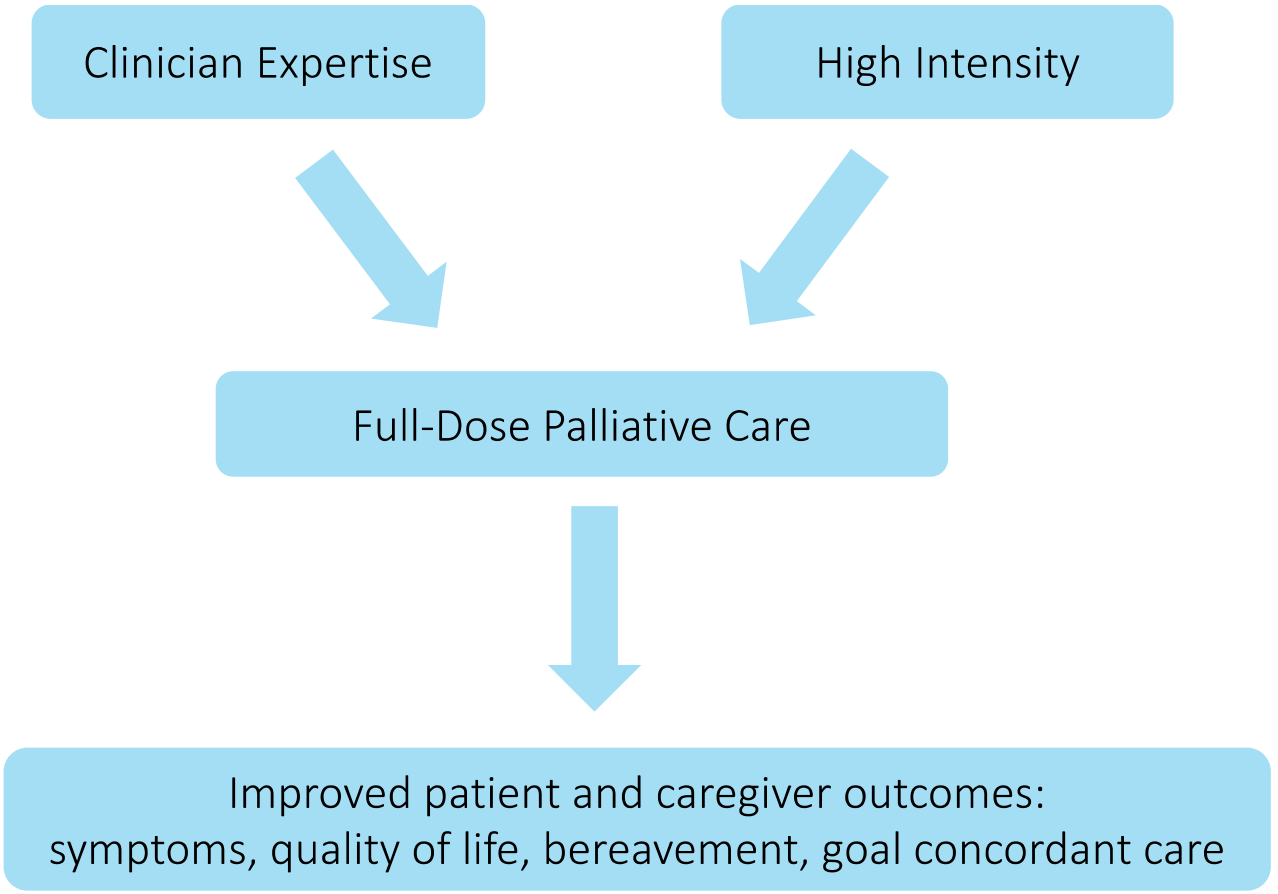
Even when Z51.5 is used correctly, it gives us limited information

- Even when the ICD billing code correctly identifies specialty palliative care consultation, it is **binary** (i.e. did or did not receive palliative care during admission)
- Cannot **quantify the timing or amount of services delivered** (i.e. timing of palliative care consultation in relation to hospital admission, number of visits with physicians and/or advanced practice registered nurses)

Current billing practices mean we don't know who is getting "full-dose" palliative care



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JF

Research Implications: Example

Are there Racial Disparities in Access and/or Use of Palliative Care?

→Mixed findings

- Articles that found Black patients receive less palliative care than White patients
- Articles that found Black patients receive the same palliative care as White patients
- Articles that found Black patients receive more palliative care than White patients

→How are they defining “palliative care”? What methodology are they using?

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Policy Implications – Questions that the Data Isn't Providing

- How many palliative care providers are there in a specific jurisdiction?
- How can we tell whether quality palliative care is being delivered?
- How many patients are receiving palliative care in their jurisdiction?
- What is the shortfall?

Passing and Implementing Policy

Advocating for policies on:

- Workforce
- Payment
- Quality
- Etc.

Why is this information needed?

- Provides impetus to act
- Facilitates implementation
- Enables evaluation

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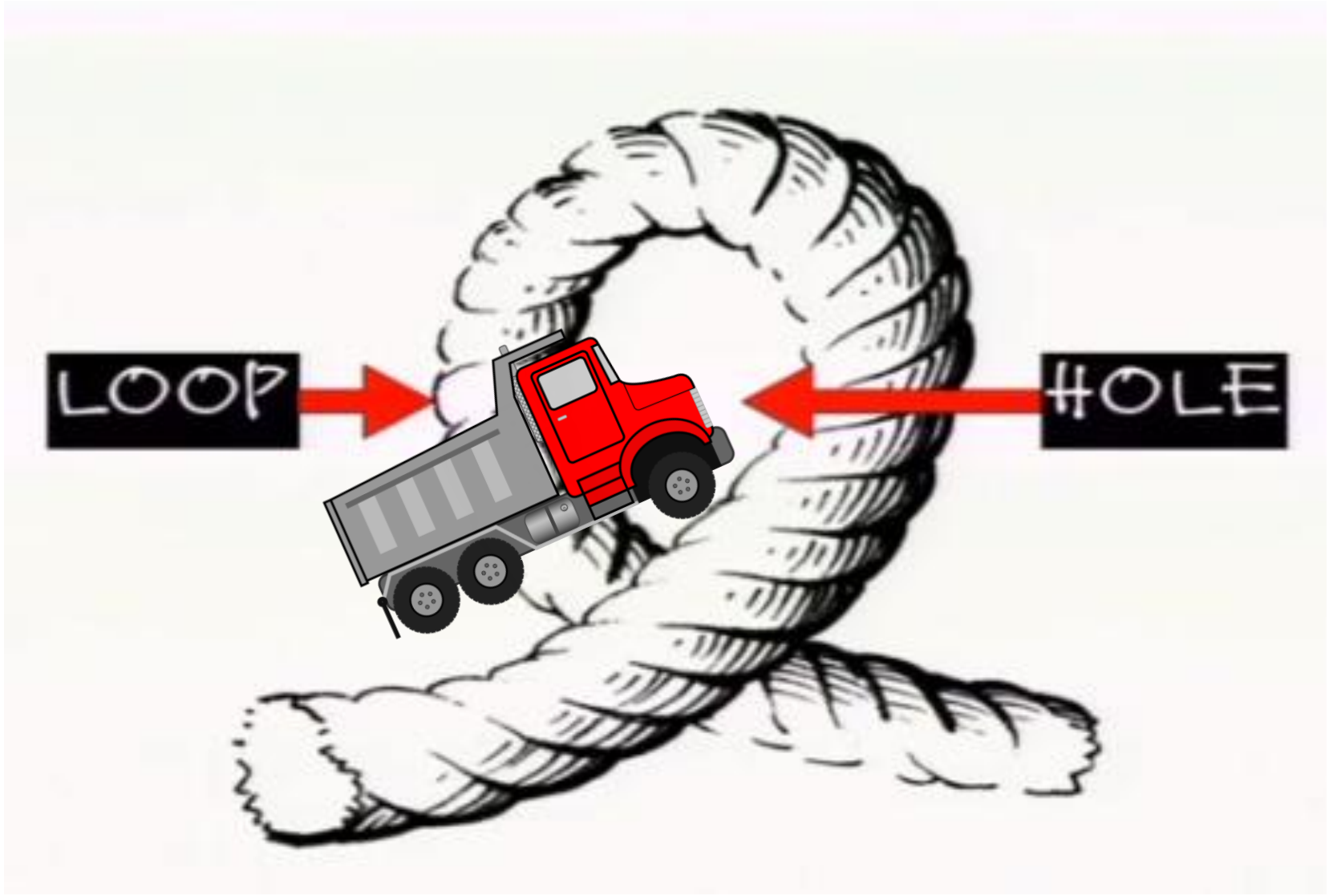
Opioid Prescribing Policy

States such as AZ, HI, or ME specifically exempt palliative care in laws that otherwise restrict opioid prescribing

- Few specify what that means
- Even less information on how that is enforced



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Limited Identification Can Lead to Payment Denials

Pal Care and other clinician see same pt, same day

Both bill for visit, using principal dx

Both credentialed in same primary specialty

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Limitations of Credentialing Systems

- Can only designate ONE primary specialty in the Medicare PECOS system.
- Because Hospice and Palliative Medicine is a SUB-specialty, it is often not selected.
- Private payer credentialing systems may not hold more than one specialty.

Physician Specialty	Code	Physician Specialty	Code
Addiction Medicine	79	Medical Toxicology	C8
Advanced Heart Failure & Transplant Cardiology	C7	Nephrology	39
Allergy/Immunology	3	Neurology	13
Anesthesiology	5	Neuropsychiatry	86
Cardiac Electrophysiology	21	Neurosurgery	14
Cardiac Surgery	78	Nuclear Medicine	36
Cardiology	6	Obstetrics/Gynecology	16
Chiropractic	35	Ophthalmology	18
Colorectal Surgery (formerly Proctology)	28	Optometry	41
Critical Care (Intensivists)	81	Oral Surgery (dentists only)	19
Dentist	C5	Orthopedic Surgery	20
Dermatology	7	Osteopathic Manipulative Medicine	12
Diagnostic Radiology	30	Otolaryngology	4
Emergency Medicine	93	Pain Management	72
Endocrinology	46	Pathology	22
Family Practice	8	Pediatric Medicine	37
Gastroenterology	10	Peripheral Vascular Disease	76
General Practice	1	Physical Medicine and Rehabilitation	25
General Surgery	2	Plastic and Reconstructive Surgery	24
Geriatric Medicine	38	Podiatry	48
Geriatric Psychiatry	27	Preventive Medicine	84
Gynecological/Oncology	98	Psychiatry	26
Hand Surgery	40	Pulmonary Disease	29
Hematology	82	Radiation Oncology	92
Hematology/Oncology	83	Rheumatology	66
Hematopoietic Cell Transplantation & Cellular Therapy	C9	Sleep Medicine	C0
Hospice and Palliative Care	17	Single or Multispecialty Clinic or Group Practice	70

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Other Payment Implications

Organizational Support

- Lost “credit” for RVUs
- Cannot prove impact

Patient Financial Burden

- Cannot waive cost-sharing

Payer Initiatives

- Inpatient incentives impeded
- Network building difficulty

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So what can we do?

Options for Policymakers and Advocates

- → Create a statewide database/directory including NPI numbers
  - → Lots of legwork needed from the field first!
- → Program credentialing requirements to receive payment
- → Standalone licensure for palliative care
  - → Pros and cons, but feasibility is limited

Options for Clinicians

- → Add specialty code 17 in the Medicare PECOS system
- → Clarify with Administration how your revenue/RVUs get reported
- → Discuss credentialing complications/limitations with Health Plan Network Managers
- → When overlapping with other clinical services, use symptom as the primary diagnosis for the visit
- → *Coming Soon*: Register your program with the Getpalliativecare.org Directory

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Options for Researchers

- → Ideally, we need a **new ICD-10** code for palliative care but without incentives for implementation it won't get us the information that we need
- → For now, **electronic medical record data** are our strongest way to understand specialty palliative care consultation; team up with colleagues at other institutions, with different patient populations, to understand patterns of consultation

Thoughts from the Field