

NATIONAL QUALITY FORUM
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RESOURCE USE BONE/JOINT

TECHNICAL ADVISORY PANEL MEETING

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Thursday,
July 7, 2011

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The Technical Advisory Panel met at the National Quality Forum, Suite 600 North, 601 13th Street, N.W., Washington, D.C., at 8:30 a.m., James Weinstein, Chair, presiding.

PRESENT:

JAMES WEINSTEIN, DO, MS, Chair, The Dartmouth
Institute for Health Policy

MARY KAY O'NEILL, MD, MBA, CIGNA HealthCare

ELIZABETH PAXTON, MA, Kaiser Permanente*

JOHN RATLIFF, MD, FACS, Thomas Jefferson
University

CATHERINE ROBERTS, MD, Mayo Clinic

CRAIG RUBIN, MD, University of Texas
Southwestern Medical School

PATRICIA SINNOTT, PT, PhD, MPH, VA Health

Economics Resource Center

NQF STAFF:

TAROON AMIN

HEIDI BOSSLEY, MSN, MBA

LAURALEI DORIAN

SARAH FANTA

ASHLIE WILBON

ALSO PRESENT:

DAN DUNN, PhD*

TODD LEE, PharmD, PhD*

LAWRENCE MANHEIM, PhD*

HOWARD TARKO, MD*

CHERI ZIELINSKI*

*Present via telephone

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P-R-O-C-E-E-D-I-N-G-S

8:41 a.m.

MS. WILBON: So, Operator, we're going to go ahead and get started.

OPERATOR: Okay. You are connected. Go ahead.

MS. WILBON: Okay. So good morning, everyone. We are actually going to go ahead and get started now that we have everything. The technology is all set up.

So welcome, everyone. I know everyone came from near and far and we are excited to finally be able to discuss the bone/joint measures. We are about three-quarters of the way through our TAP meetings. We have got one more meeting in a couple of weeks with the Pulmonary TAP. So we are excited that things have been going well.

And hopefully along the way, we will be able to, based on some of the meetings that we have had already, offer some guidance on how to make things a little bit more

1 efficient as we go.

2 So my name is Ashlie Wilbon. I'm
3 the project manager for this project. And
4 I'll just I guess introduce my staff or let
5 them -- my team, our team. And you guys can
6 introduce yourself.

7 MR. AMIN: Hi, my name is Taroon
8 Amin. I'm the Senior Director supporting this
9 project also. I recently joined NQF from the
10 Brandeis Team working on the episode group or
11 software for the public sector program.

12 MS. DORIAN: Good morning, I'm
13 Lauralei Dorian. I have also recently joined
14 NQF. I've actually come from New Zealand and
15 I'll be working as a project manager on this
16 project.

17 MS. FANTA: Good morning,
18 everyone. I'm Sarah Fanta. I'm project
19 analyst on this project.

20 MS. TURBYVILLE: Good morning.
21 I'm Sally Turbyville and I'm serving as a
22 consultant in helping supporting this effort

1 with the staff.

2 MS. BOSSLEY: Hi, I'm Heidi
3 Bossley. I'm the Vice President of
4 Performance Measures at NQF. And we are
5 thrilled to have you here. Truly appreciate
6 all the work that you have done and what you
7 are going to do today. We know it is not a
8 small amount of work we have asked you to do.

9 So it's very much appreciated.

10 MS. WILBON: So actually, I'm
11 going to throw it back in Heidi's corner. We
12 are going to have you each go around and
13 introduce yourselves to each other and at the
14 same time, Heidi is going to give you
15 instructions on how to -- about the disclosure
16 of interests that we will do before we start
17 evaluating measures. Thank you.

18 MS. BOSSLEY: Okay. So as you all
19 may remember, it was a while ago, but we asked
20 you to fill out Disclosure of Interest Forms.
21 What we are asking you to do today is just
22 orally provide information on anything that

1 may be directly related to the work here.

2 So you don't have to give a list
3 of everything. You don't have to say what
4 every membership that you have, but anything
5 that may be funding that you received or any
6 work related to this project, I would
7 disclose.

8 The other thing I would remind you
9 all as you are sitting as individuals, not
10 representing the organization you work for or
11 who nominated you. It's just a reminder we
12 like to give everyone. You are here to give
13 your expertise.

14 So we will just maybe start around
15 the room and give some introductions as well
16 as any disclosures you may have.

17 DR. RATLIFF: Hi, I'm John
18 Ratliff. I'm a neurosurgical spine surgeon
19 from Thomas Jefferson in Philadelphia. Can
20 you guys hear me okay? I don't have any
21 direct conflict of interest related to
22 outcomes assessment and neither conflicts I

1 stated in instrumentation development and
2 royalty payments for same. And we're glad to
3 be here.

4 DR. O'NEILL: I'm Mary Kay
5 O'Neill. I'm the Chief Medical Officer for
6 CIGNA in the Pacific Northwest. And I'm board
7 certified in PMnR. And I don't have any
8 conflicts.

9 DR. SINNOTT: I'm Patsy Sinnott.
10 I'm from San Francisco. I'm from the VA, the
11 Health Economics Resource Center. I'm a
12 physical therapist originally by training.
13 And my only disclosure would be that when I
14 was at PBGH for two years after my graduate
15 work, I worked with the Ingenix Episode
16 Grouper and the Cave Episode Grouper, so that,
17 you know, I have my experiences with both of
18 those.

19 DR. RUBIN: I'm Craig Rubin. I'm
20 from the University of Texas Southwestern
21 Medical School in Dallas. I'm the chief of
22 the geriatric section and I have no conflicts

1 to report.

2 DR. ROBERTS: Good morning. I'm
3 Catherine Roberts from Mayo Clinic in Arizona.
4 I don't think I have any pertinent conflict of
5 interest, but I do work on -- as a
6 musculoskeletal radiologist. I do work on the
7 appropriateness criteria for the American
8 College of Radiology and also for national
9 quality improvements, metrics for the American
10 College of Radiology.

11 CHAIR WEINSTEIN: Jim Weinstein
12 from Dartmouth. I think my conflicts are
13 probably the Dartmouth Atlas, which works on
14 lots of claims data for Medicare data mostly.
15 I also have several NIH grants related to
16 spine and will probably want to state some of
17 the literature issues that are missing
18 probably biasly because of my own work.

19 So, please, forgive me ahead of
20 time. I also am the editor and chief of
21 Spine, so I have some other literature
22 knowledge. I currently serve as President of

1 the Dartmouth Hitchcock Clinic, a 1,000-
2 physician group. I'm a spine surgeon and I'm
3 the Director of the Dartmouth Institute, which
4 does the Dartmouth Atlas.

5 MS. BOSSLEY: Okay. Anyone on the
6 phone, any Committee Members? Liz Paxton?

7 MS. PAXTON: Hi, Liz Paxton. I'm
8 the Director of our National Implant Registry
9 for Kaiser Permanente and that does include
10 both cardiac and orthopedic and I do not have
11 any conflicts of interest.

12 MS. BOSSLEY: Okay. This is the
13 usual question we ask. Does anyone have any
14 questions for your colleagues or anything you
15 would like to discuss that they have
16 disclosed? That's the typical answer, too.

17 So we are going to -- thank you
18 very much.

19 MS. WILBON: Okay. Great.
20 Thanks. So what we have is just a brief kind
21 of introductory slide presentation for you
22 guys to kind of get everyone on the same foot

1 this morning, go over the criteria and kind of
2 some operational things that we will encounter
3 as we go through the day.

4 So I think everyone has the slide
5 packet in their folders as well, if you want
6 to follow along.

7 So today, essentially through this
8 presentation, we are going to be briefing
9 giving an overview of the consensus
10 development process. You can get an idea of
11 how this meeting and this project kind of fits
12 into that overall process.

13 Obviously, we want to make sure
14 that you have a good understanding of the
15 evaluation criteria. You have already started
16 evaluating the measures that you did before
17 you got here, so I'm assuming you guys already
18 have some understanding of it, but hopefully
19 we can clarify any questions that you had in
20 that process as well, obviously, to evaluate
21 the sub-criteria of the four bone/joint
22 measures.

1 And then throughout the day, at
2 the end of the day, if you have any
3 suggestions on process improvements or, you
4 know, how we might be able to do things better
5 in the future, we do have one more TAP
6 meeting. So to the best of our ability, we
7 are trying to carry forward any, you know,
8 efficiencies and lessons learned along the
9 way. So we are definitely open to that input.

10 So the consensus development
11 process is, approximately, an eight-step
12 process. The two steps that are grayed out
13 have already been completed.

14 We are in the Consensus Standards
15 Review step at this point. Once these TAPs
16 have finished evaluating all the measures, and
17 that input is forwarded to the Steering
18 Committee, staff will put together a draft
19 report that summarizes all the discussions of
20 the TAP and the Steering Committee, all the
21 recommendations that was forwarded to the
22 public and Member comment period.

1 We send those comments back to the
2 Steering Committee and to the TAP, if
3 necessary, to see if there is anything that
4 might impact the measure moving forward or any
5 changes in recommendations.

6 We then put those back out for
7 Member voting and then it goes to our
8 Consensus Standards Approval Committee, which
9 we call the CSAC, which is an oversight body
10 that we have here at NQF that reviews the
11 recommendations. It makes sure that the
12 process that we use for project was followed
13 and so forth.

14 And they will make recommendations
15 or confirm the Committee's recommendations and
16 then the Board will ratify that.

17 So this is just a pictorial of the
18 process here. And, obviously, the technical
19 advisory panels and work groups feed into that
20 Steering Committee review process.

21 So just a brief kind of overview,
22 we -- actually, this project has been going on

1 for two years now. So we started in 2009
2 working with the Steering Committee, of which
3 both Dr. Weinstein and Dr. O'Neill were a part
4 of, in really thinking through, you know, this
5 was our first time evaluating resource use
6 measures, how are we going to define them, how
7 should we evaluate them, what are the
8 important aspects of resource use measures
9 that we should be aware of before we start
10 evaluating them?

11 And this is a definition that we
12 landed on for resource use measures, that they
13 are broadly applicable measures that compare
14 health services counts in terms of units or
15 dollars. They can be applied to a population
16 or event.

17 And those counts of frequency of
18 defined health system resources, some may
19 further apply a dollar amount, amount for
20 charges, paid amounts and so forth for each
21 unit of resource.

22 So keeping that in mind, I'll just

1 kind of go back a little bit about how this
2 project is structured.

3 Again, because it was our first
4 time doing -- reviewing resource use measures,
5 we wanted to kind of break it up and not do it
6 all at once. We ended up with about 36
7 measures to put through this process. And as
8 you can see, they are huge measures.

9 And so we wanted to kind of focus
10 on one condition area, if you will, which we
11 selected the cardiovascular diabetes and non-
12 condition-specific measures. So we have one
13 TAP for cardiovascular and diabetes measures.
14 And the Steering Committee reviewed the non-
15 condition-specific measures.

16 So that Cycle 1 is still ongoing,
17 but it's kind of a parallel process of this
18 now. This bone/joint TAP is actually part of
19 Cycle 2. And so we are expecting that the
20 measures will go -- within the Cycle 2 will be
21 through the process by the first quarter of
22 2012.

1 So this is just a brief time line
2 of each of the steps for Cycle 1 and Cycle 2.
3 And you guys can take a look at that. I'm not
4 -- I won't spend any time on that this
5 morning.

6 The review process that we set up
7 for this project was essentially that, as the
8 measures came in, staff would review them,
9 make sure they were complete. We did a lot of
10 work with the developers up front, although
11 they are still not the perfect submissions, we
12 did try to have conversations with them up
13 front to make sure that they understood what
14 we were asking for and that to the best of
15 their ability, they were providing information
16 that we were asking for before we pass it on
17 to the TAP Members and the Steering Committee.

18 We simultaneously after that would
19 send it to our statistical consultant, who
20 prepared those summaries of the scientific
21 acceptability for you. And he reviewed them
22 and then, obviously, we passed that on to the

1 TAP for review.

2 And as mentioned before, your
3 evaluations and issues that you identify with
4 the measures will be passed onto the Steering
5 Committee for their review and final
6 recommendations for endorsement.

7 So in terms of the role of the
8 TAP, we are looking for you to evaluate the
9 measures against the sub-criteria, and we will
10 talk a little bit more about what that is.
11 But particularly to identify the strengths and
12 weaknesses of the measures. And we are
13 hoping, you know, that you guys are going to
14 focus, obviously, on the scientific
15 acceptability section where all of the
16 clinical construction logic, the -- all that
17 stuff where, obviously, your expertise is
18 needed to kind of make sure that the episode
19 construction, you know, not just the -- you
20 know, your expectations of how clinical course
21 should go.

22 And then that guidance, obviously,

1 is passed on to the Steering Committee. And
2 the composition of the TAPs is very different
3 than the composition of the Steering
4 Committee. Obviously, we have seen the people
5 on the TAPs with very specific clinical
6 expertise that aligned with the type of
7 measures that we received.

8 The Steering Committee is composed
9 of a little bit broader expertise. Obviously,
10 there are some physicians on the TAP or on the
11 Steering Committee, as are seated here. But
12 they tend to be more kind of maybe policy or
13 higher -- a little bit further removed
14 sometimes from the clinical level. So we
15 wanted to make sure that we had the specific
16 clinical expertise as well as the
17 methodologists on the TAP to provide that
18 specific expertise to the Committee.

19 So what we are going to do today
20 is a very systematic review of the evaluation
21 criteria. We will move through each of the
22 criteria in order sequentially from importance

1 all the way down through feasibility.

2 And again, we will be looking at
3 how well the information that the developer
4 submitted meets the criteria that are outlined
5 in the table that we will refer to. We will
6 be asking you to rate the sub-criteria on a
7 scale of high, medium or low or insufficient.
8 And we will talk a little bit more about how
9 the voting tool is used, but each of you
10 should have a little black remote that we will
11 be using to capture your votes and they will
12 show up on that screen up there as we go
13 through the day.

14 And we can decide along the way,
15 but we can -- what we have been doing is kind
16 of talking through all the sub-criteria for
17 importance and then voting on each one and
18 then go through scientific acceptability and
19 then vote or sometimes if we vote on a couple
20 from scientific acceptability, discuss, go
21 back and vote, discuss.

22 So we can kind of see how that

1 goes, but, essentially, we will be voting
2 along the way.

3 The ratings that you submitted on-
4 line are really just preliminary ratings. We
5 expect that when you get here and you hear
6 your colleagues discuss some of the same
7 things, that you may change -- want to change
8 some of your ratings. So what we capture here
9 are your final ratings that will be submitted
10 to the Steering Committee.

11 So don't feel bad if you feel like
12 you rated it one way and you want to change
13 your rating; that's okay. We expected that
14 will happen along the way.

15 So to just talk a little bit more
16 about the sub-criteria. So again, we talked
17 about how we will be rating those
18 sequentially. And as you probably are already
19 familiar with, we have four major criteria:
20 importance to measure or report; scientific
21 acceptability of measure properties; is the
22 measure usable and is it feasible.

1 So for importance to measure or
2 report, we are really talking about the focus
3 area of the measure. So not whether or not
4 the measure itself, the way it is constructed,
5 is important, but is the topic area that they
6 have chosen important? And is the information
7 they submitted, does it support that it is
8 important, that focus area is important?

9 What we found in the other
10 committees and TAPs is that because this
11 project is so focused and we chose the
12 conditions, that everything is pretty much
13 going to be important.

14 So what we are going to do is have
15 Dr. Weinstein lead the group through that
16 discussion to try to keep it as brief as
17 possible. We expect that the discussion for
18 scientific acceptability will be where the
19 bulk of the, you know, discussion will be, so
20 we don't -- we want to try to use our time
21 wisely and not kind of belabor an issue that
22 is going to end up being important anyway.

1 So, again, the scientific
2 acceptability is where we address the
3 reliability and validity of the measure. And
4 the usability criteria looks at whether or not
5 the measure and the results of the measure are
6 usable for the intended audiences. We will
7 talk a little bit more about that.

8 And then we will also -- the last
9 criteria is feasibility. And that looks at
10 whether or not there is any sufficient burden
11 on implementing the measure for any measure
12 users.

13 So importance to measure report,
14 I'm not going to spend a lot of time on these.
15 We will actually go through them as we are
16 evaluating the measure. We can address any
17 questions that you have there. But it looks
18 at whether or not it's a high-impact area that
19 they have selected; whether or not the purpose
20 and objective of the measure is clear; and
21 whether or not the resource units and service
22 categories that they have selected to measure

1 make sense based on the focus area that they
2 have chosen to measure.

3 Scientific acceptability, again,
4 looks at reliability, whether or not the
5 testing -- the information they submitted on
6 testing the measure demonstrates that the
7 measure can be implemented consistently across
8 different systems or users; that it is valid
9 and credible that you are actually measuring
10 what you say you are measuring.

11 And then the last kind of dangling
12 sub-criteria for scientific acceptability is
13 about disparities and that has come up across
14 all the TAPs and with the Steering Committee
15 as well. And I think there will probably be
16 a separate discussion here as well about that.
17 And I think what we found so far is that they
18 are important.

19 Disparities are important, but
20 that there are some limitations with
21 administrative data in capturing that a lot of
22 times. And so I think the TAP -- for each TAP

1 and committee, they have just been weighing
2 the importance of that based on the type of
3 measure and the condition that it is and how
4 well the developer has demonstrated the
5 ability to do that with the measure as it is
6 constructed.

7 Okay. So particularly with the
8 reliability and validity, we had a task force
9 that was done, I think, last year that looked
10 at evaluating reliability and validity. And
11 they came up with some guidance, particularly
12 for TAPs and Steering Committee, so that the
13 evaluation of the reliability and validity
14 across these groups is consistent.

15 And so as you are rating these
16 sub-criteria, we just kind of want to give you
17 an idea of what a high would sound like, what
18 a medium would sound like and what a low would
19 sound like.

20 So for a high rating for
21 reliability and validity, you would tend to
22 think in your review that all the measure

1 specifications are unambiguous and likely to
2 consistently identify who is included and
3 excluded from the target population; that the
4 resources -- and the resources and costs being
5 measured and how to complete the score is
6 clear and unambiguous; that the empirical
7 evidence that they have submitted about the
8 reliability and validity of data elements and
9 with the measure score is consistent; and that
10 they have -- the appropriate method and scope
11 of reliability and the statistics are within
12 acceptable norms.

13 For validity, much the same thing,
14 that you will be -- that the measure
15 specifications are consistent with the intent
16 described and importance to measure. Again,
17 that the evidence of the validity for data
18 elements in the score are unambiguous.

19 So they are very much the same for
20 the reliability and validity for the high
21 score.

22 For a moderate score, for

1 reliability, you would think that all the
2 measure specifications are unambiguous as
3 noted and that the empirical evidence is
4 within acceptable norms. So not quite
5 perfect. Maybe some improvements, but it
6 could be workable.

7 With the validity, a moderate
8 rating, again, the measure specifications
9 reflect the intent cited in importance to
10 measure; that the empirical evidence of
11 validity is within acceptable norms and that
12 there has been a systematic assessment of face
13 validity, which is the minimum threshold that
14 we have four demonstrating validity for a
15 measure score of the measure.

16 And that the scores obtained from
17 the measure, as specified, will provide an
18 accurate reflection of cost and resource use
19 being used to distinguish high and low
20 resource use.

21 For a low score, there is one or
22 more specifications that are ambiguous with

1 the potential for confusion on identifying who
2 is included and excluded from the target
3 population or that the empirical evidence that
4 they have submitted on reliability is not --
5 is unreliable or the data elements or measure
6 score are outside the acceptable norms.

7 For validity, again, the measure
8 specifications do not reflect the evidence or
9 do not support the intent of the measure; that
10 the empirical evidence is not -- did not use
11 the appropriate method or scope.

12 So again, with the low rating, you
13 are not so -- you are not comfortable that, as
14 constructed, the measure would be able to be
15 repeatable or valid.

16 And insufficient evidence, the way
17 that other TAPs and Steering Committees have
18 been rating it is that based on the
19 information they have submitted, you don't
20 feel like that you could come to a conclusion
21 on any one of those. So maybe there is a, I
22 don't know, statistical score or something

1 missing that you feel like you would need that
2 in order to determine whether or not the
3 measure was reliable or valid.

4 So briefly, this is, again, kind
5 of going back to some of what was discussed
6 with the Steering Committee last year. And we
7 broke up the construction of the resource use
8 measures into five modules to accommodate not
9 only our submission form, which you kind of
10 got an export of, which is what we sent you,
11 an evaluation form, but so that we could kind
12 of better breakup the evaluation of the
13 resource use measure to ensure that everything
14 that we needed to evaluate was there.

15 And what we ended up with was five
16 modules:

17 One for data protocol, which can
18 be submitted as guidelines or specifications,
19 which looks at the beginning stuff like data
20 cleaning or aggregating the data necessary to
21 implement the measures.

22 The clinical logic, which is

1 obviously what we are going to be looking for
2 you guys to focus on.

3 The construction logic, which
4 looks at, you know, triggering mechanisms, how
5 they eliminate redundancy and overlap.

6 Adjustments for comparability,
7 which is where the risk adjustment and any
8 stratification methods will be addressed.

9 And then the reporting guidelines,
10 which is where the reporting module, which can
11 be submitted as guidelines or specifications,
12 which would be where they would address
13 attribution rules, benchmarking, how peer
14 groups are defined and so forth.

15 So I'm going to kind of skip
16 through this a little bit. And we have been
17 through these. I'm going to just kind of --

18 CHAIR WEINSTEIN: Great.

19 MS. WILBON: Okay. Sorry. We had
20 a brief discussion yesterday about this
21 particular criteria and what public reporting
22 really means. And I think it was more so

1 around the public reporting, right?

2 So we did want to provide a little
3 bit of additional guidance on that, because I
4 think that's something that a lot of our TAPs
5 and Steering Committee have been struggling
6 with. And it's also something that NQF, as an
7 organization, has been discussing internally
8 and how best to define this and make it
9 clearer.

10 So, Heidi, I'm going to be looking
11 to you periodically for your clarification
12 here.

13 These -- the ability criteria has
14 three sub-criteria. The first one focuses on
15 whether or not the results are reported to the
16 public at-large and particularly for the ABMS
17 measures, because they are new measures and
18 they haven't been in use, this becomes a
19 little bit more of an issue.

20 We don't require that measure
21 developers that submit measures to the project
22 that they have been in use, but we do ask them

1 to demonstrate or describe how it would be in
2 use or what their plans are for getting it out
3 there or how they intend it to be used.

4 In terms of identifying the
5 public, we do define that as the public at-
6 large. Correct, Heidi?

7 MS. BOSSLEY: Yes.

8 MS. WILBON: And particularly for,
9 I think, other measure developers like
10 Ingenix, for instance, where they have other
11 entities using their measures, it's not always
12 clear exactly how other people are using their
13 measures or how it is being reported. So I
14 think it comes down to, you know, weighing how
15 the information that has been submitted by the
16 developer and whether or not you feel that
17 that is sufficient, based on your scores.

18 MR. AMIN: Actually, I would just
19 add something to that.

20 MS. WILBON: Sure.

21 MR. AMIN: Considering that
22 resource use measures are sort of new, keeping

1 this criteria in mind that we really want to
2 have the measure be -- whether it is
3 meaningful and understandable to the -- to an
4 observer evaluating this, you know, the
5 outcome of the score of the measure.

6 And the process, the NQF process
7 will be, after three years when it goes under
8 maintenance, this specific criteria, expected
9 -- there will be an expectation that there
10 would be more provided on how the actual
11 measure has been used over the three years.

12 So keep it in mind that although
13 it is clearly a very important criteria, this
14 is the first time that we are going through
15 resource use measures. So, you know, as a
16 building block to measuring efficiency, we may
17 -- you know, they may not have had the
18 opportunity to have it be published at the --
19 for the public at-large.

20 MS. WILBON: Sure.

21 CHAIR WEINSTEIN: Can I comment
22 just for a second?

1 MS. WILBON: Sure, yes.

2 CHAIR WEINSTEIN: I'm sorry, did
3 you want to say something?

4 DR. SINNOTT: No, go ahead and
5 I'll go next.

6 CHAIR WEINSTEIN: It's just I
7 think these measures are fairly complicated,
8 even for me, let alone the average provider,
9 let alone the public, so, I mean, there is a
10 huge bunch of steps that have to occur here to
11 make these decision tools, which I consider
12 these potentially for patients at some point,
13 to understand cross-benefit resource
14 utilization around their treatment options.

15 So I would hope that NQF will have
16 a process by which this gets decoded into
17 something that is understandable.

18 I go through this every day with--
19 not every day, every week with our physicians
20 on new episodes of groupers and trying for
21 them to understand most have no idea what it
22 costs to deliver the care they are delivering

1 today, let alone what an episode is.

2 MS. WILBON: Yes. Thank you.

3 DR. SINNOTT: So all that just
4 brings up the kind of basic question for me
5 and that is are we talking about the grouping
6 function or the physician's scoring function
7 when we are evaluating this?

8 Because we seem to be moving back
9 and forth between that terminology. And when
10 you talk about score, I'm not sure what the
11 score is from or for. Is it a score of
12 physician performance, resource utilization or
13 is it a score on something else about the
14 episode grouping function?

15 MS. WILBON: So, Taroon, you can
16 clarify, if you need to. The grouping
17 function is a part of the construction of the
18 measure and what would actually be reported
19 out of the measure as -- for the public would
20 be that score. So whether or not it is an O
21 to E ratio for physician, you know, costs, so
22 if it is that's like a one --

1 DR. SINNOTT: It's a score of a
2 physician activity.

3 MS. WILBON: It depends on the
4 measure. There -- depending on how the
5 measure is, I was using that as an example.
6 There are some measures that are specified for
7 a level of analysis of physician. There are
8 some that are at health level. There are some
9 at the director regional level.

10 DR. SINNOTT: Right. Okay.

11 MS. WILBON: So whatever that
12 level of analysis is, you -- for most of these
13 measures, you will end up with a score. Maybe
14 it's a ratio. In some of them, it may be a
15 dollar amount. But whatever that end result
16 is is what would be reported.

17 DR. SINNOTT: So when we are
18 looking at validity and reliability, we are
19 looking at the validity of the episode
20 grouping function as well as the validity of
21 the scoring function or not?

22 MS. WILBON: I would say both.

1 DR. SINNOTT: Okay.

2 MS. WILBON: Because the logic
3 behind the grouping function is about how the
4 measure is constructed and whether or not that
5 is a valid approach is what we are asking you
6 to evaluate.

7 DR. SINNOTT: But you are not
8 asking us then to evaluate how the episode --
9 Dr. X has 45 episodes. And there are
10 mechanisms in the resource use compilation
11 into a doctor's bundle of activities that then
12 that score to give a physician a score --

13 MS. WILBON: Yes.

14 DR. SINNOTT: -- so they are two
15 different things. Number one, are the
16 episodes valid in their construction?

17 MS. WILBON: Yes.

18 DR. SINNOTT: And number two, is
19 the analysis that goes into the OE or whatever
20 it is --

21 MS. WILBON: Yes.

22 DR. SINNOTT: -- appropriate?

1 MS. WILBON: Right. You will be
2 looking at both of those.

3 DR. SINNOTT: Okay.

4 MS. WILBON: Yes.

5 DR. SINNOTT: I just wanted to
6 clarify that.

7 MS. WILBON: Yes, thank you very
8 much. Those are on the table now.

9 CHAIR WEINSTEIN: But you are
10 going to get -- this methodology is going to
11 get us into trouble when we get down to a
12 doctor who has a small end from any kind of --

13 DR. SINNOTT: Oh, I understand.
14 Believe me, I understand.

15 CHAIR WEINSTEIN: Yes.

16 DR. SINNOTT: I spent two years at
17 PBGH trying to instruct, help, provide the
18 information to doctors.

19 CHAIR WEINSTEIN: Yes, yes.

20 DR. RATLIFF: I'll bring up one
21 point that I wanted to bring up with each of
22 these measures. The costs that we are talking

1 about are not really costs. They are like
2 healthcare costs. They are like how much
3 money the hospital is spending. How much
4 healthcare resources are being expended in
5 this treatment.

6 We don't talk about loss of work
7 or time out of work. We don't talk about
8 other societal expenditures in these measures.
9 So when you are talking about physician costs,
10 it's direct healthcare expenditures or related
11 to what resources acquisition is expending, it
12 seems.

13 MS. O'NEILL: Well --

14 DR. RATLIFF: Because I have
15 looked at --

16 MS. WILBON: The charges.

17 MS. O'NEILL: Not the charges, no.
18 Unless it is -- unless I missed it and it was
19 completely different from what we have already
20 discussed. There -- every measure except one
21 was based really on account of services that
22 was translated into a standard price.

1 And so it isn't true costs. It's
2 just --

3 CHAIR WEINSTEIN: Resources.

4 MS. O'NEILL: -- it's a resource
5 use. So, I mean, the health partners try to
6 put that forward for one of their measures to
7 actually allow people to understand that if
8 you went here, it would cost you this much,
9 actual dollars. So we do have -- I personally
10 have a concern that we are putting a standard
11 price out and -- by usability criteria, that
12 people will not be able to interpret what that
13 means outside of people that do this kind of
14 work.

15 But there is no, you know, time
16 loss productivity. I mean, there -- none that
17 --

18 DR. RATLIFF: Not the real capture
19 of societal costs.

20 MS. O'NEILL: No.

21 DR. RATLIFF: Or societal
22 expenditure in each of these measures. And

1 going to your point, we are using a cost
2 basis. Like, essentially, standardizing
3 costs. So you come up with a number that we
4 can work with.

5 MS. O'NEILL: Well --

6 DR. RATLIFF: But then we are
7 going to have based like a physician score on
8 that that is going to be reported to the
9 public, that everybody is going to see, so
10 they can see how efficient their physician is.

11 I mean, I think going back to the
12 point that you are moving around, like that to
13 me is dangerous. And then it becomes very
14 pejorative in terms of how these outcome
15 measures may be used five years of now to
16 grade "physician efficiency."

17 CHAIR WEINSTEIN: Let me just help
18 out. I think we are all having trouble
19 grappling with some of the methodology by
20 which -- and then advancing ourselves to the
21 point of somebody using this in some way to
22 determine the efficacy or efficiency of a

1 system, at some point.

2 And I think what you know from
3 reading this stuff and from the Ingenix work,
4 they have actually used this in some
5 organizations to try to help physicians
6 understand their resource use compared to
7 their colleagues for certain diagnostic
8 categories.

9 And it seems to have been helpful
10 in those cases. For example, I know the
11 Sutter system has done some of that in
12 California. The point -- and I think most of
13 the people who do this work, this methodology
14 is not that uncommon using the BETOS system
15 from CMS and other methodologies for looking
16 at this resource use.

17 The problem is most people are
18 worried that just like outcome measures, you
19 know, or any of the standard measures that CMS
20 is putting in place, process measures, you
21 know, which are probably the most accepted,
22 did you get a hemoglobin A1c? Okay. I did

1 that. I got it.

2 But when you start to then look at
3 my outcomes compared to my other colleagues'
4 outcomes, well, my patients are always
5 different. And these things try to adjust, as
6 you know, for the various difference in
7 patients. But getting the sort of clear
8 populations that physicians and/or the public
9 will understand is very complicated.

10 And we were talking before we
11 started, you know, I have been working on this
12 for a long time, as all of you have, this does
13 not get simple that people are willing to
14 accept. I think we have to accept that for
15 today. Try to do the process of grading these
16 measures.

17 As good or bad as the grades come
18 up, we just say what we think. But I think
19 this is a long way from acceptability at the
20 physician/patient level, because the people
21 who work on these things in finance and
22 working on the groupers.

1 What Ingenix, you know, owned by
2 United Healthcare, is doing now is a business
3 strategy. They want to figure out how to
4 manage cost as the Federal Government does
5 around efficiency.

6 So this is an exercise to sort of
7 move towards that. Let's not hide that. On
8 the other hand, you know, let's point out some
9 of the issues that we have, that's our job.

10 But let's try to get through the
11 process today and point out the shortcomings
12 that we have and then we will have done our
13 job.

14 MS. WILBON: Thank you. So I
15 think Taroon alluded to this, but I just want
16 to kind of piggyback on what he said, again,
17 the resource use we recognize that this
18 resource -- you know, evaluating resource use
19 measures is not the whole picture. That we
20 are kind of framing this in the context that
21 one day they will be, hopefully soon, working
22 towards bundling them with efficiency measures

1 or trying to figure out -- I'm sorry, with
2 quality measures to try to figure out how to
3 get a better picture of value and
4 efficiencies.

5 So we are looking at this as a
6 step in a multi-step process, but in order to
7 bundle them, we have to kind of make sure that
8 this building block of that bundle is valid
9 and reliable. So that's kind of -- that's our
10 approach to this point. Realizing that it's
11 not there yet, but it's a first step in a
12 process.

13 And this is just a pictorial of
14 the spectrum of accountability and
15 transparency and kind of how public reporting
16 fits along that spectrum.

17 And this is just a brief slide.
18 NQF has done some work in the past around
19 efficiency measurement. And they established
20 some definitions of quality of care, cost of
21 care and efficiency and they defined
22 efficiency of care as a measure of cost of c

1 are associated with the specified level of
2 quality of care.

3 And that the value of care, as a
4 measure of specified stakeholders preference,
5 we did assessments of a particular combination
6 of quality and cost of care performance.

7 So that said, this is kind of in
8 the realm of where we are going. We recognize
9 that again, this will be in the context of
10 quality at some point in the future.

11 Feasibility is one of those
12 criteria. Hopefully that will go relatively
13 quickly. For 4A and 4B, we have --

14 CHAIR WEINSTEIN: Could you go
15 back to the slide you skipped?

16 MS. WILBON: Sure. Sure.

17 CHAIR WEINSTEIN: I mean, really
18 what this -- this is other work done by NQF
19 earlier on as well. There is kind of phases
20 of care and I'm not sure all of our group for
21 the TAP, this bone and joint one fit into
22 everything so neatly.

1 But the fact of the matter is
2 there is a population of patients that have
3 some series of diagnostics or diseases. There
4 is a process by which, you know, you want to
5 understand that the patient actually knows
6 what is wrong with them, so that valid.

7 That there is going to be an
8 intervention where the patient has a choice,
9 another methodology that would get into
10 preferences here, which isn't included in much
11 of this work, but is another effort that
12 people are trying to get into, preference-
13 based decisions around elective kind of
14 things, not emergency things.

15 That there is some measure of
16 value with quality or cost in some way that
17 people find acceptable. And so part of the
18 denominator issue that we are working on now
19 is this real cost issue and how you measure
20 that in a way that would be acceptable as part
21 of the value equation. And really, that sort
22 of gets to what we need to get to in

1 healthcare and we could argue that that's
2 right or wrong.

3 But I think what we all would
4 agree to is if we could understand what the
5 value is, quality or cost, in using some
6 specified measures, then we could understand
7 how we are going to pay for things, based on
8 that method.

9 And when you get into some of the
10 conditions we are talking about today, they
11 are pretty much preference kind of decisions.
12 They are elective for the most part for a back
13 operation. A hip fracture is not.

14 And there is not a problem with
15 hip fractures because everybody has them
16 fixed. There is not a lot of choice. You
17 know, 96 percent of people have them fixed.
18 And the 4 percent who don't is because they
19 are too sick to go to the operating room.

20 But the 30 -- and there is a one
21 year 30 percent mortality. So it's a problem.
22 When you get into hips and back, those become

1 a lot different. So how do you actually
2 understand the value of that?

3 If you understand the numerator/
4 denominator and if a patient was given good
5 information and had a preference, you would
6 probably get to this episode kind of thought
7 process. And that's where we are sort of
8 thinking big picture. We are just taking a
9 piece of this in the denominator and trying to
10 get to the cost piece now.

11 MS. WILBON: Thank you. So the
12 feasibility criteria is the last criteria.
13 There is four sub-criteria. The first two we
14 found tend to go pretty quickly. Most of
15 these measures, I think, from both the
16 developers today, are focused on admin claims
17 data, so both of which you could say admin
18 claims data is routinely generated during care
19 and that they are available electronically.
20 So for the most part, those tend to go pretty
21 quickly.

22 4C and 4D, obviously, will render

1 a little bit more discussion, but just a brief
2 overview of those. So transitioning now into
3 a little bit more operational things, I'm
4 going to hand it over very shortly to Dr.
5 Weinstein, so you guys can get started.

6 We will open it up for public
7 comment briefly, before we get started. And
8 then hopefully the measure developers will be
9 on the phone. We will ask them to briefly
10 introduce each measure before you start
11 discussing them, to kind of get you in the
12 mindset and kind of explain what the intent of
13 the measure is and so forth.

14 They will also be available to
15 respond to any questions that you have during
16 your discussion of the measure.

17 And then once you, obviously, have
18 heard what you need to from the developer,
19 then the TAP will go into their evaluation of
20 the measures.

21 So each of the TAP Members are
22 assigned, I think, one or two measures for in

1 depth review and then we have actually broken
2 up the criteria even more. So when we get to
3 those criteria, we will just ask that you, you
4 know, identify any issues that you did, maybe
5 refer to some of the other evaluations that
6 were submitted before here and kind of
7 summarize and recap and identify any issues
8 that you think should be addressed by the
9 entire TAP for discussion.

10 Again, we will have Dr. Weinstein
11 kind of lead us through a brief discussion of
12 the importance and 4A and 4B, which should go
13 relatively quickly. And those are the measure
14 assignments.

15 So for the electronic voting, so,
16 again, everyone will -- has a little remote.
17 We will decide -- we will prompt you at which
18 point we should be using them. But for most
19 of the measures, you will be -- all of them
20 you will be rating on a scale of high, medium
21 or low or insufficient. High is 1, low is --
22 these are all yes/no, but high is 1, low --

1 moderate is 2 and low is 3 and insufficient is
2 4.

3 And we also have a handout in your
4 folder that gives you a little bit more
5 instructions on what to do if you want to
6 rescind, if you mess up, and you want to send
7 a different score.

8 And as you vote, they will show up
9 in real-time on the screen, so you can kind of
10 see the distribution of how people rated it.

11 And what we have done for the past
12 meetings, and Dr. Weinstein can talk a little
13 bit about how he would like to do this, if you
14 get like all highs and one low, particularly
15 if it's not quite in alignment with how the
16 discussion has gone, that we will kind of ask,
17 hopefully not to call anybody out, but just
18 ask you to kind of explain for our notes and
19 for the developer, so they can kind of have an
20 idea of how the ratings have been -- are
21 justified essentially.

22 After the meeting -- well, first,

1 let me just say we are expecting that we are
2 going to get through all the measures today.
3 So we are hoping and crossing our fingers
4 anticipating that there won't need to be any
5 follow-up necessarily with this particular
6 group. But there may be, you know, an email
7 or two with follow-up from the developers, if
8 you need additional information.

9 But we are very hopeful that we
10 will get done today. So other groups have
11 gotten through, I think, up to like six
12 measures in a day, so --

13 CHAIR WEINSTEIN: This isn't a
14 challenge, is it?

15 MS. WILBON: No. Not a challenge.
16 It is somewhat of a challenge. I'll say that.

17 So we are -- we have a lot of
18 confidence in you that you will be able to get
19 through all of these in one day. So --

20 CHAIR WEINSTEIN: We have got a
21 couple surgeons here, we're going to get it
22 done.

1 MS. WILBON: Yes, all right. All
2 right. If needed, we will schedule any -- we
3 will schedule a follow-up call or two, but we
4 are hoping not to have to do that. There will
5 probably be some emails after, but so you've
6 got your work cut out for you, we realize, but
7 I think you guys can do it.

8 So that's the end of the
9 presentation. Do you guys have any questions?

10 CHAIR WEINSTEIN: Just make sure
11 you bring us through everything in the right
12 order.

13 MS. WILBON: Oh, absolutely. I do
14 want to refer everyone to this table that is
15 in your folder that I think everyone has that,
16 at this point. We will, essentially, be
17 following this for each of the measures, kind
18 of sequentially in order for the sub-criteria
19 on the left side of that column.

20 So that will be pretty much your
21 primary guide for the day. So that said, I'm
22 going to go ahead and hand it over to Dr.

1 Weinstein to get started on the first measure.

2 And can I just --

3 CHAIR WEINSTEIN: What's the first
4 measure?

5 MS. WILBON: The first measure is
6 1586.

7 MS. BOSSLEY: Radiculopathy.

8 CHAIR WEINSTEIN: Oh, good. Okay.

9 MS. WILBON: And that's an ABMS-
10 REF measure. Robin, are you there on the
11 phone?

12 DR. MANHEIM: Larry Manheim. I'm
13 here. Robin might be on the phone, but --

14 MS. WILBON: Oh, okay. Great.
15 Great. Can we just -- I'm going to hand it
16 over to Dr. Weinstein, but can we just have
17 you start off with a brief introduction to the
18 TAP for this measure?

19 DR. MANHEIM: Right. I'll be very
20 brief.

21 MS. WILBON: Okay.

22 DR. MANHEIM: This measure

1 measures resource use and cost associated with
2 the management of an episode of care for
3 acute, subacute lumbar radiculopathy with or
4 without lower back pain.

5 I would note there is another
6 measure being considered, which is unspecified
7 lower back pain measure. And, basically, this
8 distinguishes from that in terms of severity,
9 because the work groups we used thought there
10 was a difference in severity that was
11 important and required separate measures.

12 The episode for this is triggered
13 by an initial ambulatory care visit for
14 radiculopathy, which is defined by ICD-9 Codes
15 and it lasts -- in other words, the episode
16 lasts for three months following the initial
17 visit, plus we pull in non-E&M costs related
18 with diagnoses related to radiculopathy for 14
19 days prior to the trigger visit, because it
20 was felt that there may be orders done before
21 that were done over the phone before the
22 patient came in.

1 So it's a three month period, plus
2 the 14 days prior to the initial visit. And
3 people who had a radiculopathy diagnosis in
4 six months prior to the initial visit are
5 excluded from the diagnosis. There is a bunch
6 of other exclusion criteria.

7 The age groups are 18 to 64,
8 that's the age group considered in the
9 measure. And people -- I'll just note that
10 people are assigned to a physician, based on
11 them having -- they are assigned to only one
12 physician if 70 percent of their E&M visits
13 were -- at least 70 percent were to one
14 physician.

15 Otherwise, all physicians with
16 more than 30 percent of the E&M visits during
17 the episode receive assignment, so you could
18 have multiple assignments if two physicians
19 had more than 30 visits -- 30 percent of the
20 E&M visits.

21 If no physician had at least 30
22 percent of the E&M visits to them, then it's

1 not a sign to any physician.

2 The only other thing I would
3 mention is we include chiropractic and
4 physical therapy care in those providers and
5 we adjust BETOS Codes accordingly to make sure
6 they are included.

7 I'll stop there.

8 CHAIR WEINSTEIN: Yes, thanks.

9 This is Jim Weinstein. I'm going to just get
10 us started on this. And I'm going to take the
11 prerogative of questioning the inclusion
12 criteria right away.

13 When you use ICD-9 Codes and when
14 you get in to your chiropractic and other
15 things and you look at the actual use in some
16 of your tables of the most commonly used
17 treatments, you know, you wonder if the
18 diagnoses are actually correct.

19 And I guess I have raised this a
20 little before the meeting, but I think this
21 undermines the whole process. And I only want
22 to have it clarified for the group, because I

1 think it's an issue in this particular
2 diagnosis where, from my own work and again,
3 I mentioned my conflict, the Sport Trial.

4 We know that the surgery actually
5 works for the right patients, better than non-
6 surgery, although not all patients certainly
7 need to have surgery. 30 percent of our
8 patients didn't and are quite happy even
9 though they didn't do as well.

10 But I feel like when you include
11 chiropractic, physical therapy and all these
12 large numbers using that ICD-9 Code without
13 any physical findings, confirmatory MRR, et
14 cetera, you are including way too many people
15 in this diagnostic code, which then starts to
16 undermine the validity of the model.

17 And so that's a very core issue
18 for me before we even move forward into the
19 model. And I applaud you on the excellent
20 work. I know how hard this is, so I'm not
21 criticizing you or anybody else personally.

22 But I am criticizing the inability

1 of a data system to actually group patients in
2 large cohorts in this particular diagnosis
3 when, in fact, you show that the payment is
4 better for this diagnosis for others, who tend
5 to use this, which is a problem with the
6 system.

7 And I would be curious what my
8 colleagues on the panel think before we go
9 forward with answering that question.

10 Who wants to start? John? Then
11 we'll go over to May Kay.

12 MS. O'NEILL: One of my concerns
13 with this topic area for a venture as opposed
14 to concerning with the measure itself may be,
15 as you are saying, really the problem is that
16 in my experience, my clinical experience in
17 rehab, I take care of a lot of people that
18 had, you know, complex scenarios two and a
19 half years out from their presenting back
20 pain.

21 So I saw all kinds of story lines,
22 if you will. And the concept of what

1 radiculopathy is and is not is not at all
2 clear. I mean, people, I mean even within my
3 specialty, certainly within primary care,
4 certainly within some of the other types of
5 healthcare professionals, will call anything
6 that has leg pain radiculopathy.

7 And those certainly aren't
8 documented nerve root, mechanical nerve root
9 impingement, which would lend itself to a
10 mechanical decompression. And a lot of people
11 got surgery that should never have gotten
12 surgery, for example.

13 So it's just starting at the very
14 first criteria of can you look at a group of
15 ICD-9 codes from this cohort of providers and
16 think that you are seeing the same diagnosis
17 in the patients is hugely problematic, which
18 is very different than whether you have bumped
19 your enzymes when you have had an MI or you
20 broke your hip.

21 So, yes, just from the get-go, we
22 are challenged.

1 DR. RATLIFF: I think that's an
2 extremely well-put point. How an orthopedic
3 spine surgeon or a neurosurgical spine surgeon
4 may apply a group of ICD-9 Codes to a patient
5 with radiculopathy is probably pretty similar.
6 But at issue to widen that, as you have a more
7 heterogeneous group of practitioners
8 diagnosing patients, you are probably going to
9 have heterogeneous use of the codes. And then
10 extrapolating to form this from say the market
11 scan database as done here. I mean, that's
12 introducing one potential source of bias right
13 at the outset with how you are defining your
14 patient population.

15 In working with insurers through
16 our national organizations, we find that Aetna
17 has one definition of radiculopathy. United
18 may have a different definition of
19 radiculopathy. Some want straight leg raise,
20 some want sensory changes, some want motor
21 deficits. It is, as you point out, a free-
22 floating term.

1 But still, I think it's something
2 that you've got to work with. And all that we
3 really have to work with are these ICD-9 Codes
4 and I think the way the measure developers
5 have put these together is not unreasonable
6 with the caveats that we have offered.

7 I think they have done about the
8 best that they can with kind of an imperfect
9 definition.

10 CHAIR WEINSTEIN: Please, yes.

11 DR. SINNOTT: I have just a
12 question. Are you concerned that the two
13 measures are separated and not a single
14 measure?

15 CHAIR WEINSTEIN: In what?

16 DR. SINNOTT: The two ABMS episode
17 definitions are separated as -- rather than a
18 single measure?

19 CHAIR WEINSTEIN: You mean the
20 back pain versus radiculopathy?

21 DR. SINNOTT: Right. Because of
22 the in --

1 CHAIR WEINSTEIN: No. I'm --

2 DR. SINNOTT: -- what is it the
3 garbage can we throw our papers into?

4 CHAIR WEINSTEIN: Well, back pain
5 is more of the garbage can. I mean, I think
6 that's the problem --

7 DR. SINNOTT: Yes.

8 CHAIR WEINSTEIN: -- with that
9 one. The radiculopathy to an orthopedic and
10 a neurosurgeon that is a surgical indication
11 is very different than all the --

12 DR. SINNOTT: Of course.

13 CHAIR WEINSTEIN: -- people I
14 think included in this claims-based look.

15 DR. SINNOTT: Right.

16 CHAIR WEINSTEIN: Because they are
17 just taking these codes that are written down
18 by people who make that diagnosis for whatever
19 reason and I'm sorry to say that you do get a
20 better payment if you use that diagnostic code
21 versus another.

22 And so I just -- I'm not -- I

1 don't want to undermine the process.

2 DR. SINNOTT: Right.

3 CHAIR WEINSTEIN: But we have to
4 recognize the limitations. Because when you
5 get into the episode, and what the cost --
6 these numbers are fairly low for what you
7 would reimburse for an episode if somebody
8 actually went to a surgical case versus
9 somebody who had, you know, radiculopathy that
10 was not.

11 And in our study, they had to
12 have, you know, all the definitions that you
13 would expect from a surgeon. They had to be
14 a surgical candidate. They had to have an
15 MRI. They have to have radiculopathy of leg
16 pain below the knee. It had to be present for
17 more than six weeks, those symptoms.

18 And it's not possible in the
19 database to do that. I mean, not easily
20 possible. But so I'm not saying don't use
21 this or let's throw it out. I'm saying that
22 this is a big disclaimer that we need to

1 recognize.

2 DR. SINNOTT: Yes.

3 CHAIR WEINSTEIN: Please.

4 DR. RUBIN: Just for more
5 clarification. So this measure, the intent is
6 only to be used for people less than 65? I
7 mean --

8 CHAIR WEINSTEIN: That's now
9 included in criteria.

10 DR. RUBIN: That's included in the
11 criteria?

12 CHAIR WEINSTEIN: Yes.

13 DR. RUBIN: So if this moved
14 forward, it would not be, I'm not used to my
15 word marketed, but applied to other
16 populations, because --

17 CHAIR WEINSTEIN: Well, their
18 database was for people less than 65.

19 DR. RUBIN: Right.

20 CHAIR WEINSTEIN: We have done the
21 same thing with Medicare over 65. And it is
22 the same trouble. People over-utilizing that

1 diagnostic code, because they don't know what
2 else to write down.

3 DR. RUBIN: No, but if you are
4 evaluating this measure and endorsing it, then
5 taking it from this point on would only be
6 specifically for those who would be not valid
7 or we're not talking about proving this for
8 any other population than what is being
9 recommended.

10 CHAIR WEINSTEIN: Correct.

11 DR. RUBIN: Or what was -- well,
12 my concern is that you have --

13 CHAIR WEINSTEIN: A MarketScan is
14 only --

15 DR. RUBIN: Well, right, but my
16 concern is that you have a tool now, a measure
17 that is "approved" and what is done with this
18 after this point in time and if it's applied
19 to patient population --

20 CHAIR WEINSTEIN: Well, this
21 measure, if it's approved, will be for the
22 specific purposes by which it was developed

1 and for the specific criteria.

2 DR. RUBIN: Okay.

3 CHAIR WEINSTEIN: And they showed
4 their table.

5 DR. RUBIN: No, no, I --

6 CHAIR WEINSTEIN: Yes, yes.

7 DR. RUBIN: -- respond.

8 MS. O'NEILL: Jim, I just wanted
9 to make one more sort of statement about a
10 categorical concern that I have in this
11 diagnostic group compared to the other ones we
12 have looked at. And that is if we were
13 looking at commercial databases, commercial
14 administrative databases, for example, within
15 CIGNA, you know, we have 13 million lives. We
16 could look at who had the ICD-9 Codes and we
17 could look at what the utilization patterns
18 are.

19 But since we are dealing with
20 working age adults, one big cohort of people
21 with this group of diagnoses are injured
22 workers. And they would not have data in the

1 commercial database.

2 And even some of the exclusion
3 criteria, the look-back on the exclusion
4 criteria, if those diagnoses and service
5 delivery were under a Workers Comp payment
6 methodology, they would be invisible to the
7 analysis. And this is the leading diagnostic
8 category in Workers Comp.

9 So just in terms of an
10 understanding of what slice of the population
11 we are able to look at by these criteria, I
12 think people should just be mindful that we
13 are missing that whole group of people.

14 CHAIR WEINSTEIN: Absolutely.
15 It's a whole other issue that, you know, I'm
16 sitting with the IOM looking at Social
17 Security Disability, it's another issue as
18 well.

19 Any other comments from the panel?

20 DR. SINNOTT: Just that they may
21 not be completely missing.

22 MS. O'NEILL: I know.

1 DR. SINNOTT: And that they might
2 be partially missing. And, therefore, the
3 resource use is very limited for that
4 diagnosis. It looks very efficient, but your
5 -- because they have gone. And the reclaim
6 process from the insurer, back to the Workers
7 Comp to get repaid for the -- has not
8 occurred.

9 CHAIR WEINSTEIN: I mean, it gets
10 to John's point about a lot of these costs
11 that are outside of the episode.

12 MS. O'NEILL: Sure.

13 CHAIR WEINSTEIN: The total costs.

14 DR. RATLIFF: I'll have to bring
15 up one more point, since you bring up the
16 sports study. I think -- and again, I don't
17 think this is a bad measure just go -- I think
18 they put a lot of work into this. It's pretty
19 reasonable.

20 The key with a randomized control
21 target, your standard RCT is at control. Like
22 here, with using this measure, you don't have

1 that. You don't have control over who is
2 coming in. The same way I can't control who
3 is coming into my office.

4 The patient comes in bringing all
5 their comorbidities. They have just put out
6 a cigarette as they are walking in the front
7 door. You can't control for all that.

8 And I think capturing this data
9 for all of its inconsistencies and with the
10 issues we have brought up, it's still a
11 starting point. It's kind of a step one
12 towards understanding better how we are
13 expanding this portion of healthcare
14 resources.

15 CHAIR WEINSTEIN: Yes. I think
16 the way to make this better though is in your
17 -- using a string of codes. So, you know, if
18 they had an MRI, you know, they have that
19 information. A lot of them probably did.
20 Although, you will see, I mean, when you look
21 at these databases, a lot of them don't and
22 they go to surgery still, even without an MRI,

1 which is hard to believe.

2 So it is complicated. I just want
3 to make sure that there is a disclaimer in our
4 report that talks about these limitations,
5 that we have recognized them, because our
6 colleagues and the public would not want us
7 not to.

8 It is not a bad place to start.
9 This is an important measure, which is our
10 first question --

11 MS. O'NEILL: Yes.

12 CHAIR WEINSTEIN: -- of high
13 importance. It's a diagnosis that is costing
14 a lot of money that is not doing very well in
15 its outcomes and costs, so it's very
16 important. But I want to make sure we
17 understand the limitations, but not saying
18 that we throw it out.

19 Any other comments? Okay. So we
20 should go on.

21 MS. WILBON: Yes. So it sounds
22 like -- and actually, I think a lot of that

1 will probably come up again when we get to the
2 scientific acceptability sub-criteria.

3 CHAIR WEINSTEIN: Right.

4 MS. WILBON: So with those caveats
5 on the table, we could probably move pretty
6 quickly through the sub-criteria for
7 importance.

8 CHAIR WEINSTEIN: Yes.

9 MS. WILBON: Which asks you to
10 determine whether or not the measure focus is
11 a high impact area, whether or not they have
12 demonstrated that it is a high -- that there
13 is high resource use or cost problems or
14 variation within this focus area, whether or
15 not the intent of the measure is clear and
16 whether or not the resource use service
17 category selected makes sense for this
18 particular condition.

19 DR. RATLIFF: Can anyone on the
20 panel for that, are we for voting on the
21 resource use, kind of Step 1? Can we pass
22 that as a consent calendar if kind of

1 everybody agrees or do you want individual
2 votes for each?

3 Because I think everyone agrees,
4 at least for these first few measures, this is
5 pretty important to investigate. Yes?

6 MS. WILBON: Oh, okay.

7 DR. RATLIFF: Do you want to
8 actually have -- what is actually -- do you
9 want us to actually have to push the buttons?

10 MS. WILBON: Yes. Would you rate
11 them? Would anyone rate them as high --

12 DR. RATLIFF: We're moving quickly
13 to the end of --

14 CHAIR WEINSTEIN: We think there
15 is consensus --

16 MS. WILBON: Okay.

17 CHAIR WEINSTEIN: -- with what
18 John says, that this is a highly important
19 measure.

20 MS. WILBON: Okay.

21 DR. RATLIFF: I mean, correct me
22 if I'm wrong.

1 MS. WILBON: I think we can
2 actually move through pretty quickly, if you
3 hit the button, rather than -- just I realize
4 that --

5 DR. RATLIFF: You want to have it
6 for the record?

7 DR. SINNOTT: Yes.

8 MS. WILBON: Yes. It goes pretty
9 quickly. So what we --

10 MS. FANTA: You have to point and
11 it's fun.

12 CHAIR WEINSTEIN: Uniform data
13 collection.

14 MS. WILBON: Yes. So Sarah has a
15 computer with a sensor on it, so if you could
16 just kind of point your remotes to her.

17 CHAIR WEINSTEIN: Where is Sarah?
18 Sarah, Sarah?

19 MS. WILBON: So when that timer
20 starts, you can go ahead and hit that.

21 CHAIR WEINSTEIN: Did you feel
22 anything, Sarah? We are all pointing at you.

1 Okay.

2 MS. WILBON: So --

3 CHAIR WEINSTEIN: There is a next
4 question.

5 MS. WILBON: Is whether or not the
6 measure demonstrated considerable variation
7 across providers of population.

8 CHAIR WEINSTEIN: Yes, this is an
9 important question, because I'm not sure it
10 does that effectively. Was the data submitted
11 that demonstrated considerable variation?

12 MS. O'NEILL: So you are saying
13 that --

14 CHAIR WEINSTEIN: That's a good
15 question.

16 MS. O'NEILL: -- they showed less
17 variation than some of us who do this work --

18 CHAIR WEINSTEIN: Yes, exactly.

19 MS. O'NEILL: On the front line?

20 CHAIR WEINSTEIN: Exactly.

21 DR. RATLIFF: Exactly.

22 CHAIR WEINSTEIN: Is this an

1 observed variation or is this what they are
2 bringing to us? Do we see variation?

3 MS. O'NEILL: This is an area of
4 huge variation, but they are called to find as
5 much as I see.

6 CHAIR WEINSTEIN: Correct.

7 MS. O'NEILL: Correct?

8 CHAIR WEINSTEIN: Yes. So that's
9 the issue. So I wouldn't want everybody to
10 just say this is high again, just being
11 cautionary, because I'm not sure that the
12 measure did do that. So vote your conscience.
13 Okay. You have an official vote.

14 MS. WILBON: Oh, yes.

15 CHAIR WEINSTEIN: Do you have
16 another one for us?

17 MS. WILBON: So there was one
18 high, four moderate and one low, for those on
19 the phone.

20 And the next one that we will be
21 evaluating is whether or not the intent of the
22 measure was clearly described in the

1 submission. Right. So, Liz, sorry, can you--
2 we will send you an email to kind of delineate
3 how you should submit your ratings throughout
4 the process. Okay?

5 MS. PAXTON: Okay.

6 MS. WILBON: Sorry about that.
7 Okay.

8 CHAIR WEINSTEIN: Did you -- are
9 you -- can we vote now?

10 MS. WILBON: Yes, unless there was
11 some -- any discussion about whether or not
12 this --

13 CHAIR WEINSTEIN: I thought I did,
14 but we didn't see the clock running.

15 MS. WILBON: Yes.

16 DR. RATLIFF: I can't vote more
17 than one.

18 MS. WILBON: Right. So there is
19 four high and two moderate for 1p.

20 And 1(d) asks whether or not the
21 resource use service categories that they
22 identified for this particular measure,

1 basically, makes sense for this condition in
2 the focus of the measure.

3 So there is three high and three
4 moderate.

5 So that wraps up importance, which
6 we thought would go relatively quickly. And
7 we will move into scientific acceptability,
8 which I think is going to be where the bulk of
9 your discussion is.

10 And it looks like Dr. Ratliff was
11 assigned 2(a)(1). So we will start with you,
12 if you want to kind of summarize what you
13 found.

14 DR. RATLIFF: So I didn't prepare
15 any slides. I'm not sure how you want to go--

16 MS. WILBON: That's fine.

17 DR. RATLIFF: -- or move through
18 this.

19 CHAIR WEINSTEIN: Thank God.

20 DR. RATLIFF: So we are going to
21 go over leading off the 2(a)(1), which is
22 scientific acceptability. The idea here

1 really is what I took from our definition or
2 the definition offered by the NQF was whether
3 or not this measure specified a patient
4 population that you could generalize.

5 So not just the MarketScan data,
6 but the measure is based upon whether somebody
7 could be measured or spread out to all of the
8 U.S. Healthcare System or any place where you
9 have like an EHR.

10 And I guess we would open up the
11 discussion with that. I mean, these are
12 episode-based resource measures, but for this,
13 again, I kind of looked first at the patient
14 definition and maybe we should talk about that
15 again, briefly, since we are already talking
16 about radiculopathy and then talk about how
17 they defined the episode itself.

18 If I look at the discussions that
19 were emailed out on what other folks thought,
20 I must have been in a good mood, because I
21 thought they did a pretty good job of defining
22 this measure and I seem to be the only one who

1 like forwarded responses back who thought so.

2 I should take that back. It looks
3 like some of the like highs were recorded.

4 Craig, you had comments that you
5 brought up in the email about the ages of the
6 patients. And that was one of the few written
7 comments that I saw that got emailed about.
8 I don't know if you guys want to start with
9 the discussion of the definition of
10 radiculopathy or discussion of particular
11 issues from the 2(a)(1).

12 DR. SINNOTT: I just had a
13 question about, besides the definition, the
14 truncation at 90 days. And why that was
15 selected when these events, generally, are
16 recurrent and prolonged. So I don't know if
17 the developer is still on the call?

18 DR. MANHEIM: Yes.

19 DR. SINNOTT: You might talk about
20 the truncation. I mean, I appreciate the
21 subacute "ends" at 90 days, but --

22 DR. MANHEIM: Well, that was the

1 point was that it was subacute ends at 90
2 days. In fact, the distinction they made was
3 whether to do six weeks or three months. And
4 we presented them, the work group, some data
5 for both. And it was decided three months.

6 But they were trying to not get
7 into chronic and to have recurrent episodes.
8 I'm sorry, that was separated more than six
9 months as new episodes, so that was the
10 rationale.

11 CHAIR WEINSTEIN: Could you ask
12 that question again? Could you ask your
13 question again? I'm sorry.

14 DR. SINNOTT: Sure. My question
15 was why truncate the episode at 90 days. I'm
16 just repeating the question.

17 CHAIR WEINSTEIN: Yes.

18 MS. SINNOTT: And I mean, I
19 recognize that, in general, the literature
20 says subacute ends at 90 days and chronic
21 starts at 90 days. So I was concerned that we
22 are losing some of the recurrence in that

1 particular.

2 So let's say somebody has
3 treatment for six weeks and then stops
4 treatment, which is all you can tell from the
5 administrative data. And then at 89 days
6 starts back again. It's, essentially, the
7 same episode of six months is your definition
8 of absence of care.

9 But then that it ends up being
10 neither a second episode nor a prolonged first
11 episode.

12 CHAIR WEINSTEIN: I mean, John,
13 what do you think in the sense of, you know,
14 a patient who you watch, you end up operating
15 on at 12 to 25 weeks, they don't get back
16 within, you know --

17 MS. SINNOTT: Right.

18 CHAIR WEINSTEIN: -- another 12
19 weeks, potentially, you know, so is that
20 episode too short in the context of the ideal
21 patient even? Is what I'm asking. And is the
22 idea of the measure, and I'll direct this to

1 the developer, to try to capture the initial
2 presentation of radiculopathy?

3 DR. RATLIFF: Through treatment.

4 DR. MANHEIM: Well, that's right.

5 A part of it is to capture the variation, so
6 is there unnecessarily high variation? So if
7 -- I think part of the reasoning is there may
8 be a surgery down the line, but that's not
9 part of the initial presentation. In fact, if
10 it's in the code within the first three
11 months, and I shouldn't use the word, but,
12 maybe that's more appropriate surgery than if
13 you had a surgery within those three months
14 before to watch the patient some more.

15 I think that's the rationale for
16 eventually cutting it off, that you are
17 looking at variation. You know, it's not a
18 research study you are looking at for disease,
19 but given the data limitations, and the, you
20 know, amount of time you can actually observe
21 them, basically, like use two years of
22 administrative data, it's felt that that was

1 the best time limit.

2 DR. RATLIFF: I guess I would open
3 up following up on the other points made. Is
4 that really modeling our patient or is that
5 the patient that is coming in -- is that the
6 patient that I'm ending up doing surgery on?
7 Is that representing and capturing the overall
8 group of patients or are you already
9 restricting it down to such a small subset
10 that you may not be able to generalize your
11 outcomes from that?

12 DR. MANHEIM: Can I just state one
13 more thing and I'll stop, which relates to
14 that of an earlier question is we might not
15 have made it clear enough, but the intention
16 is always that any physician will be compared
17 to its peer group.

18 Chiropractors would only be
19 compared to chiropractic and so on. It might
20 not really solve your problem, but there is no
21 intention of chiropractors being compared to
22 surgeons in terms of the patients they see.

1 DR. RATLIFF: Now, wait a minute.
2 You give a table at the end of your little
3 presentation where my specialty is the most
4 expensive in the entire group. So that kind
5 of invites comparison. You may say you are
6 not comparing, but it's certainly there.

7 MS. O'NEILL: Well, we are
8 comparing them.

9 DR. MANHEIM: I would call it
10 validation, rather than comparison. It would
11 be surprising that we are not --

12 CHAIR WEINSTEIN: You know, I
13 think the problem is you are still comparing
14 the apples and oranges, which gets to these
15 ICD-9 Codes and that you can't get away from
16 that. But the reality is if it's true
17 radiculopathy, surgical or non-surgical, that
18 a lot of these patients can get better on
19 their own anyhow.

20 And it might take more than 90
21 days for them to go through a -- we know from
22 the sport data again that over time, these

1 patients can get to a point where they can
2 function. 30 percent of them never had
3 surgery, even now, eight years, nine years
4 later.

5 The episode can't go that long,
6 but I'm not sure that 90 days is enough. When
7 you are going to -- realize what we are saying
8 here, at least in my opinion. And Heidi
9 should correct me or somebody should, because
10 what you are getting to is a public reporting,
11 us supporting a policy that potentially will
12 stop payment for this episode after 90 days.

13 If -- or at least it is going to
14 be bundled potentially by somebody.

15 MS. O'NEILL: Well, I mean, I
16 guess, part of the problem when I was wading
17 into this, on a number of the different
18 measures, is to think about what it is we are
19 measuring. And so are we measuring resource
20 utilization as it tracks the natural history
21 of these back pain cases following the patient
22 over time?

1 You know, what is the natural
2 history of back pain? And one of the problems
3 we are going to have with any measure in any
4 time frame is that has less -- there is a less
5 standard story --

6 CHAIR WEINSTEIN: Well, let's
7 stick to radiculopathy though, first.

8 MS. O'NEILL: But if we are
9 comparing with the measure, the performance of
10 whoever is delivering care, the individual or
11 the system, over the first 90 days of the
12 onset, then that's different.

13 Now, I know that there is a -- you
14 know, you could have some kind of thing
15 develop in the future where people are being
16 paid on this basis and everybody would get
17 surgery on the 91st day and they would look
18 real cheap in the first 90. I mean, any
19 measure can be gamed, right?

20 But I think it is a little hard if
21 we are looking at these measures as,
22 essentially, payment policies, which is, I

1 think, where we go the push back on one of the
2 health partners things earlier.

3 It was like oh, no, you are going
4 to tell me I can't do this, but our -- I don't
5 see that that is what we are doing with these
6 measures.

7 CHAIR WEINSTEIN: Yes, but, you
8 know, even in your own company, there are risk
9 contracts now for, you know, managing certain
10 populations for a specific bundle of payment.
11 And all I'm suggesting is we have to be
12 careful.

13 You know, if we think 90 days is
14 right, then great. Let's agree that that's
15 the group, the episode and say that's okay.
16 And maybe that is okay for this sub-population
17 that they have studied in this database.

18 The problem is with the -- which I
19 go back to the original question, they are
20 mixing a lot of patients in this that where 90
21 days, on average, looks okay.

22 MS. O'NEILL: No.

1 DR. RATLIFF: I would ask the
2 developer that as well. Did you model this
3 from like your data and look, are most of
4 these patients finishing their treatment
5 before 90 days? Is that why you chose the 90
6 day cutoff? Is the developer --

7 DR. MANHEIM: Ninety days was
8 chosen based on the work group and some
9 subacute -- there is never any notion that
10 this would be used to come up with a payment
11 scheme. The noting was going to be used -- it
12 would be used for quality measures to come up
13 with comparing physicians in terms of their
14 cost.

15 CHAIR WEINSTEIN: No, but his
16 question is did you model this with the data
17 showing some set of patients were done with
18 their episode within 90 days? Yes or no?

19 DR. MANHEIM: We took the 90 day
20 and we didn't go -- we looked -- compared --

21 CHAIR WEINSTEIN: Was that
22 arbitrary or did you actually base it on --

1 DR. MANHEIM: It was arbitrary
2 based on --

3 CHAIR WEINSTEIN: I think it's
4 arbitrary.

5 DR. MANHEIM: -- physicians that--
6 (Simultaneous speakers.)

7 DR. RATLIFF: It kind of
8 arbitrarily pulls out 90 days, too. So there
9 is foundation, but it's following our -- would
10 we suggest a different time course? Would we
11 suggest a longer period, a shorter period?
12 What would be consensus of the panel?

13 CHAIR WEINSTEIN: My sense is you
14 would want to validate that against sub-
15 populations within this diagnostic group.

16 DR. RATLIFF: Other comments on
17 that with regards to the 90 days?

18 DR. RUBIN: I just think it is a
19 dirty, it's a messy clinical problem. And,
20 you know, if it's reasonable, I mean, with all
21 the limitations, I think somebody could come
22 out and say 120 days and there will be

1 problems with that.

2 But to sort of try to grapple with
3 this in a measured way, in a -- I think they
4 have done reasonably well in, at least, trying
5 to characterize the problem and trying to
6 assess it. I think there will be criticisms,
7 you know, whatever number you choose.
8 Certainly, more information would be helpful,
9 more evidence.

10 CHAIR WEINSTEIN: My only comments
11 for you, John, are I thought there were a lot
12 of pros to this. I like their use of the
13 claims. I like their standard pricing list
14 for costing. I thought they had good detail
15 on how to standardize cost in patient,
16 outpatient and pharmacy.

17 I thought that they used the
18 categories of services, the BETOS thing, which
19 is easy for people to get to from CMS. I
20 thought the methodology was easy to follow, in
21 some ways easier than the Ingenix were going
22 to come up with.

1 Their trigger events were very
2 clearly defined. I think they excluded
3 patients without pharmacy benefits, which was
4 good. Their winsorization methodology was
5 good. They excluded patients, you know, with
6 the kinds of diseases that would confound this
7 significantly.

8 I thought their group cost is
9 related to the diagnosis and unrelated to the
10 diagnosis were good. And I think their risk
11 adjustments were good. I thought some of the
12 cons of what they did was their coding. It
13 assumes coding is consistent across
14 facilities, which generally it isn't.

15 Time limits on episodes, I said
16 may be artificial. There is no mention of
17 software automation of this process, so I'm
18 not sure, but we'll get into usability. And
19 it does not address specific resource
20 utilization within a procedure or E&M visit,
21 so the type of provider is not addressed to me
22 in the model specifically.

1 And it's not to address non-
2 billable activity. So those are the pros and
3 cons from my perspective.

4 DR. RATLIFF: I'm picking up on
5 one of those points and kind of one of the
6 talking points that I wanted to bring up.

7 The ICD-9 and CPT Codes that are
8 included on page 12 of the PDF that they sent
9 out for 1586, I'm okay with those from the
10 panel. I wanted to make sure the other panels
11 thought that that was an inclusive list and
12 that we think that we are capturing the data
13 that we want to capture with regards to
14 treatment of radiculopathy.

15 With the caveat that we discussed
16 earlier, there is not going to be a
17 standardized use of those codes in between
18 different practitioners and possibly even
19 between the same practitioners in different
20 institutions.

21 But I think that if you get into
22 that with any kind of population or database

1 approach to assessment, is everybody okay with
2 the CPTs that they chose?

3 CHAIR WEINSTEIN: Those top 20?

4 DR. RATLIFF: Yes.

5 CHAIR WEINSTEIN: The thing that
6 that pointed out to me, again, was that these
7 subcategories of patients are probably pretty
8 different, because the top two by far, you
9 know, 14 and 7 percent of those, so 22 percent
10 of those are therapeutic exercise and manual
11 therapy.

12 That's almost routinely used. The
13 efficacy of that is questionable in this kind
14 of diagnosis, but that is a huge expense that,
15 to me is questionable efficacy, but,
16 obviously, you know, only 6 percent had
17 surgery, 6.8 percent as a code.

18 And so, to me, again, these ICD-
19 9s, if you do some sub-groupings or different
20 method of breaking these down, you would
21 probably get more specificity. But it just
22 pointed to me again that these are different

1 populations across this database potentially.

2 MS. O'NEILL: On the list of the
3 common non-related diagnoses and procedures,
4 there are columns that are entitled "Related
5 and Non-Related," so that in certain -- do
6 those columns indicate that the related costs
7 were grouped to the episode and the not-
8 related ones were not grouped, so that these
9 non-related E&M Codes, occasionally, are
10 related? Do you know what I'm saying?

11 DR. RATLIFF: Are you directing
12 that to the developer?

13 MS. O'NEILL: Yes.

14 DR. MANHEIM: If I understand
15 right, I hope I'm stating this correctly, but,
16 what we looked at was for cases where there
17 were a related diagnosis in terms of having
18 the correct diagnostic categories to include
19 them versus those where those codes came out,
20 they had a different diagnostic category.

21 DR. RATLIFF: Does that answer
22 your question?

1 MS. O'NEILL: Well, I mean, there
2 are some small numbers here that confuse me.
3 I don't want to get off the main point of it,
4 but, I mean, some of the non-related E&M Codes
5 and procedures are things that, you know, I
6 think people might use in this patient
7 category.

8 So just for example on that ICD-9
9 list, there is a pain in the limb and there is
10 279 of these are under the related column and
11 4,000 are on the non-related column.

12 DR. MANHEIM: Yes.

13 MS. O'NEILL: And is that because
14 that diagnosis occurred by somebody who
15 provided care to this patient and it turned
16 out that they did not have a diagnosis of
17 radiculopathy? I'm just trying to --

18 DR. MANHEIM: Right. That's
19 right.

20 MS. O'NEILL: Okay.

21 DR. MANHEIM: Within the episode,
22 those were cases where that was the CPT Code,

1 but because they did not have related
2 diagnosis, it was not included as part of the
3 cost.

4 MS. O'NEILL: Okay. But that
5 was --

6 DR. RATLIFF: You lost me there.

7 MS. O'NEILL: Those in the related
8 column are included?

9 DR. MANHEIM: Yes.

10 CHAIR WEINSTEIN: So the way I'm
11 understanding this is that when they did their
12 -- your algorithm for inclusion of patients,
13 you went through these different coding
14 exercises. And when you found out that they
15 had -- they didn't have a back pain code, but
16 they had a leg pain, you know, it wasn't
17 related, because of the coding, it wasn't.

18 MS. O'NEILL: Right.

19 CHAIR WEINSTEIN: Yes.

20 DR. MANHEIM: Right. So what we
21 did is, you know, we had a number of meetings,
22 mostly by telephone and we presented tables

1 saying well, here is the CPT Codes and they
2 are or they aren't included, based on
3 criteria. Does this look okay to you? Should
4 we be including something else, via expanding
5 diagnosis codes or including this regardless
6 of the diagnosis code, et cetera?

7 So they would look at this and
8 scratch their heads and talk about it and
9 decide whether it needed to change, which we
10 already had.

11 CHAIR WEINSTEIN: I think it was
12 their grouping methodology that, you know,
13 right or wrong, that's how they made their
14 rules. Yes. Any other questions? John, do
15 you --

16 DR. RATLIFF: Slowly advancing.

17 CHAIR WEINSTEIN: All right.

18 DR. RATLIFF: Can we discuss age
19 and the fact that you said the cutoff was 64,
20 because Craig did bring up a good point? And
21 what we emailed around, I would like him to
22 voice here for the minutes, just with regards

1 to the MarketScan data versus general
2 population data.

3 DR. RUBIN: Yes. My concern, I
4 think, are major limitation, even though they
5 clearly state that it will include the age of
6 64, although there are some errors in some of
7 the paperwork provided. And the reason for
8 excluding people over 65, I don't think there
9 was sufficient explanation.

10 DR. RATLIFF: It was your
11 database, right? That's what you had access
12 to?

13 DR. MANHEIM: Yes. In fact,
14 through, I think it is probably my error,
15 sometimes 84 mixed in -- which is in the
16 original work group, 84 was mentioned, but
17 there was a question about how people 65 to 84
18 differed. And given that the only data we had
19 was through 64, we felt we could not go beyond
20 that.

21 DR. RUBIN: Well, right. Well, so
22 it seemed to be a convenience issue. And I

1 think that this is a non-reason to state that
2 people over 65 would be treated differently.

3 The point of these measures, from
4 my perspective as a clinician, is to try to
5 identify variations, so we can identify better
6 outcomes, identify poor outcomes to try to
7 develop interventions to reduce poor outcomes.

8 And if your -- I realize that this
9 is, again, you know, fine to be limited to
10 less than 65, but from a national basis, we
11 have this huge population of people. And we
12 don't know -- we need to assume that just
13 because they are going to be treated
14 differently, I mean, you can say the same
15 thing for any age group. It doesn't seem to
16 be a scientifically valid or clinically valid
17 approach.

18 And I just want to say it's a very
19 shortcoming of the tool and would have been an
20 opportunity, unfortunately I think, to look at
21 this age group to measure important
22 comorbidities and to identify either regions

1 or practitioners who performed better in terms
2 of -- and this is a lot of the issues and we
3 repeat this, but if the surgery is involved,
4 you know, wound infections, this kind of
5 surgery, pulmo-emboli, very valid
6 comorbidities. That is applicable for all age
7 groups, but particularly in this group over
8 65.

9 So I guess I would encourage that
10 the developers would include this group and
11 not, you know, sort of refrain from measuring
12 and assessing this group.

13 CHAIR WEINSTEIN: Just one
14 clarification. Epidemiologically, this is a
15 diagnosis that mostly occurs between 33 and
16 55. It doesn't mean it doesn't occur in over
17 65. It does. And it is often diagnosed and
18 it's another problem with ICD-9 coding or
19 whatever, but you are exactly right.

20 But the reality is from an
21 epidemiology standpoint, this is not a common
22 diagnosis in people 65 and older.

1 MS. O'NEILL: But --

2 CHAIR WEINSTEIN: For which there
3 is good studies that suggest it is treated
4 well by surgical intervention or any other
5 method. So that's all I'm saying.

6 MS. O'NEILL: But I would say that
7 you could certainly call it out on your
8 criteria from a scientific perspective that
9 exclusion is not serving the greater good.
10 However, on a feasibility criteria, when we
11 get to that part of the measure, the fact that
12 it is so expensive for most people to get
13 access to the Medicare Database, it is
14 untenable.

15 And so I think that when they
16 limit their analysis to the data that they
17 have available to analyze, then they have to
18 give those metrics, because that is the
19 limitation of their database. And Medicare
20 has not made that easy for anybody who is
21 trying to understand that.

22 DR. RATLIFF: We are getting ahead

1 of ourselves, but it's a good point. Have you
2 validated this measure in something besides
3 the MarketScan Database or have the developers
4 looked at this outside of MarketScan?

5 DR. MANHEIM: No. There is some--
6 no, not to this point. So, you know, it's
7 just no.

8 DR. RATLIFF: And moving ahead
9 through my submission items that I was
10 assigned to discuss, we are on page 14 of like
11 8,000 in your like PDF, so I'll try to move us
12 forward.

13 Is everyone okay with the trigger
14 visit or the idea of a trigger visit for the
15 episode or what they choose as a trigger for
16 bringing in their episode? Patricia?

17 DR. SINNOTT: Now, this is a two-
18 part comment. Number one, am I right that you
19 are attributing episodes to both physical
20 therapists and chiropractors as well as
21 physicians?

22 DR. MANHEIM: Yes. I mean, not to

1 be attributed to all three.

2 DR. SINNOTT: Correct. Okay.

3 Just very much a side note, in the PT Codes
4 that you include for identification of the
5 provider visits, you don't include the PT
6 Evaluation Codes 970001 and 2, even though
7 they show up as high utilization codes in your
8 report of utilization. So they just need --
9 if you are going to include them, they should
10 be correct.

11 DR. MANHEIM: Okay.

12 DR. RATLIFF: Any other issues
13 with the trigger? Hearing none, very good.
14 Do we want to talk about relative risk and
15 comorbidities modeling? Should that come up
16 in this portion? I mean, obviously, we need
17 to discuss it. I'm open to the panel's input.

18 CHAIR WEINSTEIN: I'm not sure how
19 those were adjusted for in the model or
20 whether they did or not. I can't remember.
21 I'm trying to find my notes on that. Does
22 anybody know?

1 To the developer, did you guys
2 adjust --

3 DR. MANHEIM: Yes. The way they
4 were adjusted was well, the final model chosen
5 and provided Medicare instead of a Medicare-
6 developed comorbidities were entered and those
7 that were present more than 1 percent of the
8 time and that were -- had a significance of P
9 = .1, at least, were included in the model,
10 controls the dose when comparing across
11 physicians.

12 So it's a regression model that
13 was used.

14 DR. RATLIFF: So I bring up as a
15 point, and again, I like this measure, the
16 risk adjustment model issue provided in your
17 slides is various -- seems to go over pretty
18 cleanly how you approach this data. But then
19 it should go through your risk adjustment
20 methodology in the PDF that you forwarded
21 where you go through a lot more detail.

22 I mean, I get a little lost going

1 through this and I think even your
2 statistician got a little bit lost when they
3 reviewed this in terms of how you chose
4 statistical significance for each model. We
5 could bring up the point that you are using
6 Medicare HCCs in a non-Medicare patient
7 population, people that are under the age of
8 64.

9 I mean, this to me is certainly
10 not intuitive. And even after reading it a
11 few times and trying to study it, I'm not sure
12 I fully comprehend how you are doing your
13 relative risk modeling for this patient
14 population, which, of course, is important
15 from a surgeon's perspective, maybe not so
16 much for chiropractic care, physical therapy
17 or other aspects of this measure.

18 CHAIR WEINSTEIN: And the
19 statistician had some comments about that as
20 well, I was just trying to pull those up, who
21 also felt that some of these things weren't
22 managed well or, you know, I don't know if

1 that's the right word, managed, also forgive
2 me.

3 DR. MANHEIM: Well, yes.
4 Significance was used, I know he criticized
5 that. And we did also look at predictability.
6 The slides we used weren't included here. In
7 terms of whether the predicted values varied,
8 would be simply relative to the actual values.

9 The other thing we looked at, we
10 used a large number of models to -- basically,
11 it generally ended up in this measure using
12 one where all the conditions were considered
13 and then pared back based on what was
14 significant or was not significant.

15 CHAIR WEINSTEIN: You used like 12
16 models or something, but it wasn't clear how
17 you decided on which one, you know?

18 DR. MANHEIM: Right. It was
19 stated --

20 CHAIR WEINSTEIN: It was a little
21 bit of a fishing expedition.

22 DR. MANHEIM: That's right. I

1 would not -- and it wasn't made clear, but I
2 think you're right about how it was dosed.
3 Basically, it looked at how the -- they said
4 the predicted value compared to the actual
5 value in terms of maintaining the variability
6 across physicians and not eliminating the
7 variability across physicians.

8 CHAIR WEINSTEIN: Yes. I think
9 for --

10 DR. MANHEIM: But I -- yes, and I
11 actually did speak to the person who did it
12 out here, so --

13 CHAIR WEINSTEIN: Yes.

14 DR. MANHEIM: -- I wouldn't want
15 to say more.

16 CHAIR WEINSTEIN: I think just for
17 the panel's sake though, John, it's important
18 that we bring this out that there are these
19 limitations and that's all.

20 DR. RATLIFF: I think it needs to
21 be somewhere in the minutes with regards to
22 the product of our panel that after they

1 caught their fish, I don't see where they
2 compared it to other fish to make sure it was
3 actually a fish.

4 Like whether or not this was
5 actually validated through looking at
6 different databases, validated through looking
7 at it, I assume other approaches to modeling,
8 which is essentially a medical condition,
9 being low back pain with radiculopathy.

10 DR. LEE: So this is Todd Lee from
11 ABMS. Actually, I'll jump in here. I did the
12 risk adjustment modeling and I can speak to
13 some of the questions that you all have
14 raised.

15 We went through a process, and I
16 apologize for sort of the lack of clarity in
17 the submission, in which our work group
18 identified conditions that they felt would be
19 important in modifying costs for this patient
20 population.

21 And then we also compared that to
22 models where we included all other health care

1 conditions that were identified with the HCCs.
2 Now, we don't use the HCCs that Medicare --
3 the coefficient ways that Medicare developed.

4 We use them only to identify the
5 chronic conditions and then we estimate the
6 relative cost of each of these chronic
7 conditions through out modeling exercise.

8 We did this in a split sample
9 approach. So we took 75 percent of the sample
10 from the Med-Stat data and developed a model,
11 tested the model fit in a 25 percent
12 validation group. And what we ended up
13 selecting was the model that fit the data the
14 best out of all these 12 different
15 specifications that we originally
16 investigated.

17 Now, yes, it is, as you described
18 it, a bit of a fishing expedition. We are
19 trying to understand or sort of get rid of
20 variability due to patient case mix, but we
21 want to keep variability that is attributable
22 to the episode and not completely wash away

1 all the variability that exists.

2 So we try and account for
3 differences in case mix across these
4 populations and we select the model that has
5 the best performance. And we didn't provide
6 all of the fixed statistics that the
7 statistician would have liked to have seen and
8 we have done -- we have subsequently done that
9 for some of our other models or some of our
10 other measures that have been evaluated. And
11 we could certainly do it for this measure as
12 well.

13 DR. RATLIFF: Thank you. Gently
14 moving the discussion along, the costing
15 method is something that is also assigned in
16 this initial measure. Any comments from the
17 Committee, comment from our group with regards
18 to how they did their cost calculations? And
19 I'm specifically looking at page 23 of the PDF
20 that they have forwarded where they go through
21 the standard cost calculation and then how
22 they do standard units of service and standard

1 costs.

2 Would the developers like to
3 comment on how they approached, just briefly,
4 developing standardized units of cost for the
5 therapeutic interventions we are discussing?

6 DR. MANHEIM: Well, I would just
7 say that we -- the data we had from Med-Stat,
8 we took the average cost for each code, for
9 each outpatient code. And for inpatient
10 codes, we took the average cost for each DRG
11 and we -- but we did it on a per diem basis.

12 And then we discussed those few
13 cases where there wasn't a DRG, what we did,
14 which is somewhat complicated for a small
15 portion of cases.

16 But basically, we took the average
17 cost within a specific category, specific CPT
18 or DRG level. And the average cost -- I
19 should say average cost, obviously, we don't
20 know the specific economic cost in abstract
21 terms, so the average payment, the average
22 amount, the payment that was designated to be

1 received by the provider, that includes the
2 payment from the patient and the insurers.

3 DR. RATLIFF: Well, how do you do
4 the observe versus expected ratioing for these
5 costs as you go into your provider scoring?

6 DR. MANHEIM: Right. Do you want
7 to address that, Todd?

8 DR. LEE: You bet. So each
9 individual we look at the expected costs based
10 on their case mix from our regression model,
11 so we calculate an expected radiculopathy-
12 associated cost for each person. We compare
13 that to the observed cost and across each
14 physician that it would attribute the care, we
15 calculate from summary statistics of the
16 observed to expected.

17 The average, the median for their
18 entire population to which the care is
19 attributed to that provider. And then we can
20 compare observed to expected across peer
21 groups.

22 DR. RATLIFF: Any comments on

1 that? Because I know the statistician brought
2 up the point that this isn't an episode-based
3 comparison, but something taking a step away
4 from that that may kind of confound how you
5 are going to compare between groups.

6 DR. MANHEIM: Yes, I think the
7 comment was that -- that I saw was that it was
8 not an average physician-base, but was for
9 each episode. I didn't really understand
10 that, but --

11 DR. RATLIFF: Oh.

12 DR. MANHEIM: So I can't respond
13 to it.

14 DR. RATLIFF: I have a couple
15 other points that I wanted to bring up, again,
16 not validated. We haven't looked at your
17 exclusions and validated them through using
18 something besides the MarketScan Database.
19 I'm afraid I'm bringing up stuff that we have
20 already discussed earlier. And your risk
21 adjustment methodology, you haven't explored
22 outside of the MarketScan Database.

1 DR. MANHEIM: No. Most of the
2 exclusions we have are standard exclusions are
3 -- were based on NCQA. But we personally
4 haven't used other data.

5 DR. RATLIFF: Well, that, for me,
6 gets through 2(a)(1). I don't know if anyone
7 else has other issues they want to bring up
8 before we go to 2(a)(2) where we talk about
9 reliability testing. We are kind of moving
10 around a lot.

11 CHAIR WEINSTEIN: Yes. Are there
12 any other comments about scientific
13 acceptability? I think we have hit most of
14 the points that I wanted to bring up and a lot
15 of issues that I wanted to have kind of noted.
16 I'm comfortable with moving ahead to other
17 aspects of acceptability or even to usability.

18 DR. RATLIFF: We have sort of gone
19 through all three at once.

20 MS. WILBON: So I think --

21 CHAIR WEINSTEIN: We don't rule
22 out anything here.

1 MS. WILBON: -- we have actually
2 covered a lot of it in kind of going through
3 the specifications to see if they were clear
4 or not. We have actually hit a lot of the
5 other sub-criteria. So what I would propose
6 is that we go through each and bring them up
7 on the voting screen and read them aloud and
8 just make sure if any -- yes, make sure
9 everyone has covered everything.

10 And if there is anything else to
11 discuss, when we get to it, we can just have
12 that discussion, vote and then move on.

13 So we will start with 2(a)(1),
14 which asks whether or not you feel that the
15 specifications they provided were clear, such
16 that, you know, any organization could pick it
17 up and implement it consistently.

18 DR. RATLIFF: That would be also
19 just for the methodology that you can
20 generalize this.

21 MS. WILBON: Right.

22 DR. RATLIFF: It's not just good

1 for MarketScan, but you can take this to NIS.
2 You can take this to the Medicare Database.
3 This is going to be translatable to a larger
4 patient population.

5 MS. WILBON: Well, this particular
6 criteria is more so whether or not it can be
7 implemented for comparability across
8 organizations. So are the specifications
9 clear enough, such that it would be
10 consistent?

11 CHAIR WEINSTEIN: It doesn't get
12 into the validation issue.

13 MS. WILBON: Right.

14 CHAIR WEINSTEIN: I don't think.

15 MS. WILBON: Validity comes up --

16 CHAIR WEINSTEIN: A later section.

17 MS. WILBON: Yes, later on. But I
18 think we did talk a little bit about that, so
19 we can --

20 CHAIR WEINSTEIN: But it's not
21 this question.

22 MS. WILBON: Right, not this

1 specific question.

2 DR. RATLIFF: So it's not
3 validation of the measure. I misspoke, but
4 that you could use this measure in partners in
5 like Medicare. It is generalizable. You can
6 extract it.

7 CHAIR WEINSTEIN: To totally
8 understand this and follow it, I think is --
9 yes.

10 MS. O'NEILL: But you -- we're
11 just saying that this --

12 CHAIR WEINSTEIN: Microphone.

13 MS. WILBON: Mike. Use your
14 microphone.

15 MS. O'NEILL: Oh, I'm sorry. I'm
16 used to being loud. So but this is really
17 saying that you could take -- based on a
18 commercial administrative data set with these
19 criteria, this rule could be applied at some
20 delivery system in Seattle, in some delivery
21 system in LA and that you would be,
22 essentially, measuring the same things in the

1 different delivery systems.

2 That's what I understand this to
3 be.

4 MS. TURBYVILLE: It gets to that
5 this sub-criteria is specifically focusing on
6 whether the specifications are written in a
7 manner that someone could then take it and
8 apply it consistently when we start talking
9 about the data systems at a place would
10 support it, that gets more into the validity.

11 This is really as written, was it
12 clear, were the diagnostic codes provided?
13 Could a programmer program this measure and
14 implement it?

15 CHAIR WEINSTEIN: Yes, to me, this
16 is easier to follow than some of the Ingenix
17 stuff actually. So it gets to this easy --
18 could somebody follow this? Whether it is
19 right or wrong, inclusive or not inclusive,
20 valid or not valid, isn't the question. Is it
21 laid out in a way that you can understand it
22 and try to do it?

1 That's the way I'm answering this
2 question.

3 MS. WILBON: And that's correct.

4 CHAIR WEINSTEIN: Okay.

5 MS. WILBON: And that's correct,
6 yes. So does everyone feel ready to rate it
7 based on Dr. Weinstein's -- okay. So let's --

8 DR. SINNOTT: So what happened to
9 the previous counts?

10 MS. WILBON: Yes, we -- I think we
11 started talking, so we will redo it.

12 DR. SINNOTT: That's fine.

13 MS. WILBON: Okay.

14 CHAIR WEINSTEIN: Should we go
15 into -- there are some issues here, you know.

16 MR. AMIN: That was two high and
17 four moderate.

18 MS. WILBON: Okay.

19 CHAIR WEINSTEIN: Yes. What's the
20 next question? Could we just see the next
21 question? Because I think somehow if we know
22 the question, we can have a discussion that

1 may be very focused.

2 MS. WILBON: Right.

3 CHAIR WEINSTEIN: So this question
4 is does the reliability testing -- and I'm not
5 sure they did reliability testing.

6 Does the group want to -- does the
7 creator want to say something about that? Did
8 you guys do any reliability testing?

9 DR. MANHEIM: Not the extent of
10 did not have an independent programmer try and
11 program it. They got the same results as us.

12 CHAIR WEINSTEIN: Yes. So I don't
13 -- so how do we -- they didn't do it.

14 MS. WILBON: Insufficient.

15 CHAIR WEINSTEIN: Insufficient.

16 Okay. Can we vote now or do you want to have
17 more discussion?

18 MS. TURBYVILLE: So, yes, just a
19 couple of things to think about reliability
20 before you vote. There is in some cases some
21 of the TAPs have presumed, at minimum, a date
22 element reliability, because it is a

1 commercial database.

2 CHAIR WEINSTEIN: Oh, but this
3 isn't --

4 MS. TURBYVILLE: And that is --

5 CHAIR WEINSTEIN: -- though.

6 MS. TURBYVILLE: This is a -- it
7 was tested on a commercial database and it's
8 administrative data, which typically goes
9 through when you are talking about the data
10 element --

11 CHAIR WEINSTEIN: Yes.

12 MS. TURBYVILLE: -- certain checks
13 prior to it being in the database, so they
14 have considered that. And then also, I
15 believe, and correct me if I'm wrong, with the
16 measure developer with all the ABMS-REF
17 measures, they -- in their reiterative process
18 in reviewing it with the work groups, because
19 of the complex programming, they were using
20 that as a proxy to demonstrate reliability.

21 How you rate that, you know. So
22 insufficient would indicate that we would, I

1 presume, and correct me if I'm wrong, Ashlie,
2 because this gets into NQF process, would we
3 ask them to submit something? How would we in
4 this context handle an insufficient on this
5 versus a low or moderate?

6 MS. WILBON: Well, at this point,
7 the Committee does have to -- or the TAP does
8 have to rate the measure as it is. So even if
9 they were to submit additional information, if
10 you wanted to see that and then we could go
11 back and you guys could rate it later, based
12 on what they submitted, that's an option.

13 But today, you have to evaluate
14 what you see in front of you as is.

15 Taking what Sally said into
16 consideration, beyond the data element, I'm
17 just looking at Carlos' analysis. He didn't
18 find any other reliability testing that had
19 been done.

20 CHAIR WEINSTEIN: That's where I
21 was going.

22 MS. WILBON: So I did want to get

1 some guidance from Heidi on whether or not --
2 how we distinguish -- how we would distinguish
3 between a low and insufficient if nothing was
4 submitted versus it not being sufficient.

5 MS. BOSSLEY: Right. I mean, they
6 have submitted something. So I think I would
7 probably not do insufficient or make it more--
8 or you would have to really provide that
9 explanation.

10 CHAIR WEINSTEIN: Can I say that
11 it's different based on what Sally said?
12 Maybe this will help us. Maybe this will help
13 based on what Sally said and what I heard you
14 say and you guys, I get the sense, don't want
15 us to say insufficient, right or wrong.

16 But the issue is they didn't do
17 reliability testing. I just want to be clear.
18 What Sally said was that given the database
19 they used and the coding they used and the
20 process they went through to do this, it was
21 a reliable process is what I heard you say,
22 Sally. Don't let me say what -- this is what

1 I heard.

2 And so that, you know, because
3 they did some windsoring and they did some
4 other things that, you know, this is reliable.
5 To me, reliability is test/retest kind of
6 work, which they didn't do, to my knowledge.
7 And they can correct me if I'm wrong.

8 DR. MANHEIM: We have another
9 program -- a look over the program, but we did
10 not have someone do specification and run it.
11 You know, we do rerun, reprogram everything
12 without having the program in front of them
13 and see if they get the same answer.

14 DR. RATLIFF: And what you offer
15 as reliability testing again goes straight to
16 like MarketScan and just to like MarketScan
17 and saying MarketScan is reliable, therefore,
18 our approach is reliable.

19 And I think considering the impact
20 and the power of what the NQF product is, we
21 have got to be cautious with appropriately
22 scoring like this measure. And if it is

1 insufficient, it's insufficient.

2 And then your argument could be
3 offered that, okay, well, that installation
4 doesn't really mean anything, because
5 MarketScan is reliable. That's okay.

6 But in terms of assessing this
7 measure, I think we have to assess this
8 measure.

9 MS. BOSSLEY: So I would say if
10 you all are feeling that it is insufficient,
11 you should say it's insufficient and staff
12 will just need to ask you, if they don't feel
13 that they have enough information, to write
14 the rationale of why you scored it that way.
15 They may ask you that.

16 But I think it is perfectly
17 appropriate for you to feel this is a tough
18 one. Insufficient, typically, is when we say
19 they haven't given anything. But it sounds
20 like they haven't given the right thing or
21 enough information.

22 So or if they haven't given

1 anything, then you just say that it's
2 insufficient. So you just need to provide a
3 good rationale to the staff, so that they can
4 provide it to the Steering Committee.

5 So it's truly your call on whether
6 you want to say low or insufficient.

7 MS. O'NEILL: That's -- the
8 reliability definition up there is pretty
9 narrow. So it pretty much is saying if you
10 ran the same tests on the same population at
11 the same time, you would get the same result.
12 So it's not like some capricious process.

13 And so I think we -- it meets
14 this, but that the point that you are making
15 is if we go out into the general public and
16 use the term reliable, is this what they are
17 going to think we mean or are they going to
18 think we mean something else?

19 CHAIR WEINSTEIN: But you would
20 imagine that if somebody brought a program on
21 running some data with these elements, they
22 get the same result. But you yourself said,

1 Mary Kay, early on about health partners and
2 comparing. You can run into problems. And so
3 I think without being capricious, I think we
4 can say that they didn't run reliability data.

5 So it isn't that it wouldn't be.

6 MS. O'NEILL: Yes.

7 CHAIR WEINSTEIN: It's just not
8 there.

9 MS. O'NEILL: Right.

10 DR. RATLIFF: Shall we vote?

11 MR. AMIN: That was three low and
12 three insufficient.

13 CHAIR WEINSTEIN: But I think the
14 question here precise specifications, I think
15 they did a great job. But then when you take
16 reliability testing, you run into the -- so --
17 I mean, in this one, I would give a little
18 more levity, because I think that the measures
19 they used were reliable.

20 MS. BOSSLEY: No, I understand.

21 Right, no. And here again is where I think
22 you need to use your judgment --

1 CHAIR WEINSTEIN: Yes.

2 MS. BOSSLEY: -- as to how you
3 will rate this.

4 CHAIR WEINSTEIN: Yes.

5 MS. BOSSLEY: And then --

6 CHAIR WEINSTEIN: But I feel this
7 is a little easier to --

8 MS. BOSSLEY: Yes.

9 CHAIR WEINSTEIN: -- rate, because
10 they did have precise specifications. And
11 they probably figured them out with some
12 algorithmic testing that was reliable.
13 Benefit of the doubt here. So, okay.

14 DR. RATLIFF: The only thing they
15 offer for the reliability testing is that they
16 ran the same assessment again using the same
17 database where they measure the same thing
18 with the same ruler and they came out with the
19 same number, so it's entirely reliable, but
20 then they didn't go measure something else
21 with the same ruler to see if it was reliable
22 or not.

1 CHAIR WEINSTEIN: Yes.

2 DR. RATLIFF: Or if it was
3 generalizable to --

4 CHAIR WEINSTEIN: But I think we
5 can answer this one, as a group. So can we
6 score it?

7 MS. WILBON: So we had one high,
8 two moderate, two low and one insufficient.

9 CHAIR WEINSTEIN: Are the measure
10 specifications consistent with the evidence?

11 MS. WILBON: That actually should
12 be intent. Like is the intent of the measure
13 -- I'm sorry. Are the specifications
14 consistent with the intent of the measure?
15 What they are saying that they are measuring.

16 CHAIR WEINSTEIN: Let's have a
17 little discussion, so we are all feeling like
18 we are answering this based on our group
19 discussion. Do you want to say something,
20 Mary Kay? Use your microphone.

21 MS. O'NEILL: Yes. Well, I think
22 this is the one that should reflect our

1 feelings like is this the right time interval?
2 Are we counting things the same way? Are we
3 comparing different provider types?

4 And, you know, I guess part of the
5 conceptual framework that seems -- that we
6 seem to be moving back and forth between is
7 this intent of this measure to measure the
8 resource utilization as driven by a particular
9 physician or other healthcare professional.
10 And is the unit of organization around that,
11 are we really like people are concerned about
12 some may use this measure to figure out if
13 somebody is going to get paid for what they do
14 or are we trying to look at what is the most
15 efficient or, you know, what are the resources
16 used to provide care organized by the
17 individual patient through an episode?

18 And so when we have these thing
19 saying the comparison stuff is between peers,
20 surgeons-to-surgeons, chiropractors-to-
21 chiropractors, PTs-to-PTs, that's one purpose.
22 But if we are going to say if somebody, you

1 know, walks into your hospital or your
2 healthcare delivery system in Dallas, are they
3 cared for well, then it really doesn't make
4 sense to then just compare the surgeon-to-
5 surgeon.

6 What makes sense is to compare
7 episode-to-episode and whether that is four
8 PTs, an average .5 surgical, you know, X
9 number. You know what I'm saying? So I have
10 a hard time trying to figure out if we are
11 talking about the performance of an individual
12 physician or the care of an individual through
13 an episode. And those are really different
14 kinds of things.

15 And O & E, expected and observed--

16 CHAIR WEINSTEIN: But these are
17 things, you know, in models you could adjust
18 for, if you characterized that. And you could
19 understand the variance based on that specific
20 variable. So it could be done. It wasn't
21 done, but that's okay. And they are saying
22 they should correct this if we are

1 misinterpreting.

2 They are saying that they are
3 doing this by comparing apples-to-apples. I'm
4 not sure that's so easy with the coding
5 issues, but I think your point is well-taken.

6 MS. O'NEILL: Well, the intent is
7 to look at the episode of care. So then some
8 of the issues around comparing physician type-
9 to-physician type moves me away from thinking
10 that supports the resource use of the episode
11 with the organizing principle being the
12 patient as opposed to the provider.

13 DR. RATLIFF: Yes, I would like to
14 touch on that. Again, their end result seems
15 to be more physician or provider centric. A
16 little less a group of patients say in Dallas
17 versus a group of patients in Philadelphia,
18 does Philadelphia do a better job than Dallas?
19 Not so much. Nor does a physician at HUB do
20 a better job than a physician at Jefferson in
21 terms of resource utilization for a given set
22 of patients' episodes of care. Is that

1 getting to what you are asking?

2 MS. O'NEILL: Yes, yes.

3 DR. MANHEIM: And that was our
4 intent.

5 CHAIR WEINSTEIN: If you did turn
6 this to the patient, independent of the
7 provider, which ideally would be the case,
8 because a patient should be treated, you know,
9 fairly uniformly in a system, given a
10 diagnosis. You know, if they have
11 hypertension, they are going to get X. If
12 they have an MI, they are going to get Y,
13 independent of who the treating person is.

14 In this case, the multidiscipline
15 confounding that occurs makes this very hard
16 to discern. And that is where I think you
17 have to do these sub-categorization analyses,
18 because what you would probably find is that
19 the outcomes could be the same, if you had
20 some systematic approach, which we are not
21 seeing here and it's not really addressed.

22 But I think for this particular

1 question, as we have been instructed, are the
2 measure specifications consistent with the
3 method or consistent with -- what term did you
4 use, other than evidence?

5 MS. WILBON: The intent.

6 CHAIR WEINSTEIN: The intent.

7 MS. WILBON: Or the focus of that.

8 CHAIR WEINSTEIN: So I think they
9 laid out what the intent was. I assume they
10 were consistent with their intent. Is that
11 intent going to help the measure be more valid
12 or not? I don't know. We have some questions
13 about that as a group.

14 Any more discussion? Patricia or
15 anybody else about this?

16 MS. TURBYVILLE: Just for -- to
17 capture, so it was two moderate and four low.
18 So was the voting -- the rating of this based
19 on some concern of the administrative data as
20 well as some of the -- so that the diagnostic
21 codes perhaps aren't -- so if you could
22 rephrase what -- for this particular validity

1 issues are, so we can --

2 CHAIR WEINSTEIN: Somebody who had
3 low -- well, this isn't a judgment. Can
4 somebody who picked low speak to why they said
5 low?

6 MS. WILBON: It would be helpful.

7 MS. O'NEILL: So if the measure
8 intent is to measure the resource uses in the
9 episode of care, and you -- and as we have
10 established with our earlier discussions, that
11 there is a lot of variability in what kind of
12 resources can be put forward to a given
13 episode, if we start sorting things then by
14 physician type and comparing people to peers,
15 you will end up with an analysis that says
16 that whatever provider type is driving the
17 episode is the appropriate one and that will
18 not come into question.

19 So surgeons will be related to
20 surgeons, whereas, I think as Jim points out,
21 there is a subgroup within this population
22 that are surgical cases and a subgroup that

1 are not. And there would be no way to
2 differentiate whether the surgical services or
3 the extensive or minimal PT services or
4 whatever is the right application of resource
5 to the particular episode.

6 So I think we lose the ability to
7 critically look at the resource uses on an
8 episode from an appropriateness perspective by
9 the way it is constructed. And that's my
10 concern.

11 CHAIR WEINSTEIN: Anybody else
12 want to comment for Sally's question?

13 MS. TURBYVILLE: So that would be
14 then shared across the others who rated low.
15 And the other reasons that we should be sure
16 to capture to understand that rating.

17 DR. RATLIFF: I voted moderate,
18 but I don't disagree with that at all. I
19 think that's a pretty succinct explication of
20 one of the major weaknesses of this approach.

21 CHAIR WEINSTEIN: Is that helpful,
22 Sally?

1 MS. TURBYVILLE: Yes. Thank you.

2 DR. SINNOTT: It doesn't mean that
3 any of us have a better idea of how to do it.

4 CHAIR WEINSTEIN: Well, I
5 disagree. I disagree, because I think you
6 could validate this. In validation, you could
7 look at subgroups treated by different
8 specialties and actually do some, you know,
9 chart reviews. There is ways to validate
10 this.

11 And people have done those kinds
12 of things. So we shouldn't suggest it is
13 impossible.

14 MS. SINNOTT: I'm not suggesting
15 it isn't possible, but I'm assuming that we
16 haven't -- if we are limited to administrative
17 data --

18 CHAIR WEINSTEIN: Yes.

19 MS. SINNOTT: -- as currently
20 known, then we haven't figure it -- we may not
21 have figured it out yet.

22 CHAIR WEINSTEIN: But I think

1 there is an algorithm you could apply to this
2 that might be more acceptable. And what I
3 alluded to before is, you know, beginning of
4 episode with symptoms, MRI, time to surgery,
5 length of stay, did they go -- you know, did
6 they have other visits?

7 You could look at their -- a
8 cohort of patients with an administrative
9 database and get a sense of are they different
10 than those treated by chiropractors or
11 physical therapists or even surgical
12 differences.

13 So I agree with the limitations of
14 the database for sure, but there are some
15 other kinds of codes and other codes where we
16 could actually probably get more specificity
17 around a cohort of patients.

18 MS. SINNOTT: My only concern
19 about that is what we refer to in California
20 as the Redding effect, which is that people
21 get heart surgery when they don't need it and,
22 therefore, the outcomes look great.

1 CHAIR WEINSTEIN: Yes, that's the
2 Dartmouth data. We reported that.

3 MS. SINNOTT: Right.

4 CHAIR WEINSTEIN: Yes, so I'm very
5 familiar. We see that all --

6 MS. SINNOTT: We'll call it the
7 Redding effect.

8 CHAIR WEINSTEIN: Yes. But that's
9 pervasive. The issue really is, and that's
10 why I brought that up in the very beginning,
11 the indications and the way we use these
12 codes. And NQF is very interested in patient
13 preferences. We just talked about it. None
14 of these things are captured giving good
15 information when patients have chosen those
16 kind of treatment algorithms.

17 And we know from our studies the
18 answer is no. 30 percent wouldn't have. So
19 we are taking the best we have to look at
20 something in a phase and we are going to
21 continue to make it better.

22 But I think our job is to try to

1 congratulate the people who are doing this
2 work, because it's really hard, to try to help
3 us get to a new level of understanding. And
4 then improve the database, so that we can get
5 more specificity and more validity of sub-
6 populations.

7 Until we include patient
8 preferences, so informed choice I would say,
9 until we include outcomes and the diagnostic
10 testing that validates, including the physical
11 exam, we are not going to have the physician
12 groups, anyhow, agreeing that this is a valid
13 sub-population that is like my patients, you
14 know.

15 So we all understand that.

16 MS. WILBON: So this question is
17 about validity testing and whether or not what
18 they submitted reflects that they have
19 demonstrated that the measure score or the
20 data elements are valid.

21 CHAIR WEINSTEIN: Any comments on
22 this before we vote from the group?

1 MS. O'NEILL: I just have to make
2 my standard comment on costs. So if you want
3 to know what that is, I mean?

4 CHAIR WEINSTEIN: We do.

5 MS. O'NEILL: I think actual money
6 spent is a resource used and so standardized
7 pricing while understanding that they even out
8 market differences and contractual differences
9 and look at utilization decisions, I do think
10 that it needs to be really clearly put
11 forward, first of all, that if something looks
12 like a dollar figure on the results, that they
13 aren't real dollars, that they are standard
14 dollars. And it think that is hard for the
15 public to interpret.

16 And that there is value to be able
17 to crosswalk these things in different
18 situations to actual dollars, because those
19 are the resources people are using for care.

20 CHAIR WEINSTEIN: Just to be
21 clear, are you suggesting that resource
22 utilization is not a surrogate for cost?

1 MS. O'NEILL: It is not a
2 completely accurate surrogate for cost, no.

3 CHAIR WEINSTEIN: But a lot of
4 people use that methodology?

5 MS. O'NEILL: Oh, I know that.

6 CHAIR WEINSTEIN: Yes. Yes. No,
7 but I want to understand why it is -- I mean,
8 it does -- again, I go back to the notion it
9 gets us started on a path. You know, Kaplan
10 uses TD ABC, you know, activity-based cost
11 accounting, where you actually have to measure
12 every time that a nurse is there for 30
13 seconds or a radiologist spends two minutes on
14 an x-ray film.

15 MS. O'NEILL: Yes, but he is
16 talking about his business costs under his own
17 roof. It has nothing to do, I'll tell you, I
18 contact with them, with what he is charging
19 me.

20 CHAIR WEINSTEIN: Yes.

21 MS. O'NEILL: Or the employers
22 that we represent or the out-of-pocket of our

1 membership.

2 CHAIR WEINSTEIN: No. I

3 understand the different --

4 MS. O'NEILL: Okay.

5 CHAIR WEINSTEIN: -- methodologies
6 to costing, but I think what they are trying
7 to simply do is say that resource utilization,
8 which is being measured here, is a surrogate
9 for cost in some way.

10 MS. O'NEILL: Well, just as it is
11 -- other things that we are measuring are
12 approximations and not completely accurate and
13 we feel like to be fully transparent, you need
14 to call that out.

15 CHAIR WEINSTEIN: Yes, yes.

16 MS. O'NEILL: You know, because I
17 can tell you I did a little work on some spine
18 fusion practices in the State of Wyoming and
19 not only was the frequency considerably
20 different, the cost per case was considerably
21 different.

22 So if we did standardized costing

1 between a fusion and -- you know, I mean, we
2 are losing 50 percent of the financial
3 information, if you will.

4 MS. SINNOTT: But --

5 MS. O'NEILL: So but I understand
6 why we are doing it. I just want it -- I want
7 -- people look at a dollar figure and that is
8 something that most people think they
9 understand what it means.

10 If we are doing standardized
11 costing, and we are reporting it out, it just
12 needs to be clear that this has taken away the
13 -- it has nothing to do with the -- what has--

14 CHAIR WEINSTEIN: It's the average
15 versus the variability. Is that what you are
16 worried about?

17 MS. O'NEILL: Yes. And then in
18 given markets it may be way -- nowhere near
19 average. So I mean --

20 CHAIR WEINSTEIN: Because I know
21 your point.

22 MS. O'NEILL: Yes.

1 CHAIR WEINSTEIN: I mean, spine
2 fusion is a good example.

3 MS. O'NEILL: Yes.

4 CHAIR WEINSTEIN: Where, you know,
5 there is -- but the rates of those procedures
6 in various areas are so different and the
7 utilization or resources to get a fusion is
8 very different, depending on where you live
9 and who you see.

10 MS. O'NEILL: Yes.

11 CHAIR WEINSTEIN: Is that your
12 point?

13 MS. O'NEILL: Well, there is that.
14 And there is -- some of this, I don't know if
15 they were -- the NCQA methodology -- there was
16 some discussion in an early measure looking at
17 charge data.

18 CHAIR WEINSTEIN: Yes.

19 MS. O'NEILL: And we have, for the
20 region around Seattle, a 20-hospital grid
21 based on public available data on the
22 differences between charges and payments and,

1 you know, there is completely different games
2 that are played with charge-master and
3 discount levels.

4 So there was one hospital that had
5 huge discounts, but they still were more
6 expensive than everybody else, because they
7 started with such a high charge-master and the
8 other hospitals said well, we don't charge
9 very much, had a low charge-master, but almost
10 no discount.

11 You know, I mean, there is lots of
12 number games out there that are -- that end up
13 being significant to --

14 CHAIR WEINSTEIN: I want to
15 understand the variables of those number
16 games, so that we can be clear for our
17 reporting.

18 MS. O'NEILL: Right.

19 CHAIR WEINSTEIN: Because you
20 mentioned contracting and everybody has got
21 sort of a secret contract. And what they pay
22 for things is different with CIGNA than it is

1 with United.

2 MS. O'NEILL: Correct.

3 CHAIR WEINSTEIN: It's different
4 than Medicare. Is that your point in some
5 ways?

6 MS. O'NEILL: That is.

7 CHAIR WEINSTEIN: Okay. I wanted
8 to try to be clear.

9 MS. O'NEILL: So how much it costs
10 to care for these folks, really costs to
11 people who are really paying the bills, that
12 actual piece of information is only vaguely
13 approximated by standardized pricing and
14 that's a --

15 CHAIR WEINSTEIN: Agree, agree.
16 Thank you.

17 MS. SINNOTT: But I think we are
18 also interested in the variation in
19 utilization. So there is really a
20 standardized cost that gets applied to the
21 utilization variation, which is different from
22 the variation in the contract charge or

1 contracted payment.

2 MS. O'NEILL: Correct. I mean,
3 and when I first started this, I was trying to
4 make the position that we should count things,
5 instead of put a dollar figure on it that was
6 an average, because it started leading us down
7 to a path of having an apparently
8 interpretable piece of information that was
9 really inaccurate on the local level.

10 However, I understand standardized
11 pricing also functions to relatively weight
12 different types of utilization. So, you know,
13 if we do standardized pricing, you can
14 relatively weight over-utilization of labs
15 versus over-utilization of surgery, which
16 would have very different impacts.

17 So I understand the purposes of
18 it, but I just think it needs to be called out
19 that there would need to be a translation, if
20 financial decisions or economic decisions are
21 being made, there needs to be a translation,
22 to the real number.

1 Not to stop it, but those are two
2 different columns on the sheet.

3 CHAIR WEINSTEIN: And there are
4 regional differences in those payments.

5 MS. SINNOTT: Yes.

6 CHAIR WEINSTEIN: At least
7 threefold, at least.

8 MS. SINNOTT: Oh, yes.

9 CHAIR WEINSTEIN: So --

10 MS. O'NEILL: And within regions.

11 CHAIR WEINSTEIN: Right.

12 MS. O'NEILL: By the way.

13 CHAIR WEINSTEIN: Right, right.

14 DR. RATLIFF: So from a patient's
15 perspective with this episode, it may be
16 easier to use those kind of calls to base
17 those or use like one unit cost, because then
18 you may be able to see the patient's
19 utilization of a given resource. So that's
20 the kind of patient.

21 From a physician's perspective,
22 that may be completely meaningless, because

1 what you charge for like a surgery, what a
2 given physical therapist may charge for an
3 intervention may be different than a physical
4 therapist down the street, which is also
5 irrelevant to what the person, the payer is
6 experiencing, since they are seeing all these
7 charges.

8 So again, I think it's a choice of
9 like how you are approaching. Going back to
10 an earlier point that we brought up, how you
11 approach utilizing this evidence-based
12 measure. Whose perspective are you looking
13 from with regards to utilizing this?

14 MS. O'NEILL: But, I mean, from a
15 choice perspective, increasingly all the
16 national carriers right now have on their
17 membership website the actual relative -- the
18 actual different costs of getting different
19 procedures at different facilities based on
20 their benefit design and the contracted rates.

21 CHAIR WEINSTEIN: This is, you
22 know, the whole tiering that is occurring,

1 which gets into that, you know, which then
2 gets in to patient's copays, which gets
3 complicated.

4 MS. SINNOTT: Yes, it does.

5 CHAIR WEINSTEIN: But let's just
6 take the question now with those caveats. No,
7 no, it's very helpful. Thank you. Thank you.
8 It's important. It's important.

9 So does the validity testing
10 demonstrate that the measure data elements are
11 correct and/or the measure's score correctly
12 reflects the cost of care or resources
13 provided adequately distinguishing high or low
14 cost or resource use?

15 Which I think is some of your
16 point. You are not sure that it does.

17 MS. SINNOTT: Not the cost, the
18 resource.

19 CHAIR WEINSTEIN: Yes. Any other
20 questions before we answer this one? Okay.
21 So are exclusions supported by the clinical
22 evidence for analysis of frequency and

1 distribution? Is information about impact of
2 exclusions for patient preference transparent?

3 Now, this is impossible. I'm
4 sorry, because patient preference isn't really
5 measured or captured, yes. Thank you. So
6 it's another one where we have insufficient
7 information.

8 Are you okay, Heidi, with this?

9 MS. BOSSLEY: Yes.

10 CHAIR WEINSTEIN: Sorry to
11 distract you.

12 DR. RATLIFF: I don't think we
13 measured all of them --

14 MS. BOSSLEY: Sorry, I'm multi-
15 tasking.

16 CHAIR WEINSTEIN: Yes.

17 DR. RATLIFF: -- or discusses this
18 even.

19 CHAIR WEINSTEIN: Right. Okay.
20 Can we go onto the next one?

21 MS. WILBON: It was three low,
22 five insufficient. I'm sorry, one low, five

1 insufficient.

2 CHAIR WEINSTEIN: This gets into
3 risk adjustment, 2(b), for outcome measures.
4 Is there evidence-based risk adjusted strategy
5 or rationale data support -- no risk
6 adjustment. So we think that there needs to
7 be risk adjustment, so the second part of this
8 isn't necessary, because if we didn't, then it
9 wouldn't need to be there.

10 So the question is is there
11 evidence that risk adjustment strategy was
12 used? Any discussion about this before we
13 vote?

14 DR. RATLIFF: We discussed this
15 earlier in terms of a risk adjustment
16 methodology and the complexities entailed
17 there. Obviously, they have a methodology,
18 I'm just not sure that it has been validated
19 or that it is generalizable.

20 I mean, it seems reasonable from
21 my interpretation of it, but, again, it's a
22 relatively dense approach to risk adjustment.

1 CHAIR WEINSTEIN: Any other
2 comments?

3 MS. WILBON: So I just wanted to
4 point out, so the -- what we have on this
5 slide is an abbreviated version of the
6 criteria, so I just wanted to read the full
7 2(b)(4).

8 So it says that "For outcome
9 measures and other measures, which includes
10 resource use, when indicated, and evidence-
11 based risk adjustment strategy is specified
12 and based on patient clinical factors that
13 influence the measured outcome and that they
14 are not risk adjusting away disparities, that
15 they are measuring patient clinical factors
16 that are present at the start of care and they
17 have demonstrated adequate discrimination and
18 calibration."

19 So that's the whole criteria that
20 we are evaluating, at this point.

21 CHAIR WEINSTEIN: But not
22 including disparities?

1 MS. WILBON: Right. So NQF,
2 basically, has done work and wants to ensure
3 that people are not including disparity type
4 factors, race, ethnicity, into risk models,
5 which those things should actually be
6 stratified for, so they can be addressed
7 rather than adjusted away.

8 So that's just something we had in
9 there for clarification.

10 CHAIR WEINSTEIN: I'm not sure
11 they did that though. And I'm not sure their
12 population addressed that. Could I have
13 clarification on that?

14 MS. WILBON: Sure.

15 CHAIR WEINSTEIN: Did you
16 stratify, based on race, in your mind?

17 DR. MANHEIM: No, we did not,
18 because we cannot measure it in mixed up data.

19 CHAIR WEINSTEIN: Yes, that's what
20 I thought.

21 MS. WILBON: So this question is
22 just asking about their risk adjustment model

1 and what they actually -- there is actually a
2 separate criteria for disparities that we will
3 get to in just a second. But this one is
4 asking specifically about their risk
5 adjustment model.

6 So it was two moderate and four
7 low.

8 CHAIR WEINSTEIN: Next question.
9 This is about the scoring analysis. Are
10 performance results reported? Do they
11 identify differences in performance or overall
12 less than optimal performance?

13 And, to me, they didn't actually
14 compare performance. Unless this means --
15 they didn't do it across systems, because they
16 only had one, but they did it across
17 providers. Is that where we are at here?

18 MS. WILBON: Observe versus
19 expected?

20 CHAIR WEINSTEIN: Yes.

21 DR. RATLIFF: That would appear to
22 be it, just observe versus expected per

1 provider.

2 CHAIR WEINSTEIN: Right.

3 DR. RATLIFF: As opposed to --

4 CHAIR WEINSTEIN: So is that okay?

5 DR. RATLIFF: -- really scoring
6 the performance.

7 MS. WILBON: Yes. I just want to
8 again read the full criteria. So again, these
9 are just kind of abbreviated versions and it's
10 not as robust as what we have on the slide.

11 So 2(b)(5), actually, asks
12 "Whether or not the data analysis demonstrates
13 that the methods for scoring an analysis of
14 the specified measure allow for identification
15 of statistically significant and practically
16 or clinically meaningful differences in
17 performance."

18 CHAIR WEINSTEIN: Yes, I just --

19 MS. WILBON: Or that there is --

20 CHAIR WEINSTEIN: Just go back to
21 the statistician's problems, which we
22 discussed, that they weren't adequate, but it

1 doesn't mean they didn't try. So that's all.

2 Any other comments by the group
3 before we vote?

4 DR. RATLIFF: I guess the
5 statistician's concern was that they were
6 extracting from like the raw numbers to these
7 ratios based on their distributions and that
8 like extraction was an issue for the
9 statistician.

10 CHAIR WEINSTEIN: Right. And they
11 tried to address it.

12 MS. WILBON: So the score was six
13 low.

14 MR. AMIN: Can I ask the Committee
15 to give a little bit more clarification on
16 this one, just for our rationale?

17 CHAIR WEINSTEIN: The last one?

18 MR. AMIN: This last one, the one
19 with six low. Is the concern around the
20 distribution of the ratio or how the ratios
21 are actually developed for the scoring?

22 CHAIR WEINSTEIN: I think it's how

1 they were developed.

2 DR. RATLIFF: I would almost defer
3 to your statistician's comments with regards
4 to how they are extracting.

5 CHAIR WEINSTEIN: Which we are
6 weighing some of our thoughts based on that as
7 well.

8 DR. RATLIFF: Right.

9 CHAIR WEINSTEIN: We are weighing
10 some of our thoughts based on Carlos'
11 interpretation.

12 MS. O'NEILL: Yes. So it was hard
13 to tell if the numbers were different, that's
14 one piece. And, you know, I guess back to my
15 more philosophic thing, some of the
16 practicality of what is measured in terms of
17 what intervention you might take within a
18 system to improve things, you know, seems to
19 me a little limited, because we go from -- we
20 go directly to peer physician resource
21 utilization and not episode of care of the
22 patient in terms of efficient -- you know, the

1 utilization.

2 MR. AMIN: Thank you.

3 DR. RATLIFF: I guess for me it
4 would work a little bit better if it was just
5 kind of clean and here is your expenditures
6 per episode, per physician as opposed to
7 extrapolating out or kind of normalizing
8 between different episodes and then giving
9 that normalized data as an observer versus
10 expected for a given physician.

11 I voted a little bit crisper and
12 like here is what your payment was per
13 episode. Okay.

14 CHAIR WEINSTEIN: And it gets into
15 these, you know, sub-populations that may be
16 different, too. So it's not bad, it's just
17 the best you can do with this.

18 Oh, is that it?

19 MS. WILBON: There is one more.
20 And this one tends to be not applicable, only
21 because there are only -- yes, they are only
22 using one data source which is the admin data,

1 so --

2 CHAIR WEINSTEIN: So do we have to
3 vote?

4 MS. WILBON: No. We will just
5 make this one not applicable.

6 CHAIR WEINSTEIN: Okay. So is it
7 break-time?

8 MS. WILBON: Not quite. We have
9 got a couple more.

10 CHAIR WEINSTEIN: Oh, right.

11 MS. WILBON: So we do need you to
12 kind of give a roll-up score of the overall
13 validity based on those five -- well, minus
14 the multiple data sources, but those four
15 bullets about the specifications being
16 consistent, the validity testing, the risk
17 adjustment and the identification of
18 statistically meaningful differences.

19 So kind of a summary judgment on
20 how they scored on validity.

21 CHAIR WEINSTEIN: Just for
22 comment, because I think for the people from

1 NQF, I mean, I think this is complicated. And
2 we will find this, you know, at least for me,
3 that Ingenix did a lot more work with a lot
4 more population, so you have more testing of
5 it, which allows you to make some different
6 interpretations maybe.

7 This measure has not -- this ABMS
8 effort has not going through that sort of
9 process. And I think they are early in their
10 work. Maybe I'm wrong, but it's my
11 interpretation.

12 But I want you to understand it's
13 not we are trying to make this harder or
14 easier, we are just trying to base it based on
15 what we have seen.

16 DR. RATLIFF: And I would echo
17 that comment. I don't think this is at all
18 saying that this is not a reliable measure.
19 It's simply that the testing hasn't been done.

20 I think the measure itself is like
21 very promising. It just hasn't been exported.

22 CHAIR WEINSTEIN: Their stuff is

1 very, you know, I think, clearer than I think
2 Ingenix in many ways.

3 MS. O'NEILL: And I think if some
4 of the issues that we have raised here and the
5 testing were available in many regards, I
6 think the sort of philosophic structure of
7 these measures is actually in a practical
8 sense somewhat more actionable than Ingenix.

9 You know, because as a clinician,
10 I look at Ingenix and I'm like what would I do
11 next? I don't know. So anyway, I guess I
12 also would like to put it -- if there is an
13 encouragement -- is there an encouragement
14 vote? Keep going, keep going.

15 MS. WILBON: So the overall, for
16 those on the phone, the overall validity
17 rating was six low. We are just going to vote
18 on the last sub-criterion which is 2p for
19 disparities and then we will take a break.

20 DR. RATLIFF: And if their
21 database didn't give them data to assess
22 disparities between different ethnic groups,

1 then we ought to opt out of this one, also.

2 MS. WILBON: Right. I mean, it
3 could be insufficient and this, again, is
4 something that other committees and TAPs have
5 weighed and whether or not it is a limitation
6 of the measure or a limitation of the data of
7 the admin data itself and just kind of where
8 we are with collecting disparities data, in
9 general.

10 So I think, you know, --

11 DR. RATLIFF: This is a limitation
12 of -

13 MS. WILBON: -- weigh that -

14 DR. RATLIFF: -- the database they
15 used.

16 MS. WILBON: Right. And so, you
17 know, weigh that in your consideration and
18 then we will just make sure, depending on the
19 rating that we get rationale for why that
20 particular rating was as such.

21 MR. AMIN: That was one low and
22 five insufficient.

1 MS. SINNOTT: I just wanted to say
2 something about the validity scoring just to
3 reinforce that it is not a belief that it
4 couldn't be good, but it is a criteria for
5 making it better. You know, and that the
6 group has strong feelings that it is very
7 interpretable and would be very well-received
8 by physicians or other providers.

9 DR. RATLIFF: And I would echo
10 that as well. I think we are more or less
11 answering the questions you are posing. So we
12 are not at all saying that this is not a valid
13 measure or that we would all imply that there
14 is low validity applied to this measure.

15 I think it's a very good measure.
16 It's simply that it was explored in one
17 database. And in answering the question that
18 you posed, some of these issues have not been
19 fully sussed out, but that's more perhaps
20 standardized questions applied to a bunch of
21 different models as opposed to a problem with
22 the model itself.

1 CHAIR WEINSTEIN: There are some
2 very specific things and we are not piling on
3 here, but I think that the notion is is that
4 I actually think this is an easier measure
5 potentially to use. They exclude some things
6 like the pharmacy benefits or exclude patients
7 without pharmacy benefits, which is really a
8 positive.

9 But I find this -- you know, most
10 people could use this. They wouldn't have to
11 buy the Ingenix tool, which I think we are
12 going to get to that, you know, later on,
13 which is a big issue, because the CMS site
14 allows this kind of use for everybody.

15 So there is some usability issues
16 here that are very significant and I wouldn't
17 want to get lost in them feeling criticized
18 inappropriately. So just to echo the comment.

19 MS. WILBON: So let's go ahead and
20 take like maybe a 10 minute break. I know
21 originally we had 15, but we're a little bit--
22 we're not that far behind, but about 15

1 minutes.

2 CHAIR WEINSTEIN: We'll catch up.

3 MS. WILBON: We'll catch up. So
4 we are going to come back and finish usability
5 and feasibility for this measure and then move
6 on to the Ingenix measure.

7 So for those on the phone, a 10
8 minute break. Thank you.

9 (Whereupon, at 11:16 a.m. a recess
10 until 11:30 a.m.)

11 CHAIR WEINSTEIN: Are the measure
12 performance results reported or suitable to
13 report to the public at-large in national or
14 community reporting programs? Is there
15 evidence that the measure performance results
16 are available?

17 So this is two separate questions
18 in some ways. I guess we have one answer for
19 both, which is hard, because right now, they
20 are not available. And they need some work.
21 They could be available for Part B. For A of
22 Part 3(a)(1), are the results reported in

1 public? They are not.

2 So do we again go with
3 insufficient or are we going to -- how are
4 people interpreting this differently than me?

5 MS. O'NEILL: It seems like
6 insufficient is the appropriate thing, because
7 the other ones seem like we are judging how
8 well they are doing this. And they aren't
9 doing it, so -- and it's part of that sort of
10 general signal that this is a measure in
11 development.

12 CHAIR WEINSTEIN: Right.

13 DR. RATLIFF: And the developers
14 know they've got Robert Wood Johnson funds for
15 their ongoing development and this is a
16 developing process.

17 MS. O'NEILL: Right.

18 DR. RATLIFF: So they are just not
19 there yet. I think it is sufficient probably
20 just, you know, making that point.

21 CHAIR WEINSTEIN: Do you have any
22 comment, Taroon?

1 MR. AMIN: I think the only
2 comment that would be made here is recognizing
3 that the process of where resource measures
4 are in development broadly, the expectation
5 that it would be reported to the public at-
6 large is not necessarily --

7 CHAIR WEINSTEIN: I think if you
8 had the question, are the measure performance
9 results expected to be reported, you know, at
10 some point? Yes. But that's not the
11 question.

12 MR. AMIN: Yes.

13 CHAIR WEINSTEIN: So we can't
14 really say anything but insufficient. But I
15 just want you to understand that.

16 MR. AMIN: Right.

17 CHAIR WEINSTEIN: Yes. I hate to
18 say that we haven't voted, but -- there were
19 six insufficient.

20 DR. RATLIFF: Yes, six
21 insufficient, sir.

22 CHAIR WEINSTEIN: So did the

1 submitted information demonstrate that results
2 produced by the measure are meaningful,
3 understandable, useful for quality improvement
4 and public reporting or was a credible
5 rationale presented? Discussion by the group?
6 I don't want to lead this one, because I'll
7 say the wrong thing.

8 MR. AMIN: It's being evaluated,
9 right?

10 CHAIR WEINSTEIN: Any other
11 comments? Anybody else? Patsy, anything?
12 No. Okay.

13 DR. RATLIFF: It's two moderate
14 and four insufficient.

15 CHAIR WEINSTEIN: Okay. Are the
16 data and result details maintained such that
17 the resource use measure, including the
18 clinical and construction logic for a defined
19 unit of measurement can be decomposed,
20 interesting word, to facilitate transparency
21 and understanding?

22 MS. WILBON: I'm sorry. I just

1 want to go back before we get into this one.
2 Can you just give me an idea of why the
3 insufficient for whether or not -- for 3(b),
4 whether or not the measure is meaningful,
5 understandable and the results are useful? Is
6 that based on some of the issues you had with
7 the scientific acceptability and the reporting
8 of the measure scores? Could you just give
9 me --

10 DR. RATLIFF: I voted moderate,
11 because I was giving them the benefit of the
12 doubt that as they developed this per their --
13 they are probably going to get there. I could
14 easily see voting insufficient, though, with
15 the idea being that this is under development
16 and we don't know where they are going to
17 bring that train into the station.

18 CHAIR WEINSTEIN: Yes.

19 MS. WILBON: Okay.

20 MS. O'NEILL: I think, you know,
21 that some of the questions even that Carlos
22 raised about the observed versus expected and

1 what those numbers were, we can't tell until
2 it has sort of been run through the drill
3 whether or not you are going to get a usable
4 result that would change practice patterns,
5 because we can't tell yet really if those are
6 different numbers, you know, with the
7 confidence intervals.

8 CHAIR WEINSTEIN: The danger of a
9 priority accepting something without the
10 evidence would not be in our best interest, at
11 this time.

12 MR. AMIN: Any time.

13 CHAIR WEINSTEIN: Are the data and
14 result details maintained such that resource
15 use measure, this particular measure,
16 including the clinical and construction logic
17 for a defined unit of measurement can be
18 decomposed, I guess disassembled, to
19 facilitate transparency and understanding?

20 So if you broke this down, this
21 measure, could people really understand it?
22 I would change the word decompose, but

1 questions by our colleagues about this?

2 DR. RATLIFF: So I guess just
3 logistically, is this referring to the observe
4 versus expected ratio that is being developed
5 by additional practitioners or is this the
6 more overall data set that is being developed
7 in evaluating each patient's episode?

8 MS. WILBON: It's more about the
9 construction of the measure. So in the way
10 that it is specified, so how they have
11 constructed the episode, how they are
12 assigning and attributing, you know, the cost
13 of the physician.

14 DR. RATLIFF: Not just the end
15 result, but the entire spectrum?

16 MS. WILBON: The entire measure.
17 Could somebody kind of take it apart and say
18 oh, okay, I understand how they are
19 attributing physicians. I understand how the
20 time -- you know, the --

21 CHAIR WEINSTEIN: As to the
22 construction of this --

1 MS. WILBON: -- how it is risk
2 adjusted, right.

3 CHAIR WEINSTEIN: -- model, is it
4 understandable?

5 MS. WILBON: Right. The different
6 pieces of it, you know.

7 MS. O'NEILL: And could you build
8 it with their --

9 MS. WILBON: Right.

10 MS. O'NEILL: -- based on their
11 definitions?

12 MR. AMIN: That's two high and
13 four moderate.

14 CHAIR WEINSTEIN: Next question.
15 Does the measure meet NQF -

16 MS. WILBON: So that's for
17 overall.

18 CHAIR WEINSTEIN: Oh, sorry. Does
19 the --

20 MS. WILBON: Yes, no, that's --

21 CHAIR WEINSTEIN: We don't do
22 that.

1 CHAIR WEINSTEIN: Are the required
2 data elements routinely generated and used
3 during care delivery?

4 MS. WILBON: So 4A and 4B, are
5 those two feasibility criteria that I was
6 telling you about, that because these measures
7 are based on admin data and admin data are
8 generally created during care delivery, and as
9 is 4B, which refers to whether or not the data
10 elements needed to run the measure are
11 available electronically, which they are.

12 So we can just do a -- if everyone
13 is okay with that --

14 CHAIR WEINSTEIN: Can I argue
15 though?

16 MS. WILBON: Sure.

17 CHAIR WEINSTEIN: Because they are
18 not all available. The preference issue,
19 which is talked about here, it's not in their
20 model, but NQF would want it. So do we --

21 MS. WILBON: But it's not --

22 CHAIR WEINSTEIN: Specified --

1 MS. WILBON: They haven't --

2 CHAIR WEINSTEIN: -- in their
3 model.

4 MS. WILBON: It's not specified in
5 their measure.

6 CHAIR WEINSTEIN: Okay.

7 MS. WILBON: So, as written, you
8 wouldn't need it to run their measure, as
9 specified.

10 CHAIR WEINSTEIN: Correct. Thank
11 you.

12 MS. WILBON: Right.

13 DR. RATLIFF: So working within
14 their model --

15 MS. WILBON: Right.

16 DR. RATLIFF: -- the data elements
17 they are looking at in their model, are we
18 recording that already? Can they get that
19 from an EHR?

20 MS. WILBON: Right.

21 MR. AMIN: That's six high.

22 CHAIR WEINSTEIN: Are the required

1 data elements available in electronic health
2 records or other electronic sources? Is that
3 the same thing?

4 MS. TURBYVILLE: Yes, it should be
5 high.

6 CHAIR WEINSTEIN: So it's just
7 asking the same question a different way?

8 MS. TURBYVILLE: Yes.

9 DR. RATLIFF: Actually, A is just
10 saying that you are measuring it and that's a
11 sign that you are putting that measure into an
12 EHR, I guess. I misspoke, but I'm saying EHR.

13 MS. WILBON: Not just EHR.

14 DR. RATLIFF: Yes.

15 MS. WILBON: This is claims data.

16 DR. RATLIFF: Or claims data.

17 MS. WILBON: Yes.

18 DR. RATLIFF: Some administrative
19 database.

20 MR. AMIN: That's six high.

21 CHAIR WEINSTEIN: Are the -- are
22 susceptibilities to inaccuracies, errors, or

1 unintended consequences and the ability to
2 audit the data items to detect such problems
3 identified? Comments by the group? I'm not
4 sure that they addressed this. Anybody?

5 MS. O'NEILL: Starting with your
6 first point about, you know, what kind of
7 inputs there are to coding, I mean, not that
8 that's an easy thing for anybody to do, but
9 that would be a source of error that is not--

10 CHAIR WEINSTEIN: But it wouldn't
11 be an error from their model, because they are
12 just taking the claims codes.

13 MS. WILBON: Right.

14 CHAIR WEINSTEIN: That would be an
15 error -- a step from the UB-92 forms or
16 something.

17 MS. WILBON: Yes.

18 CHAIR WEINSTEIN: Yes. Any other
19 comments?

20 DR. RATLIFF: I think we have
21 noted them multiple times the potential
22 sources for bias in that.

1 MR. AMIN: That's two high, three
2 moderate and one low.

3 CHAIR WEINSTEIN: Yes, sir. Can
4 the data collection strategy be implemented?
5 Is the measure already in operational use or
6 did testing demonstrate that it is ready to
7 put into operational use?

8 Any comments or questions? My
9 sense of this is just they haven't made a
10 model of this to be industrial. They have
11 just been doing their own testing of it, at
12 this point. So I don't know if it is ready.

13 Does anybody feel differently?

14 DR. RATLIFF: I mean, we discussed
15 whether or not they looked outside of
16 MarketScan or looked to a more generalized
17 approach and the answer was no. So I don't
18 know if this has been explored yet.

19 I think the general concept though
20 probably --

21 CHAIR WEINSTEIN: Yes.

22 DR. RATLIFF: -- is very valid.

1 CHAIR WEINSTEIN: Yes, I'm sure.

2 DR. RATLIFF: Or it could be.

3 CHAIR WEINSTEIN: It's just they
4 haven't done it. My sense is compared to
5 Ingenix, it's got a product out there that
6 they are testing. This is not. That's not a
7 problem, it's just not there. But am I
8 misinterpreting for the group?

9 MS. WILBON: So, again, let me
10 just read the full criteria here to help --
11 hopefully this will help clarify.

12 So it is asking whether or not the
13 data collection measurement strategy can be
14 implemented as demonstrated by operational use
15 and external reporting programs or that
16 testing did not identify barriers to
17 operational use.

18 MS. SINNOTT: So in this case, it
19 has neither external operating -- reporting
20 activities nor has testing been done.

21 DR. RATLIFF: But are you asking
22 us to speculate could it be done? Do we see

1 any barriers to applying this measure to say
2 another provider database?

3 MS. WILBON: Right.

4 MS. O'NEILL: I mean, so the fact
5 that they are just -- they are using standard
6 administrative data, I mean on a very basic
7 level, could another system get at their
8 system standard administrative data? That
9 simple answer would be yes. But has it been
10 vetted? I guess that answer is no, so far.

11 But are we really looking at are
12 the data elements that -- or the inputs to the
13 measure standardly available?

14 MS. WILBON: We're asking more so
15 about how feasible is it or how easy is it for
16 a user to pick this up and implement it? Is
17 it implementable, I guess, if that's a word.
18 And are there barriers to doing that, you
19 know?

20 Right. So examples would include,
21 you know, data availability, timing,
22 frequency, you know, complex sampling required

1 to run the measure, patient confidentiality
2 issues or fees for use of proprietary
3 specifications.

4 So those are some of the things
5 that would, you know, hinder or limit the
6 feasibility of running or implementing the
7 measure.

8 CHAIR WEINSTEIN: Well, but, you
9 know, you and I talked on the phone even for
10 the Ingenix thing, we are going to -- we would
11 have to pay a fee to be a user. We don't know
12 anything about this one.

13 MS. WILBON: Yes, it's -- it would
14 be open to the public. It's a -- it would be
15 free.

16 CHAIR WEINSTEIN: As opposed to
17 Ingenix, which wouldn't?

18 MS. WILBON: Which would not.
19 Which we will get to, obviously, when we
20 discuss that.

21 CHAIR WEINSTEIN: Yes, yes, yes,
22 gotcha.

1 MS. WILBON: Yes.

2 CHAIR WEINSTEIN: I just want to
3 be clear in my own mind.

4 MS. WILBON: Yes.

5 CHAIR WEINSTEIN: But, yes, I just
6 don't know that it is ready. I mean, it's
7 exciting. I'm struggling with the answer to
8 this question. Maybe it's I'm making too much
9 of it. Anybody else?

10 MS. TURBYVILLE: Jim, could you
11 provide some examples of the barriers that you
12 are seeing to it being feasible right now,
13 just for clarity sake?

14 CHAIR WEINSTEIN: Well, I just
15 don't know. I mean, my sense is if this gets
16 validated and it works, are they going to
17 commercialize it? I mean, I don't know what
18 is going to happen. Are they guaranteeing us
19 that this will just be a public measure and
20 they are going to give us the software free
21 for every place in the country?

22 MS. WILBON: So we have them on

1 the phone, so we can clarify. But my
2 understanding is that it would be available
3 publicly, that there wouldn't be any funding
4 for it. We do have a process with all the
5 measure developers that submit measures to us,
6 they have to tell us whether or not they will
7 be charging for it. And this -- any measure
8 that gets endorsed should be available
9 publicly in the specification.

10 So, essentially, what would happen
11 with this measure, as with other measures that
12 are not proprietary with fees, which is a
13 little bit different than what we are going to
14 see with Ingenix, but for this particular
15 measure, the specifications would be available
16 publicly.

17 The developer -- if someone wanted
18 to use this measure, they could email the
19 developer and say hey, I want to run this
20 measure. They would take the specifications
21 back to their house or whatever system they
22 are in and have a programmer program it and

1 they would use it however they intend to use
2 it in their system.

3 CHAIR WEINSTEIN: So this would be
4 Microsoft Resource Utilization Version 1 that
5 I could have for free?

6 MS. WILBON: Yes.

7 CHAIR WEINSTEIN: And install on
8 my computer system?

9 MS. WILBON: Right. Obviously
10 with some programming. But it would be a per
11 system implementation.

12 CHAIR WEINSTEIN: And ABMS has no
13 intent of trying to regain their cost, even
14 though I know they have been funded by RWJ in
15 some way. Is that --

16 MS. WILBON: Yes.

17 CHAIR WEINSTEIN: And we ask them?

18 MS. WILBON: Yes.

19 CHAIR WEINSTEIN: We are asking
20 you.

21 DR. MANHEIM: There is no
22 intention in bringing anything proprietary.

1 CHAIR WEINSTEIN: So you imagine
2 that if the University of North Dakota -- I
3 said I wanted to use your tool, I could go to
4 the website at ABMS, download it and I could
5 be in business? And you --

6 DR. MANHEIM: Yes, it would
7 require some programming on your part.

8 CHAIR WEINSTEIN: Yes. And if
9 there was a problem with it, you would have a
10 1-800 I have a problem number?

11 DR. MANHEIM: Todd, do you know
12 the answer to that?

13 DR. LEE: It wouldn't be a
14 software application that would be available.
15 It would be the specifications and the
16 technical appendices that would be available
17 that users would need to translate into a
18 software application, whether it is, you know,
19 a vast programming language or some other
20 application that they could use to run their
21 data through our algorithm.

22 CHAIR WEINSTEIN: Yes. So my

1 sense is sometimes that is not so easy. And
2 so those were my questions. Sorry.

3 MS. SINNOTT: And also, a
4 programmer isn't a programmer and that that
5 kind of translation doesn't necessarily happen
6 in a valid way.

7 CHAIR WEINSTEIN: That's right.
8 That's what I was asking. They are not going
9 to have technical support though.

10 DR. RATLIFF: But if the NQF
11 adopts this measure, does the NQF then
12 popularize it or are you just going to say
13 hey, this is a good measure?

14 MS. WILBON: So, no. NQF - once
15 they are endorsed, they are just out there.
16 We do -- we are looking to -- we will have a
17 database available hopefully later this year
18 that will provide like a central housing for
19 all of our measures that are endorsed and give
20 access to the public. Give the public access
21 to the measures and to contact information to
22 developers to ask questions.

1 But it is common that a lot of
2 developers don't have -- you know, they offer
3 support, I guess, as they are contacted, but
4 I'm not sure --

5 CHAIR WEINSTEIN: But what happens
6 often times is, you know, the SF-36 is a good
7 example now, now it's bought by Ingenix and we
8 can't really use it, you know. Or by United,
9 I should say.

10 So I just -- that's my question.
11 It's not anything more than that. It's a long
12 way from knowing that answer for me.

13 MS. BOSSLEY: Right. Just to
14 clarify, there is no requirement that
15 developers have an 800 number or anything.
16 The specifications need to be updated and on
17 their website and available for individuals or
18 maybe not on the website, but can be
19 accessible.

20 CHAIR WEINSTEIN: And you know,
21 the American Board of Medical Specialty is a
22 wonderful group, but it's not really

1 commercial. I mean, they are trying to do
2 some commercial things, I know, but they are
3 the certification board for specialties, that
4 this isn't.

5 MS. WILBON: Yes.

6 CHAIR WEINSTEIN: You know, so I
7 just worry that they are going to be able to
8 sustain this over a long period of time and
9 that's just the reality. So that's all. I
10 don't want to belabor it. Thank you for
11 answering. I'm sorry, go ahead.

12 MR. AMIN: I just want to quickly
13 clarify and ABMS might want to clarify this
14 also. This is from the Research and Education
15 Foundation, which is separate from the ABMS
16 credentialing group.

17 DR. MANHEIM: And part of the
18 purpose of this was to provide a non-
19 proprietary clear specifications with the
20 positive and negatives, I guess. It's non-
21 proprietary. You don't have as much support.
22 And, yes, this was done under the ABMS

1 Research and Education Foundation.

2 DR. LEE: And yet, I should note
3 that neither Willy nor I work for ABMS. We
4 are both academic researchers that were part
5 of the development team of this project.

6 MS. SINNOTT: Just to add a little
7 more to we don't know, once something like
8 this became public and freely available, there
9 would be nothing to restrict anybody else from
10 adopting it and commercializing it in some
11 way, either by providing support or something
12 with a feedback to ABMS or something.

13 So you would get the algorithm and
14 access to it for free, but your support you
15 would have to pay for, for example. So and if
16 I were in the business of creating measures
17 and this got endorsed by NQF, the first thing
18 I would do is integrate it into my measurement
19 software program.

20 MS. TURBYVILLE: Which a lot of
21 them do.

22 MS. SINNOTT: Which a lot of them

1 do, Sally says.

2 CHAIR WEINSTEIN: So can we vote?

3 MR. AMIN: That's four moderate
4 and two low.

5 MS. WILBON: Great.

6 CHAIR WEINSTEIN: Is there another
7 question?

8 MS. WILBON: Well, that completes
9 your first measure. Three to go.

10 CHAIR WEINSTEIN: Yes. The next
11 three are going to go fast.

12 MS. WILBON: Yes. So Ingenix,
13 let's go ahead and do the next measure and
14 then we will see how far we can get before
15 lunch.

16 Yes, the next measure is 1609.
17 It's an ETG-based Hip/Knee Replacement measure
18 by Ingenix.

19 CHAIR WEINSTEIN: Yes.

20 MS. WILBON: So do we have someone
21 from Ingenix on the phone?

22 DR. DUNN: Hi, yes, this is Dan

1 Dunn and I'm on the phone and I'll try to do
2 my best here. Also Howard Tarko, who is our
3 medical director for -- one of the medical
4 directors for the methodology. Just as a
5 note, that the lead clinician, Tom Lin, had a
6 family emergency and we'll do our best to
7 answer your questions.

8 If there is anything you would
9 like us to follow-up on, we are happy to do
10 that.

11 MS. WILBON: Thank you, Dan.

12 DR. DUNN: You're welcome.

13 MS. ZIELINSKI: Hi, Operator, this
14 is Cheri Zielinski, I'm on the line.

15 MS. WILBON: Okay. Hey, Cheri,
16 glad you guys were able to make it. If you
17 could just give us a brief intro to the
18 measure and then we will pass it back to the
19 TAP. Thanks.

20 DR. DUNN: So this is Dan. I can
21 do that. Okay. This is a hip and knee
22 replacement, correct?

1 MS. WILBON: Yes, that's correct.

2 DR. DUNN: Yes, okay. So the
3 measure focuses on resources used to episodes
4 of care for patients who have undergone a hip
5 or knee replacement. The methodology itself
6 is based on the episode treatment group and
7 procedure episode group methodologies
8 developed and maintained by Ingenix used
9 broadly in the industry.

10 The procedure episodes identify a
11 unique procedure event, as well as the related
12 sets of actions performed before and after the
13 procedure. That includes work, often therapy,
14 prior to the procedure, the procedure itself,
15 including the inpatient stay and other
16 surgeons work, et cetera, as well as post-op
17 activities, such as any repeated surgery,
18 outpatient follow-up, physical therapy.

19 The methodology is included that
20 assigns a severity level to each episode. And
21 so the results would be, you can think of it
22 as, a hip replacement episode with a severity

1 level, a knee replacement episode with a
2 severity level. And if you were going to do
3 measurement, you would, you know, take into
4 account the fact that you have a different
5 episode for hip replacement, different episode
6 for knee replacement with different levels of
7 severity. Those together define, if you will,
8 the risk values of the measurement.

9 There are a number of resource use
10 category numerators, if you will, included
11 with the measure. The total cost of care,
12 care by -- cost by type of service, as well as
13 some utilization measures for specific types
14 of care.

15 MS. WILBON: Okay. Thank you.

16 DR. DUNN: You're welcome.

17 MS. PAXTON: This is Liz Paxton.

18 I was wondering how you are handling
19 laterality, especially in terms of total knee
20 replacement.

21 DR. DUNN: That's a good point.

22 So the question is if there is a bilateral?

1 MS. PAXTON: Oh, or a subsequent
2 knee replacement, not necessarily a
3 simultaneous bilateral procedure, but --

4 CHAIR WEINSTEIN: Do you record
5 right and left? Do you record right and left
6 in your data system?

7 DR. DUNN: Yes. So there is right
8 and left, if they are indicated on the
9 administrative data, that's captured. If it's
10 bilateral in the same event, both. I mean,
11 it's indicated by the procedure code modifier,
12 that is captured.

13 If there is a knee replacement,
14 that episode, for example, and then say within
15 the time period defined to cover the -- you
16 know, say one knee replacement episode, that
17 means kind of overlaps within the episode,
18 that's also recorded as the fact that there is
19 overlapping knee replacement episodes of care.

20 In the case of the bilateral, you
21 know, that would be something that someone
22 would control for or exclude, if they decided

1 that those are going to be more work. If
2 there is overlapping, usually people treat
3 that as an episode that wouldn't likely be
4 included, you know, just difficult to have a
5 complete picture of what went on.

6 CHAIR WEINSTEIN: One of the
7 things that -- I'm still not sure that -- so
8 what you said the answer to that question was
9 is when it is available, you get it? So it's
10 sometimes available, right versus left? It's
11 not a required data field in your
12 administrative data set?

13 DR. DUNN: Yes, that's correct.
14 I'm assuming that procedure code wouldn't give
15 you that alone, that that would --

16 CHAIR WEINSTEIN: So it's not.

17 DR. DUNN: Right. It would show
18 up on the modifier.

19 CHAIR WEINSTEIN: Yes, yes. Most
20 people don't have that. I think, you know,
21 you guys have done some tremendous work, like
22 ABMS. And we appreciate that, number one,

1 because it's fairly complicated.

2 The thing I run into in this
3 particular diagnosis is preference. The rates
4 of procedures even in your write-up are quite
5 variable. You talk about, you know, Wisconsin
6 and other places with rates varying from 162
7 per 100,000 to almost 300, so there is at
8 least a twofold variation in the rates of
9 these procedures and the cost continue to
10 climb.

11 And I know just from my own work
12 that the rates of these procedures go up for
13 a number of reasons, just the aging
14 population, plus people are doing them in
15 younger populations than they have done
16 before.

17 And there is no preference. And
18 so the indications for this like back surgery,
19 get to be a little blurred, although, you
20 know, there is a clear, you know, x-ray
21 changes in the studies out of Canada that you
22 are probably familiar with where patients were

1 actually given choice.

2 There was only about 16 percent of
3 patients when given a choice in Canada
4 actually wanted the procedure, which then
5 doesn't get dealt with here.

6 And so the issue is it's a very
7 effective - cost-effect procedure. People
8 really get good relief of pain and become very
9 functional. And we're going to get into this
10 in disparities. There is quite a difference
11 in rates of these procedures in non-whites,
12 which we can talk about, which I think are not
13 talked about in your write-up.

14 But how do you address this
15 preference issue, if at all, in your data
16 systems? I'm just curious, because it really
17 is an underlying problem for preference-based
18 decisions.

19 DR. DUNN: And another great
20 point. We don't deal with it in this measure,
21 so the assumption here is that the -- a
22 decision was made to go forward with the knee

1 replacement, for example, and then, you know,
2 given that, measure the cost associated with
3 it.

4 We also, you know, have -- the
5 later discussion is joint degeneration
6 episodes that you can then, you know, look at
7 rates of surgery within those. But within
8 this episode itself, knee replacement or hip
9 replacement and the decision for surgery has
10 been made.

11 CHAIR WEINSTEIN: Yes, it's just
12 for NQF. To me, this is a major issue around
13 quality. And just because something can be
14 done and has a good result, doesn't mean that
15 it should be done. And a well-informed
16 patient might choose differently.

17 And I don't know how that gets
18 addressed, but I think it is significantly
19 important. And, of course, there is no
20 outcome data here. And, you know, the
21 readmission rates, complication rates, these
22 are fairly high in some of these things that

1 are very costly.

2 It's a great procedure. I'm an
3 orthopedic surgeon. I understand it, but I
4 worry about the ever-increasing rates without
5 those kind of things being measured. And it's
6 no function -- no reflection on Ingenix. They
7 have nothing to do with that, but the notion
8 is, I think, if NQF is going to be a quality
9 measure place, those things need to be
10 addressed in the episode, if we are going to
11 talk about the usability of these things.

12 MS. O'NEILL: So the way the
13 reporting comes at the end of this measure is
14 on a, you know, per physician measured against
15 their peers. So the decision to do the
16 procedure has already been made. So
17 basically, the measure compares resource
18 utilization once the decision is made.

19 But to your point, we are not
20 measuring the quality of the decision making
21 or the process of the decision making. And we
22 would have to probably look at some type of

1 defined population for rates and maybe even
2 cohorts from different age groups what you
3 might consider a somewhat appropriate rate for
4 people on different age cohorts within a given
5 population, how that would be managed by the
6 system.

7 But this is just after the
8 decision is made.

9 DR. RATLIFF: So as I see the
10 difference for lumbar radiculopathy, for low
11 back pain, most of the time you are treating
12 those conservatively. For a fractured hip,
13 most of the time you are going to surgery.

14 Here is the one where there
15 probably are a lot of different conservative
16 treatment options that we are ignoring and
17 going straight to the subset of patients that
18 are having surgery.

19 So going back to the lost work,
20 you may be losing a lot of healthcare
21 expenditures with regards to this conservative
22 treatment by focusing on the subset of

1 patients that are going into the operating
2 room.

3 But again, that's not really what
4 this measure is looking at. It's not looking
5 at the larger set of patients.

6 CHAIR WEINSTEIN: And you really
7 need to look at that article by Gillian Hawker
8 and Jim Wright and others that was done years
9 ago from Canada and Ontario. And you can
10 argue whether it is right or wrong, but I
11 think NQF's obligation as a quality group
12 giving the nation measures in these kinds of
13 preference-based decisions needs to get into
14 patient preferences somehow, whether it is
15 through shared decision making or some other
16 methodology, because this is a great procedure
17 for the right person.

18 But the complications can be
19 significant and the cost huge. And when you
20 start to do this in people that, you know, it
21 gets back into Windberg's work originally on
22 tonsillectomy and hysterectomy, you know, if

1 people don't have problems, they do pretty
2 well. But should they really be done, you
3 know? So we need to at least underline that.
4 At least I would like to as a Committee
5 Member.

6 MR. AMIN: We will make sure that
7 is in the report.

8 CHAIR WEINSTEIN: Any other
9 opening comments, by any of our other
10 colleagues? Can we get to the work?

11 So does this measure focus address
12 a specific national goal? So is this an
13 important condition? I think most of us would
14 say with the increasing rates of these
15 procedures and the cost issues in an aging
16 population, the answer would likely be yes,
17 but we should all make that decision.

18 MR. AMIN: That's five moderate or
19 five high, one moderate.

20 CHAIR WEINSTEIN: Was the data
21 submitted that demonstrated considerable
22 variation or overall less than optimal

1 performance across providers or population
2 groups, disparities in care?

3 Comments from the group?

4 DR. RATLIFF: It's a lot of data
5 presented in their submission, but not so much
6 data about hip and knee replacements. More
7 generalized like data about patients who are
8 sick and seeing a doctor for some reason. So
9 I don't know that specifically that relates
10 back to a patient choosing to undergo this
11 elective orthopedic procedure.

12 I mean, I know it does. It's just
13 that data is not really in their submission.

14 CHAIR WEINSTEIN: And I didn't --
15 I guess it didn't specify a cost measure, to
16 me. It gave guidelines, but no
17 recommendation. The process, to me, was very
18 complex and hard for me to follow or explain.

19 The rankings are slightly
20 confusing. In some cases, your lowest number
21 was the strongest association and in some
22 cases your highest number was the strongest

1 association.

2 And you assume coding is
3 consistent between facilities and it not
4 necessarily is, it's common. And you did not
5 address specific resource utilization within
6 a procedure or E&M visits type of provider, et
7 cetera, and you did not address non-billable
8 activities in these processes.

9 So those were things I found
10 problematic in the performance gap.

11 MS. TURBYVILLE: Can I just --

12 CHAIR WEINSTEIN: Please.

13 MS. TURBYVILLE: -- note? For
14 this performance gap, what you want to keep in
15 context is does the -- in this particular
16 measure, focus area, it's not whether the
17 measure is constructed as doing these things.

18 CHAIR WEINSTEIN: I'm sorry.

19 MS. TURBYVILLE: So for the
20 importance criteria, try to keep the kind of
21 thinking about the area in which it is
22 examining. So did they provide literature or

1 did they give you some distribution
2 information indicating that there is an issue
3 there, whether it is high variation or the
4 variation is --

5 CHAIR WEINSTEIN: Yes. They did.

6 MS. TURBYVILLE: Right.

7 CHAIR WEINSTEIN: But they didn't
8 give a preference issue, yes.

9 DR. RATLIFF: Where is the
10 variation data?

11 CHAIR WEINSTEIN: On page -- early
12 in their discussion about the procedure, they
13 had some data. It's in this page here where
14 they talk about OA accounts for 55 percent of
15 all arthritis, da, da, da, hip/knee joint
16 procedures accounted for 35 percent of the
17 procedures from 1990 to 2000, age-adjusted
18 rates of total knees in Wisconsin increased 81
19 percent from 160 per 100,000 to 294 per 1,000.

20 Rates increased among young
21 patients. Cost -- they had some rate data and
22 some references.

1 DR. RATLIFF: That's a given. But
2 what's the variation between facilities and
3 the variation between practitioners?

4 CHAIR WEINSTEIN: Oh, no.

5 DR. RATLIFF: With regards to this
6 procedure.

7 CHAIR WEINSTEIN: No.

8 MS. WILBON: So --

9 CHAIR WEINSTEIN: No. Sorry.

10 MS. WILBON: So just as a
11 reference using the table, so the submission
12 items, if you are looking at a submission
13 form, that this information should be
14 reflected in are the two, so the IM-2, 2.1,
15 2.2, 2.3, 2.4 and 2.5. So within --

16 MS. O'NEILL: So I think that --

17 MS. WILBON: -- that section is
18 kind of where you should find whether or not
19 they demonstrated that or not.

20 MS. O'NEILL: So they quoted the
21 variation and rate of the procedure being done
22 over time and in different locales, as Jim

1 pointed out, but the actual measure, as it's
2 structured, is comparing the utilization of
3 resources between people that are doing the
4 procedure.

5 So how much variation is there in
6 length of stay, drugs, endoprosthesis,
7 utilization. You know, I mean, that's really
8 what the end reporting is about. So I think
9 that's the conflict.

10 DR. RATLIFF: Okay. So their
11 point here is now going back to Dartmouth and
12 talking about different utilization of the
13 procedures. You are already taking a subset
14 of patients having the procedure. Where are
15 you showing the variation within that subset
16 when they don't get -

17 CHAIR WEINSTEIN: They don't
18 address this, but I know it is happening. And
19 I know they must have it in their data. Is
20 there a reason you didn't address it?

21 DR. DUNN: This is Dan. I'm
22 looking at the slide. We missed the mark on

1 that specific point. We could follow-up if
2 that's allowed, but you're right, we didn't
3 answer the question.

4 DR. RATLIFF: So as we discussed
5 earlier. This was cut and pasted from other
6 Ingenix things, where they just took this out
7 and like stuck it into this document, because
8 they didn't to, you know, frankly put forth
9 the work to like look up these citations.

10 And we all know that data is out
11 there. They just are not presenting it to us.

12 CHAIR WEINSTEIN: Yes, but like
13 you said, I mean, it's in their database.
14 They have these various providers across these
15 organizations.

16 DR. RATLIFF: Right.

17 CHAIR WEINSTEIN: And they have --
18 they probably have some of the best data in
19 the world on this. Yes. So we can vote.
20 That was a great discussion. Thank you,
21 everybody. It's very helpful.

22 MR. AMIN: That's one moderate and

1 five low.

2 CHAIR WEINSTEIN: Is the purpose
3 objective of the resource use measure and the
4 construct for resource use/cost, over-cost,
5 clearly described? Discussion?

6 MS. SINNOTT: I would just
7 highlight, and I think I'm on page 3p,
8 Purpose, they list four items: Payment
9 program, public reporting, quality improvement
10 internal to the specific organization and
11 quality improvement with benchmarking with no
12 further description or narrative about testing
13 or where the research is being -- I mean, it
14 looks to me like these are ideas thrown out
15 rather than reporting on their use.

16 MS. WILBON: I don't want to sound
17 like a broken record, but again, keeping in
18 mind the importance criteria is about the area
19 that is being measured. So did they describe
20 the purpose of the measure? And then later
21 on, when you get into the details of the
22 measure construction and how it is reported,

1 that's more the scientific validity,
2 usability.

3 So this whole section of
4 importance is, again, are they picking up an
5 area that demonstrates a resource use problem?
6 Are they describing what the objective of
7 their measure is, which is potentially to
8 measure the resource use of X condition or
9 surgery? And so that's it.

10 CHAIR WEINSTEIN: Other comments?
11 We can vote. Do you have to wait for that
12 clock to go down? No? Okay.

13 MR. AMIN: That's four moderate,
14 one low and one insufficient.

15 CHAIR WEINSTEIN: Next. Are the
16 resource use service categories included in
17 the resource use measure consistent with the
18 representative conceptual construct
19 represented by the measure?

20 So do they have the right
21 categories within this measure for this
22 procedure? Any comments by the group? Where

1 is that? What's the number? So the resource
2 -- what page is that on? I'm sorry.

3 MS. WILBON: Two of the PDF.

4 CHAIR WEINSTEIN: Yes, so they
5 have admissions, discharges, outpatient,
6 emergency department, pharmacy evaluation and
7 management, procedures, surgery, imaging,
8 diagnostic and lab. So are those the -- did
9 they include all the right categories? Did
10 they leave something out?

11 The one thing that happens with a
12 lot of these patients is they go to rehab
13 facilities post-procedure and I didn't see
14 that here.

15 MS. WILBON: I don't think that
16 was on our list.

17 CHAIR WEINSTEIN: But it's an
18 important one, because these patients often
19 they try to get them out of the hospital
20 really quick to a rehab facility and it's a
21 transfer of cost. And those are big costs
22 that we need to consider in the management of

1 these patients.

2 DR. DUNN: Jim, this is Dan. That
3 is part of our resource use.

4 CHAIR WEINSTEIN: What's it under
5 in the list then? Is it outpatient
6 facilities?

7 DR. DUNN: Under -- yes. We have
8 inpatient facility broken up into acute and
9 non-acute.

10 CHAIR WEINSTEIN: Page 5.

11 MS. O'NEILL: And then the DME is
12 captured, I saw, in another list. Is that
13 correct?

14 DR. DUNN: Right. That's not
15 broken out as a separate category, but it's
16 included as part of the cost under a larger
17 category.

18 MS. O'NEILL: Yes, okay. Thank
19 you.

20 CHAIR WEINSTEIN: I'm sorry, where
21 did you see the rehab on page 5?

22 MS. SINNOTT: There is a couple

1 places.

2 CHAIR WEINSTEIN: Page 12. I'm
3 sorry.

4 MS. SINNOTT: And this is a
5 question for Ingenix. Where are the rehab
6 therapies on the outpatient basis?

7 DR. DUNN: The physical therapy
8 for example.

9 MS. SINNOTT: And OT?

10 CHAIR WEINSTEIN: I got it.

11 MS. SINNOTT: Correct?

12 DR. DUNN: Yes, that's -- I'm not
13 sure what page this is on, but it's under S-
14 9.7. S-9.7 has both -- itemization of all the
15 resource use categories we included, but that
16 -- physical therapy and OT are broken out as
17 a separate measure category.

18 MS. SINNOTT: Okay. Thank you.

19 MS. WILBON: 25.

20 DR. RATLIFF: Yes, from review of
21 the Excel sheets that you provided, I mean, it
22 seems like a pretty wide net.

1 CHAIR WEINSTEIN: Yes.

2 DR. RATLIFF: So I think you are
3 capturing what you need to capture.

4 CHAIR WEINSTEIN: I thought I had
5 read it, but I didn't see it.

6 DR. RATLIFF: I think it's in
7 here, yes.

8 CHAIR WEINSTEIN: It is. It is.
9 Thank you. Okay. Do you have everybody set?
10 Good.

11 MR. AMIN: That's two high and
12 four low.

13 MS. WILBON: Moderate.

14 MR. AMIN: Oh, and moderate, four
15 moderate.

16 CHAIR WEINSTEIN: Is the measure
17 precisely specified so it can be implemented
18 consistently? Any discussion on this?

19 MS. SINNOTT: This is Patsy.
20 There is a discussion about an eligibility
21 table and the strength of the clinical
22 relationships and assignment to diagnostic

1 classes specific or not, but all of that is
2 not detailed to be repeated by anyone other
3 than Ingenix.

4 The clinical logic that goes into
5 tying events to events to create an episode is
6 not described. It is not even described as a
7 consensus process among physicians or a
8 consensus process or a research into the data
9 to see how things link up.

10 So that's my concern.

11 CHAIR WEINSTEIN: Any other
12 comments?

13 MR. AMIN: That's two moderate and
14 four low.

15 CHAIR WEINSTEIN: Does reliability
16 testing demonstrate that the results are
17 repeatable, producing the same result a high
18 proportion of the time when assessed in the
19 same population in the same period of time
20 and/or that measure score is precise?

21 Any comments?

22 MS. WILBON: So again, before you

1 guys move on, if we could just get a little
2 bit more, yes, explanation of the lows? I
3 know Patsy talked a little bit about it, but
4 is the -- did you feel like the way that they
5 were written, that they weren't clear or that
6 you feel like it is only Ingenix can repeat or
7 can actually use? I guess I'm just looking
8 for a little bit more, I guess, to that.

9 MS. SINNOTT: For a measure that
10 is supposed to be fully transparent, all of
11 that clinical logic should be there.

12 MS. WILBON: Okay.

13 MS. SINNOTT: And it's not.

14 MS. WILBON: So that was kind of a
15 general, everyone kind of agreed with that?

16 CHAIR WEINSTEIN: I think they
17 give guidelines. They are not as clear. It
18 is not obvious to the reader what they are
19 actually using. They have got very
20 sophisticated formulas, hard to interpret to
21 the novice and it's not clear what clinical
22 information they have included within these to

1 make these determinations.

2 MS. O'NEILL: And if it's a
3 proprietary measure, there is no -- I mean,
4 the expectation is that they wouldn't fully
5 divulge exactly how they get where they are
6 going, right?

7 MS. WILBON: Not necessarily. So
8 I may just have Dan talk a little bit about
9 this, but, for our process, we do ask that --
10 you know, in order to enter the process, they
11 do have to submit the specifications such that
12 they can be -- you know, that a Committee,
13 such as yourself, would be able to evaluate
14 the strength of the measure.

15 And in doing so, they should be
16 submitting it clear enough in a way that you
17 feel like you would be able to duplicate it.
18 However, there are some proprietary issues
19 with this particular measure that actually
20 operationally doing that, there are some
21 limitations to that.

22 DR. DUNN: Yes, this is Dan. Yes,

1 the intent wasn't to hide anything. And, you
2 know, the intent is to make it transparent in
3 a way that was described. You know,
4 proprietary or not, you know, what is being
5 measured and using the measurement need to
6 understand fully what is being done. So that
7 wasn't the intent.

8 CHAIR WEINSTEIN: But you
9 mentioned software, so there is an assumption
10 that there is a system that does the mapping
11 and the signing of all these diagnoses and the
12 procedures. It's not a manual process, but --
13 and we understand people are using it, but
14 it's not apparent.

15 DR. DUNN: Yes. One is obviously
16 the software is following specifications,
17 which is what, you know, the intent here was
18 to describe that at a level that could be
19 interpreted by you folks and others.

20 And then there is a set of
21 software that, you know, embeds that logic and
22 people apply it against administrative claims

1 data and returns results.

2 Now, as a note, you know, there is
3 now no one who starts from the specification
4 and goes up and tries to recode the logic
5 themselves. It has just been easier, you
6 know, for folks to use this software, rather
7 than do that.

8 DR. TARKO: This is Howard Tarko.
9 Could I make a comment and just a point of
10 clarification? Is the issue that you are not
11 exactly sure how these eligibility tables were
12 generated? Is that the question?

13 MS. SINNOTT: That's part of it.

14 DR. TARKO: There is a -- we have
15 a physician review panel that reviews all of
16 these relationships one by one and so there is
17 no automatic process that was used in creating
18 these tables.

19 There is currently a process going
20 on right now where all of the diagnostic ETG
21 relationships are being reviewed by a panel of
22 specialists. So this is not done

1 automatically at all. It is done by
2 physicians using clinical judgment.

3 CHAIR WEINSTEIN: Yes, we just
4 can't tell that from this.

5 DR. TARKO: Okay.

6 CHAIR WEINSTEIN: So --

7 DR. TARKO: All right.

8 CHAIR WEINSTEIN: I mean, is that
9 a fair statement or do you think it's
10 different?

11 DR. TARKO: No, I think that's a
12 fair statement.

13 CHAIR WEINSTEIN: Yes. Does the
14 reliability testing demonstrate that the
15 results are repeatable, producing the same
16 results a high proportion of the time when
17 assessed in the same population?

18 MS. PAXTON: I was wondering if
19 the developer could comment on the internal
20 consistency measure? They did a great job
21 explaining how the measure could be reproduced
22 in different populations. But also mentioned

1 regression models. Could you explain that
2 process?

3 DR. DUNN: This is Dan. So the
4 question is related to our internal testing of
5 the ability of the measure to be, I guess,
6 both matched in a validation perspective, as
7 well as, you know, being applied to the same
8 set of data multiple times and getting the
9 same results?

10 MS. PAXTON: Exactly. The
11 reliability issue.

12 DR. DUNN: Right. So many as a
13 note, you know, given the software
14 application, you run the same set of data
15 through, you know, multiple times and you will
16 get the same answer every time.

17 As a related point, if you -- you
18 know, one of the steps is that you need to
19 validate that the software and the measure are
20 working appropriately. As part of that, we
21 will parallel code against the software using
22 SAS, for example, at the end test and to

1 result that alignment with a 99.9 percent
2 accuracy, you know, with claim lines being the
3 -- but the measure matching on claim lines at
4 99.9 percent accuracy.

5 MS. SINNOTT: What do you mean
6 matching?

7 DR. DUNN: Meaning you get two
8 different processes. One is the software use,
9 what people would use in practice. And the
10 second is a parallel interpretation of the
11 specification by someone who isn't involved in
12 the process, who is writing code. And then
13 the match is if you have 10 million claim
14 lines, and if you compare the results from
15 Approach 1 versus Approach 2, the match rate
16 has to be at 99.9 percent or higher.

17 And also, you know, when we
18 evaluate the differences, they are determined
19 to be, you know, random in nature, that there
20 is nothing to be concerned about.

21 MS. SINNOTT: So when you say
22 matching, you are saying that it matches the

1 number of orphan claim lines or --

2 DR. DUNN: SAS.

3 MS. SINNOTT: Is that right?

4 DR. DUNN: It matches, yes,
5 exactly the episode that it was assigned to.

6 MS. SINNOTT: Okay. So you are
7 talking about episode attribution across the
8 entire data set. So not specifically for the
9 total joint replacement?

10 DR. DUNN: Correct, correct.
11 Although, one of the assessments is doing that
12 calculation separately by ETG and it has the
13 same level of required of matching.

14 MS. SINNOTT: Okay. And but when
15 your -- you are saying that when you do these
16 two methods to run the data, run all the claim
17 lines through, you are getting the same
18 grouped episodes, the same number of episodes,
19 the same number of orphan claim lines, the
20 same attribution for physician for an episode,
21 the same outliers are excluded and the cost
22 assessments for the episodes are the same?

1 DR. DUNN: The -- on the first
2 part of the metric, I was quoting you, is
3 based on the grouping of SAS and attribution
4 and then it will end up into a physician's
5 score or different component. That actually
6 goes to the same process or that same level.

7 But I was talking about the actual
8 grouping of the information, the two
9 different, again, approaches. And if you look
10 at every single claim record, what episode of
11 -- what unique episode went to what ETG was
12 assigned to that episode, what risks or
13 severity level was assigned, so on and so on.

14 But that was the matching I was
15 describing.

16 MS. SINNOTT: But you haven't
17 included a narrative about the physician
18 scoring, right?

19 DR. DUNN: Right. And that was
20 our attribution adjusted. Well, actually on
21 this one, attribution is forwarded as the
22 primary surgeon of the hip or the knee

1 replacement.

2 And on the scoring itself, we
3 described, you know, the approach that was
4 used. That's maybe a different question
5 relative to measures.

6 MS. SINNOTT: Right. But you
7 haven't talked about the reliability of the
8 physician measurement. In other words, that
9 there is -- that the physician -- in repeated
10 samples, one physician would end up with,
11 approximately, the same score.

12 DR. DUNN: Right. So repeated
13 samples of the same episodes.

14 MS. SINNOTT: Yes.

15 DR. DUNN: Repeated iteration of
16 the same episode. Yes, so that's the same
17 type of testing and reliability that is done
18 with that same threshold.

19 MS. SINNOTT: But you haven't
20 reported on the physician part of it in this
21 response, as I understand it.

22 DR. DUNN: Well, the quote is --

1 or the 99.9 percent is based on the assessment
2 of the grouping itself. You're right.

3 MS. SINNOTT: So you are saying
4 that not the -- the 99.9 percent of the time,
5 the physician gets the same efficiency score
6 in repeated samples of the same data set?

7 DR. DUNN: And by samples, again,
8 I think just to be clear, it's, you know, if
9 you run 100 episodes attributed to Dr. Smith
10 through one -- whatever, the software approach
11 and then are those same 100 episodes
12 attributed to Dr. Smith from beginning to end
13 through the SAS coded prototype parallel
14 process, you will get that match rate.

15 MS. SINNOTT: Okay.

16 DR. DUNN: The 99.9 percent.
17 That's sort of a standard threshold we used
18 matching 100 percent by the time we are done
19 almost across the board.

20 CHAIR WEINSTEIN: And can I just
21 question that? It just seems like that's not
22 possible, because every physician has their

1 own variability, you know, within these
2 measures on any given patient.

3 And to think that the utilization
4 of resources is the same --

5 MS. SINNOTT: Well, but what they
6 are saying is if they have a cash of data and
7 they run it simultaneously through the SAS
8 setup and through the group, they are going to
9 get the same results.

10 MS. WILBON: On the same case.

11 MS. SINNOTT: On the same patient
12 population.

13 CHAIR WEINSTEIN: Sort of a
14 bootstrapping. I understand that part being
15 reliable.

16 MS. SINNOTT: Right. But it's the
17 year-to-year reliability that isn't reported
18 here. In other words, how reliable is a
19 physician's score based on the population of
20 episodes that goes into the scoring mechanism?

21 DR. DUNN: Well, that's -- I think
22 you are accurate in describing what we are

1 reporting on, which is, you know, that those--
2 if you take the same set of data, run it
3 through the measure, is it going to give you
4 the same --

5 MS. SINNOTT: Simultaneously.

6 DR. DUNN: -- result, is accurate.

7 But we weren't really responding to the
8 question of -- which you could take a whole
9 bunch of different ways, you know, but that
10 bootstrapping, you know, the 100 episodes and
11 you are pulling them out 20 at a time in
12 repeated sampling or the year-over-year, I
13 didn't think that was the point of this
14 question.

15 But, you're right, we didn't
16 address that.

17 MS. SINNOTT: Yes.

18 DR. DUNN: I don't think that was
19 the question.

20 MS. PAXTON: Right. I do think
21 that's critical to address all the measures on
22 the concept that a software program is

1 reproducing and is not, you know, reliability.
2 So I think that needs to be considered in all
3 the measures.

4 DR. DUNN: And just as a note, you
5 know, in responding to the template, you know,
6 we had asked that question and reliability
7 wasn't --

8 CHAIR WEINSTEIN: I think the
9 issue is that wasn't part of the --

10 MS. SINNOTT: Question.

11 CHAIR WEINSTEIN: -- requirements
12 of NQF for the organization to provide. So I
13 think had it been, they would have done it, if
14 I'm not misunderstanding.

15 DR. DUNN: No, that's accurate.
16 Thank you.

17 CHAIR WEINSTEIN: Yes.

18 MS. PAXTON: It should be
19 considered in future projects to request that,
20 because it is really critical that these
21 measures are sound in terms of applying them,
22 especially to the physician level.

1 DR. RATLIFF: But I think they
2 answered the question that was asked or can I
3 ask them in a different question now, and our
4 question is important, too, but that really
5 wasn't posed by the NQF when they sent out
6 this request.

7 CHAIR WEINSTEIN: So I think we
8 can vote.

9 MR. AMIN: That's two high and
10 four moderate.

11 CHAIR WEINSTEIN: What is the
12 level of overall reliability testing precise
13 specifications and reliability testing based
14 on what we have just talked about?

15 MR. AMIN: That's two high and
16 four moderate.

17 CHAIR WEINSTEIN: What is the next
18 question? Validity. Okay. Does everybody
19 want to have a break for lunch? Do we have to
20 vote on this? Can we vote? High. Okay.

21 MS. WILBON: So let's take --
22 let's do a brief public comment. I know we

1 have got someone here in the room and some
2 people on the phone, so we will start with
3 those on the phone.

4 Is there anyone on the phone who
5 would like to make any comments or ask any
6 questions? Okay. I'm taking silence as a no.

7 Anyone in the room?

8 MR. MARTIN: I just wanted to
9 thank the panel for taking time out of their
10 busy schedules to work on this. It is
11 incredibly important to our members at the
12 American Academy of Orthopedic Surgeons and so
13 I congratulate you and applaud you on your
14 efforts.

15 MS. WILBON: Thank you. And on
16 that note, we will take a few minutes. Okay.
17 So it looks like we are going to do a working
18 lunch.

19 CHAIR WEINSTEIN: Yes.

20 MS. WILBON: So we will break for
21 about 10, 15 minutes to get food and come back
22 and then we will pick up with food in about 15

1 minutes. Thanks.

2 (Whereupon, the meeting was
3 recessed at 12:37 p.m. to reconvene at 1:00
4 p.m. the same day.)

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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 1:00 p.m.

3 CHAIR WEINSTEIN: Okay. So are
4 the measures -- we are on total knee still.

5 Are the measure specifications
6 consistent with the evidence? Any discussion
7 from the group?

8 MS. SINNOTT: I just had a
9 question about why the low cost outliers are
10 excluded and the high cost outliers are
11 winsorized?

12 I wonder if the Ingenix folks
13 could respond, if they are there?

14 DR. DUNN: Sure. This is Dan.
15 That has pretty much been a convention around
16 all of these measures. Logic being is low
17 cost outliers may be some indication of, you
18 know, missing data, missing services. You
19 know, the episode doesn't make sense as to
20 logic on the low end.

21 On the high end, you don't want to
22 exclude them, because you, you know, are

1 potentially giving an advantage to someone
2 being measured who has a lot of high cost
3 outliers.

4 So the idea is you winsorize them,
5 so you are measuring up to some dollar
6 threshold, but still including those episodes
7 in the measurement.

8 MS. SINNOTT: But there is no test
9 for the low cost. I mean, is it measured at
10 a comparison to the mean or is it just the
11 bottom two get thrown out?

12 DR. DUNN: The bottom -- yes,
13 there is a threshold. I'm sorry if this isn't
14 the question. There is a threshold which
15 defines, yes, the dollar amount that a low
16 outlier is defined as the same thing on the
17 high side.

18 And, you know, the argument is you
19 exclude the low outliers from the measurement,
20 so that they are put aside and not included in
21 the creation of the physician score with the
22 logic being that those episodes probably have

1 some other issues related to data.

2 CHAIR WEINSTEIN: I mean, the
3 easiest thing would be to include them and see
4 if it changes the result. So do you get the
5 same result when you include those lower
6 expense or did you find out that -- from a
7 sensitivity analysis or something, and I know
8 it's not required, but you didn't arbitrarily
9 eliminate X numbers of people because of their
10 cost or did you or what was your methodology,
11 I think, is the question for making that
12 determination?

13 DR. DUNN: Yes. The methodology
14 for determining what the low cost outlier
15 threshold is based on, you know, distribution
16 of statistics, like the bottom 2.5 percent.

17 CHAIR WEINSTEIN: So you had a
18 frequency distribution and you took two
19 standard deviations and you said, you know, at
20 three, they are out or something?

21 DR. DUNN: Yes. And that's to
22 determine that dollar amount that is kind of

1 applied as a standard. So that is repeated
2 every time you run this for a certain
3 population. That's usually done as -- even
4 though some customers do recreate their own
5 outlier thresholds, we include outlier
6 threshold as part of the methodology.

7 And then the next step was to look
8 and see what are those episodes that got
9 excluded? Do they make any sense? You know,
10 in this case, you know, do they have -- you
11 would expect the hospital stay and, you know,
12 the surgeons and so on. And in a lot of the
13 cases, those outliers in -- you know, are
14 below that threshold.

15 CHAIR WEINSTEIN: So it just
16 practically didn't make clinical sense when
17 you had your consensus panel look at the data
18 and said this doesn't make sense. How could
19 they only be in this hospital 10 hours and not
20 have an x-ray, whatever the reasons were?

21 DR. DUNN: Right. Or a \$5,000,
22 you know, knee replacement doesn't make any

1 sense. Exactly right.

2 CHAIR WEINSTEIN: Yes.

3 DR. DUNN: And on the high side,
4 the high side is more atypical. Not -- maybe
5 a good signal on how well a physician is
6 doing.

7 CHAIR WEINSTEIN: But, Patsy, are
8 you just asking for the methods by which they
9 made those determinations?

10 MS. SINNOTT: Well, yes. I mean,
11 the inclusion of the high cost outlier, the
12 problem is that that's not going to be equally
13 distributed across all surgeons. And so if
14 you have one high cost case, and you've only
15 got 30 cases that you are being measured on,
16 that's going to affect your quite comparative
17 score if nobody else has a high cost.

18 CHAIR WEINSTEIN: And even by
19 location, you could have a high cost place
20 where all the docs are high cost. You would
21 want to understand that as not representative
22 of the sample across.

1 MS. SINNOTT: Geographics.

2 CHAIR WEINSTEIN: Right.

3 DR. DUNN: But again, you know,
4 the --

5 CHAIR WEINSTEIN: But you didn't
6 see that kind of distribution or you didn't
7 look for it?

8 DR. DUNN: The logic was you
9 wouldn't want to throw them out to say the
10 threshold was \$50,000. You know, throwing out
11 cases at \$55,000, but there is a number of
12 surgeons who have cases at \$49,000 and it
13 wasn't fair. So the compromise is let's only
14 measure the first \$50,000 of these costs.

15 You're right, some surgeons may
16 have more outlier cases. You can count them
17 up, you know, as part of the investigation in
18 the results. But I guess I would argue you
19 don't want to throw them out.

20 CHAIR WEINSTEIN: Yes. Well, it's
21 so rich to actually look at this and
22 understand it, I think, is Patsy's point. And

1 that information could be incredibly valuable
2 in starting to understand episodes.

3 So there is not a criticism. It's
4 just the value of not including it or the
5 value of including it becomes an important
6 discussion. Other comments?

7 DR. DUNN: I --

8 CHAIR WEINSTEIN: Do you
9 understand?

10 DR. DUNN: Yes, I agree.

11 CHAIR WEINSTEIN: Yes.

12 MR. AMIN: And we will also take a
13 note of that in our minutes.

14 CHAIR WEINSTEIN: Yes. Other
15 comments? Oh, sorry, Craig?

16 DR. RUBIN: It's a different
17 question. Do you have the ability to report
18 the resource use in those between 63 and 75
19 versus 75 and 96, refer to age rates of 63 to
20 96?

21 CHAIR WEINSTEIN: They're
22 segmented. That's how segmented population

1 looks. Do you have the ability to do that?

2 I'm sure the answer is yes.

3 DR. DUNN: Yes. And any patient
4 or episode, clinical attribute, you can, you
5 know, process the data and upset at -- that's
6 usually part of the investigation people do
7 to, you know, get behind the overall results.

8 CHAIR WEINSTEIN: But I think that
9 it's a significant point. Yes, please, go
10 ahead, Craig.

11 DR. RUBIN: Well, just I didn't
12 see that and certainly if you are comparing
13 populations, you know, there is a lot of
14 comorbidities in the -- that's a 30-year plus
15 range and I just didn't see that in the
16 materials where that was being looked at. But
17 could be a major finding of importance,
18 depending upon the makeup of your patient
19 population.

20 CHAIR WEINSTEIN: Did you adjust
21 for comorbidities?

22 DR. DUNN: Right. So --

1 CHAIR WEINSTEIN: Yes.

2 DR. DUNN: -- age, gender,
3 comorbidities and condition status factors.

4 CHAIR WEINSTEIN: Yes, yes.

5 DR. RATLIFF: How do you adjust
6 for comorbidities? We're kind of getting
7 ahead of ourselves though.

8 CHAIR WEINSTEIN: Yes, yes, yes.

9 DR. RATLIFF: Yes, but there are
10 methods of weighing the different
11 comorbidities. They can tell us how they did
12 it.

13 CHAIR WEINSTEIN: Any other
14 comments on this one? Okay.

15 MR. AMIN: We have to vote again.

16 CHAIR WEINSTEIN: We have to vote
17 again. Do you need me or somebody?

18 MR. AMIN: It's two high and four
19 moderate.

20 CHAIR WEINSTEIN: Validity. Does
21 the validity testing demonstrate that the
22 measured data elements are correct and/or the

1 measures score correctly reflects the cost of
2 care or resources provided adequately
3 distinguishing high and lower cost or resource
4 use?

5 I wasn't actually sure about the
6 specificity of the cost measures. I mean, you
7 didn't give real recommendations there.

8 DR. DUNN: I'm sorry, whether
9 there are any recommendations on what the cost
10 measures were or what the measure of cost was?

11 CHAIR WEINSTEIN: You didn't
12 specify them.

13 DR. DUNN: Well, there is the
14 resource measure is what, you know, cost
15 overall -- you know, cost by type of service.
16 And we --

17 CHAIR WEINSTEIN: Yes.

18 DR. DUNN: Go ahead.

19 CHAIR WEINSTEIN: No, you go
20 ahead. Sorry.

21 DR. DUNN: And then we weren't
22 specific, if this is what you are getting at,

1 on, you know, whether you use standard price
2 costs versus, you know, allowed amounts, for
3 example.

4 CHAIR WEINSTEIN: Exactly.

5 DR. DUNN: Okay. And I know there
6 are people who do both and actually compare
7 them and some that do one or the other.

8 CHAIR WEINSTEIN: Do you have a
9 preference or how did you actually do it?

10 DR. DUNN: I think -- well, when
11 we shared the -- some results with you as part
12 of the submission, that was based on the
13 standard price, because our benchmark data,
14 you know, needs to be standard priced to be
15 able to put things together, the cost, the
16 different contributors.

17 But my preference is actually for
18 both. I think if you do standard cost, you
19 know, it does get around that question of
20 being able to look at utilization and
21 treatment decisions, practice patterns, but
22 the real cost and -- you know, does reflect

1 many times choice of facility, choice of
2 device, you know, things like that.

3 CHAIR WEINSTEIN: The kind of
4 things Mary Kay was talking about earlier.

5 DR. DUNN: Yes.

6 CHAIR WEINSTEIN: Any other
7 comments?

8 DR. RATLIFF: I'll bring up one
9 point. A lot of your kind of final results go
10 to the individual surgeon performing the
11 procedure that your PEG is like associated
12 around.

13 You have the near and further, I
14 believe, arms for preoperative evaluation with
15 the further being six months. So then your
16 surgeon is going to have attributed to him
17 cost accrued by the patient in the six month
18 period prior to the procedure being performed.

19 So that seems, to me, to be a more
20 valid or more representative of the efficiency
21 of say, a health care system or a local
22 practice environment, not so much the

1 individual surgeon whose outcome measure is
2 going to be influence by that further
3 assessment.

4 DR. DUNN: The FCI argument is
5 from their side that window on the beginning
6 part is too long. And this is a no given, the
7 -- given the way the logic works, you know,
8 there is a concept called the Close Windows
9 and then the Further Windows.

10 And the Close Window -- I need to
11 look this up quick, but I believe that's 14
12 days before.

13 DR. TARKO: That is correct.

14 DR. DUNN: Thanks, Howard. And
15 then the Further Windows on the beginning
16 side, it has to be a specific procedure code
17 that makes sense relative to the surgery. So
18 you really don't get a lot of -- unless it is
19 something that, obviously, would be related,
20 like an MRI or some other test to inform the
21 decision on the procedure itself, it isn't
22 likely going to find any services that relate

1 here.

2 But the things within the 14 days,
3 I think, we probably agree make sense. So
4 it's a, you know, valid point that the
5 beginning part is likely going to -- the
6 things that are happening to the patient may
7 be out of the control of the surgeon, but the
8 way the logic is constructed, it's pretty --
9 whatever. It's pretty exclusive on the types
10 of services that actually become part of the
11 episode during that, you know, longer
12 preperiod.

13 MS. SINNOTT: So are you saying
14 that primary care management or PMnR
15 management prior to the referral to surgery
16 and then physical therapy or occupational
17 therapy would likely not be attributed to the
18 surgical event or the surgical episode?

19 DR. DUNN: Physical therapy would,
20 that's one of the targets, there is a target
21 procedure code and then physical therapy is a
22 target procedure code. Pain management would,

1 MRIs would, x-rays would.

2 DR. RATLIFF: So E&M visits,
3 physical therapy, MRIs, probably injections.
4 E&M Codes, once the patient has his as a
5 diagnosis code, it's going to show up on every
6 single E&M they have from the PCP. So it's
7 probably going to be tagged and pulled out,
8 all of which is going to be attributed to this
9 PEG if you are doing the further preoperative
10 evaluation metric.

11 And I'm just saying again, not --
12 I'm just saying that there may be a lot of
13 variation there that has little to do with the
14 procedural efficiency itself.

15 DR. DUNN: Yes, and that -- E&Ms
16 actually would not be applied to that 14 day
17 window, but some of the other examples you
18 mentioned would be.

19 CHAIR WEINSTEIN: Yes. The issue
20 here is as you accept or don't accept this
21 methodology for the episode. The system's
22 efficiency or inefficiency in getting the

1 patient to treatment, should they want it, in
2 a timely way with things that matter, I mean,
3 you could be on all kinds of medications that
4 are extremely expensive and that's a burnup
5 period, have lots of images that have no real
6 impact on the then surgical procedure and then
7 the follow-up.

8 So the attribution model -- I
9 don't know how to get around this, because
10 this is what happens. But I'm thinking out
11 loud with you, which probably deserves more
12 discussion.

13 You know, when you get to this
14 data, you want to sort of get to what is the
15 ideal efficiency and effective episode for the
16 average patient. And you sort of laid out a
17 structure for that given what you perceive is
18 the average, not necessarily the best. Is
19 that fair?

20 DR. DUNN: The average and average
21 meaning that's the timing and the --

22 CHAIR WEINSTEIN: Yes.

1 DR. DUNN: That's the timing.

2 That's fair, yes.

3 CHAIR WEINSTEIN: Yes.

4 DR. DUNN: And then that logic
5 piece was designed, this is probably not
6 average here, but try to focus on what makes
7 sense to include differently depending on the
8 timing.

9 CHAIR WEINSTEIN: Yes, and with no
10 real outcome data, you don't actually have
11 some measure of effectiveness or value at this
12 point.

13 DR. RATLIFF: So again, what I
14 think you are commenting on is the system's
15 efficiency.

16 CHAIR WEINSTEIN: Yes.

17 DR. RATLIFF: Not the procedural
18 efficiency.

19 CHAIR WEINSTEIN: Or not the doc,
20 not the surgeon's efficiency, necessarily.

21 DR. RATLIFF: Yes. I agree with
22 that.

1 CHAIR WEINSTEIN: Yes. Is that
2 how you guys see it?

3 DR. DUNN: Yes, on average, at
4 least a small percent of the dollar is
5 conducting that type of --

6 CHAIR WEINSTEIN: Yes. And most
7 of the dollars are going to be to the device.

8 DR. DUNN: Yes.

9 CHAIR WEINSTEIN: The length of
10 stay, the operating time.

11 DR. DUNN: And then things that
12 you don't want to happen, that happen on the
13 back end.

14 CHAIR WEINSTEIN: Yes.

15 DR. DUNN: Right.

16 CHAIR WEINSTEIN: But in the
17 average case, it's going to -- the big costs
18 are the length of stay, the device and the
19 time in surgery. There's no question about
20 it.

21 DR. DUNN: Okay, yes.

22 CHAIR WEINSTEIN: Unless you -- do

1 you have different results?

2 DR. DUNN: No, you're right. It's
3 probably close to 90 percent of the --

4 CHAIR WEINSTEIN: Yes.

5 DR. DUNN: It depends on other
6 things, at least a dozen here.

7 CHAIR WEINSTEIN: Yes.

8 DR. DUNN: Not one.

9 CHAIR WEINSTEIN: Okay. Can we
10 answer this question?

11 MR. AMIN: That's one high, four
12 moderate and one low.

13 CHAIR WEINSTEIN: Next. So you
14 guys never ask questions about when we have
15 something high. You only ask questions --

16 MR. AMIN: Well, I was hesitating
17 on that one. In fact, that was -- I'm not
18 sure that -- but --

19 CHAIR WEINSTEIN: That's okay. We
20 will keep going.

21 MR. AMIN: Yes.

22 CHAIR WEINSTEIN: But feel free

1 to. Are exclusions supported by the clinical
2 evidence or analysis of frequency and
3 distribution?

4 Do I understand that question?
5 Are exclusions supported by the clinical
6 evidence or analysis of frequency and
7 distribution? Is information about the impact
8 of exclusions for patient preference
9 transparent?

10 It's not there. You don't have
11 that information, Part B of that or Part 2 of
12 that. So the upper part of that question are
13 exclusions supported? Any comments on that?

14 MS. SINNOTT: Only that we are
15 back to the kind of diagnostic classification
16 and the, you know, black box in this of the
17 whole system and how the diagnostic
18 hierarchies work. I mean, granted this is a
19 procedure-based episode definition, but we
20 still don't know how, you know, this episode -
21 - let's say we have a total joint replacement
22 and the patient gets pneumonia, is that in or

1 out of the episode? Do we know that?

2 CHAIR WEINSTEIN: I think it is
3 in.

4 I think it is in. You guys should
5 -- can you comment on that, the designers?

6 DR. DUNN: Yes, sure. This is
7 Dan. I'll let Howard add to this. So the
8 service -- if you think of the way the logic
9 is working, it is creating a condition
10 episode, which is a joint degeneration
11 episode, the way this one works. And then it
12 is looking at the procedure episode within the
13 context of that condition.

14 So only things that group to that
15 condition episode are going to be, you know,
16 on their way into the total knee or the total
17 hip replacement. So the pneumonia would not
18 be included, unless, you know, it happened
19 during the course of the inpatient stay and
20 made them, you know, stay in the hospital
21 longer, for example.

22 CHAIR WEINSTEIN: Only in

1 hospital? There is not like a 30 day window?

2 You don't have a window?

3 DR. DUNN: A window?

4 CHAIR WEINSTEIN: Because this
5 episode goes beyond the hospitalization.

6 DR. DUNN: Right. But the service
7 of this is that happened, you know, within --
8 part of the windows are only those services
9 that relate to the condition itself.

10 CHAIR WEINSTEIN: Yes, but they
11 didn't have pneumonia when they came in to get
12 their total knee replacement. They developed
13 it post-op, which could be possible. They
14 could have aspirated or something. I don't
15 know.

16 DR. TARKO: May I comment on that?

17 CHAIR WEINSTEIN: Yes.

18 DR. TARKO: Maybe -- what would
19 happen in the ETG methodology is there would
20 be a separate episode from the pneumonia that
21 would be created. It would be considered a
22 comorbidity of the procedure and would

1 contribute to the severity model in that
2 sense, because comorbidities can't cross
3 episodes.

4 DR. RATLIFF: Let me ask that a
5 different way. A patient gets a knee
6 replacement and gets a post-operative
7 pneumonia. On post-op day 6 and has to be
8 readmitted to the hospital for inpatient
9 treatment of their pneumonia after they have
10 had, say, a hip replacement.

11 How does that factor into your
12 model for increasing the cost of that index
13 procedure, the hip replacement?

14 DR. DUNN: Yes. This is Dan. And
15 unfortunately Tom Lin would be the best person
16 here. We can follow-up on this. My
17 interpretation is that if that admission is
18 for pneumonia, it would not be included in the
19 replacement. The cost of that admission would
20 not be included in the replacement episode.

21 DR. RATLIFF: As a proceduralist,
22 let me say sweet as not responsible for any

1 post-operative medical complications. That's
2 wonderful.

3 DR. RUBIN: Okay. I have a
4 different question. A little bit cleaner
5 maybe. So the patient comes back in three
6 days later with a pulmonary embolism, how is
7 that handled?

8 DR. TARKO: In the methodology,
9 there is a -- I'm not sure if that was in our
10 presentation, but there is the concept of a
11 consignment and the consignment is associated
12 with an episode and that would be included
13 within the consignment, even though it would
14 create another episode.

15 CHAIR WEINSTEIN: Let me try to
16 help out here and tell me if I'm wrong about
17 this. But a lot of the payers, maybe United,
18 they are thinking of the DVT pulmonary
19 embolism or infection as a new episode
20 potentially.

21 But the severity adjustment, which
22 he was started to allude to, might take that

1 into account. On the other hand, if you
2 organizationally said I'm going to do total
3 knees and take a bundle payment and go at risk
4 for any readmissions, then that's a different
5 story.

6 DR. DUNN: It --

7 CHAIR WEINSTEIN: Because I think
8 there is sort of apples and oranges here. The
9 surgeon might say okay, that DVT had to be
10 related to the pulmonary embolism and had to
11 be related to my hospitalization for my knee.
12 I don't think that's the question in this
13 grouper design, but can you guys explain that?

14 DR. DUNN: Yes. I think the point
15 that you are on, just as background, is they
16 have a discussion that took place out in
17 California through IAK where they were looking
18 at both the knee and hip replacement
19 specifications we are looking at. And, you
20 know, some of those readmissions if they are
21 not, you know, obviously attached to a
22 reoperation or, you know, something with a hip

1 or a knee, the lead diagnosis, you know, would
2 -- it has to be part of other episodes.

3 The discussion around readmission
4 actually became what else do we want to add to
5 this, either as an outcome measure or as, you
6 know, part of the cost of the episode itself.
7 So it is -- if it's not, obviously, clinically
8 related, it becomes a new episode.

9 MS. SINNOTT: I guess we are
10 struggling with not obviously clinically-
11 related as a concept or at least I am. That,
12 you know, if I have a total knee replacement
13 and I get a DVT, I think that's clinically-
14 related. And the payers will.

15 So here is another question.
16 First, it is now five months after surgery and
17 I have a 30 degree knee flexion contracture
18 and I need to go back in to have it
19 manipulated. And how is that gathered or not
20 into the surgery episode?

21 DR. DUNN: That would be Howard.
22 Would that be under physical therapy as a

1 follow-up procedure?

2 DR. TARKO: Or a --

3 MS. SINNOTT: It's a surgical
4 procedure.

5 DR. TARKO: -- separate procedure
6 like a release. I believe it would start a
7 new episode. If it were a manipulation, it
8 would be a target procedure and go to the
9 original episode.

10 CHAIR WEINSTEIN: I don't think we
11 are going to answer all these just as a point
12 of interest, but because, you know, for the
13 hospital they would like to start a new
14 episode and have a new payment. From the --
15 well, they could say the patient wasn't
16 compliant with their exercises and, therefore,
17 that's why they got the contracture.

18 They could say they didn't
19 mobilize, they didn't take their coumadin. I
20 mean, who knows the reasons. So these get
21 sort of -- yes?

22 DR. RUBIN: Critically important,

1 too.

2 CHAIR WEINSTEIN: Yes. But speak
3 up.

4 DR. RUBIN: Well, no, I think it
5 is extremely important, because you have two
6 hospital systems and one has a low rate of
7 these complications that are clearly related
8 and the other doesn't. There are
9 interventions that you can develop and
10 patients that have choices.

11 Besides, I know this tends to be
12 search eccentric, but, you know, there is
13 other consequences in terms of the costs of
14 this problem that need to be described. And
15 while I have the mike, I guess we are talking
16 about a lot of things that need to be
17 adjudicated.

18 And it's not clear to me who
19 actually makes these decisions in terms of
20 looking at a finding and saying well, it is or
21 is not linked to the prior hospitalization.
22 Is that an individualized decision or is there

1 certain training, so that it is done somewhat
2 uniformly?

3 CHAIR WEINSTEIN: There is --

4 MS. SINNOTT: I believe it is
5 built into the software.

6 DR. RUBIN: Okay. There is a lot
7 of references in terms of, you know, it will--

8 DR. RATLIFF: It's not clear.

9 DR. RUBIN: -- it seems to be by
10 choice. And computers don't usually, you
11 know, make the calls.

12 MS. SINNOTT: Choice of what?

13 DR. RUBIN: Well, for example, you
14 know, the description of somebody with
15 complication, deeming it related or not
16 related.

17 MS. SINNOTT: Oh. I think that
18 this leads to kind of a larger question, for
19 me, which is is there a place where all these
20 relationships are delineated, so that a
21 surgeon could go or a user of the methodology
22 of the software could go say, okay, I

1 understand this clinical logic.

2 Pneumonia is or is not part of the
3 episode. DVT is or is not. So that it's not
4 just -- I mean, even you folks on the phone
5 are not 100 percent clear how the episode
6 logic is being built. And I think that is --
7 what is interesting, to me, is as someone
8 evaluating for a public use methodology that
9 all this clinical logic should be accessible
10 in some way.

11 DR. DUNN: Yes. And I apologize
12 for not having the right person, Dr. Tom Lin
13 would be the right person to help you
14 understand this. And, you know, what I would
15 go to is to go to the code sets which were
16 submitted and it's either diagnoses that would
17 map to the joint degeneration episodes, which
18 then drive what ends up in the knee and hip
19 episodes.

20 So pneumonia isn't one of those
21 diagnoses. You know, some musculoskeletal-
22 related diagnosis for hip and the knee would

1 be. It's pretty clear in the set of code
2 tables what is in and what is not. I think
3 our challenges, off the top of my head, are --
4 I would say without Tom on the phone, I'm not
5 able to tell you exactly.

6 DR. RUBIN: So I could not find in
7 your -- I may be looking in the wrong
8 location. The S-5 joint degeneration hip/knee
9 codes for PE, acute MI, post-op, wound
10 infection, pneumonia, all common complications
11 from these procedures. So it would be helpful
12 to know if they are there somewhere.

13 DR. TARKO: They are not part of
14 the code set for those particular -- for this
15 particular measure, because they would be
16 codes that would begin a separate episode for
17 pneumonia.

18 CHAIR WEINSTEIN: So just touching
19 in again, are you --

20 DR. TARKO: That's just the way
21 the methodology works.

22 DR. RUBIN: Well, except in one of

1 the papers you referenced, as background,
2 quotes "those complications as being common
3 complications for these procedures." And so
4 it would seem that that should be part of the
5 coding for an episode to capture that, because
6 those are, you know, modifiable risks.

7 DR. TARKO: Yes, they do affect
8 the risk in that they are comorbidities of the
9 procedure. It's in a separate table. And
10 they will contribute to the severity of the
11 episode through the severity model.

12 DR. RATLIFF: And just for the
13 Ingenix commentators, before you mentioned
14 earlier that these were outcome measures.
15 They are not outcome measures. They are
16 resource use measures. And if you are not
17 capturing the most common perioperative
18 complications that are driving up resource
19 use, then you are missing something.

20 That may not be part of your PEG
21 model, but that probably reflects more on a
22 weakness of your model, not necessarily a

1 weakness or interpretation of it.

2 CHAIR WEINSTEIN: Yes, let me
3 defend them a little bit, not that I disagree
4 with anything that has been said, but what
5 they are trying to create is an episode
6 grouper for their routine average total knee.

7 The rates of DVTs could be as high
8 as 24 percent, whether they are clinically
9 relevant or not, it's a high rate of DVTs.
10 The rate of PEs is fairly low. It would be
11 certainly higher than a back surgery.

12 So in the episode, to include
13 complications or not, and to me this gets into
14 more of a contracting issue, because as you
15 were stating, when you look at the volume
16 outcomes data, people who do high volumes of
17 these things tend to have less complications,
18 less -- lower lengths of stay, et cetera, et
19 cetera, et cetera. And there is lots of data
20 on this.

21 I'm just -- I wonder if we are,
22 and I would appreciate NQF's help here,

1 overstepping the episode a little bit, but I
2 don't want to be the adjudicator of this
3 decision. What I want to do is try to answer
4 the question that is being raised by the
5 Committee.

6 Anybody want to help us out here?

7 MS. O'NEILL: Well, if we are
8 looking at the resources that can be used
9 affiliated with these diagnostic -- I guess,
10 the surgical treatment of these diagnostic
11 categories, and in a significant proportion of
12 people under going this treatment, those
13 resources are used, the treatment of the DVT,
14 the treatment of the pneumonia or whatever,
15 then those elements need to be captured if
16 that is what, in fact, we are measuring.

17 And now, I think a lot of our
18 filtering on these things ends up being are we
19 blaming the surgeon for all the things that
20 are happening or are we really trying to get
21 our hands around what it costs to take care of
22 folks with these conditions?

1 And if we are trying to get our
2 hands around the resource use/cost of these
3 conditions, then these common complications
4 need to be measured.

5 CHAIR WEINSTEIN: But there are
6 strategies, whether it is anticoagulation, you
7 know, extubation, early mobilization, there is
8 best practices that --

9 MS. O'NEILL: Sure.

10 CHAIR WEINSTEIN: -- limit these
11 complications in good organizations. But I
12 don't know that this is satisfactory for the
13 group or for the process. So I want to try to
14 get to some place that is satisfactory and I'm
15 not sure how far to go.

16 DR. RATLIFF: Two more points and
17 I'll shut up. For your clinical severity
18 levels, you model the severity of procedure
19 based very, very simply MSDRGs and whether or
20 not you have an MCC.

21 So you have like these severity
22 levels for the procedure you are performing.

1 Now, so going into the procedure, you have got
2 a stratification for how much you think it is
3 going to cost. But coming out of the
4 procedure, how are you capturing the increased
5 risk of perioperative adverse events that are
6 going to occur, presumably, in your higher
7 clinical severity patients? I'm not hearing
8 that.

9 And when you go from that to
10 relative risk modeling, where you go through
11 a relatively long explication of your risk
12 adjustment method on page 31 of your PDF, and
13 then that kind of disappears, I don't see
14 where that risk adjustment is brought back in
15 to either your modeling of your clinical
16 severity or of your individual physician's
17 output, for lack of a better word, in terms of
18 limiting perioperative adverse events, having
19 better outcomes in terms of we're losing those
20 adverse events.

21 So again, going back to my point,
22 I just don't think we are coming to an answer

1 for this question.

2 MS. O'NEILL: And I would just say
3 that if you are capturing complications as
4 increasing the risk, that becomes somewhat
5 circular, particularly if the incidents of
6 these complications varies by quality of
7 system.

8 So we don't want that to be pushed
9 into the risk. We want it to be pushed into
10 the resource use relative to the episode.

11 CHAIR WEINSTEIN: And what it gets
12 to is --

13 DR. DUNN: Yes.

14 CHAIR WEINSTEIN: -- is this the
15 provider level issue that you are comparing?
16 Is it an organizational level issue? Because
17 at the organ -- what you know from all of the
18 volume outcome studies, it's the system and
19 the process. It's not the individual surgeon
20 often times who creates the issue.

21 So these are all the right
22 questions. I just don't know how to

1 adjudicate this.

2 DR. DUNN: Yes. And this is Dan.
3 Maybe to state it simply what we are doing,
4 because I think we are kind of answering it in
5 different ways here. So one is the services
6 that end up grouping to the knee replacement
7 episode as we have defined it, are those that
8 are found in a joint degeneration condition
9 episode.

10 For things like the pneumonia,
11 some others, you know, vascular complications,
12 those would not group this episode. So those
13 are separate. So those complications, some of
14 them that were mentioned, unless they were,
15 you know, something related to the orthopedic
16 condition itself, would not be included.

17 The second point is which some
18 noted is correct is the only risk severity
19 adjustment that is done here is based on the
20 MSDRG. So those complications do not drive
21 the risk of the knee replacement episode.
22 Although, they may have use of risk

1 adjustments for some other episodes
2 downstream, but not for this one.

3 CHAIR WEINSTEIN: There is another
4 way to say this. For example, to me, please,
5 correct me if I'm wrong, if you had a vascular
6 event in doing a total knee replacement, which
7 happens rarely, that is not part of the
8 episode. You don't get paid for that.

9 So the hospital length of stay is
10 going to get longer, more procedures are going
11 to be done. The organization is going to have
12 to eat that cost, basically, in that, because
13 it's not part of the bundled payment episode
14 issue, because it's not supposed to occur most
15 of the time. You know, 99.99 percent of the
16 time.

17 On the other hand, you know, if
18 you get a DVT peri-op, it might be the same
19 issue. And if that happens three months
20 later, it's a new episode because now they
21 have a PE or something that -- it's not
22 supposed to happen in a well-organized, well-

1 running system.

2 So I think this is a circular
3 argument a little bit, but I think
4 organizations will worry about what is
5 included and not included, because their
6 payment will be affected by readmission or
7 not, which is, you know, Steve Janks work 70
8 percent readmission from CMS, you know, big
9 issue.

10 You know, it's a couple billion
11 dollars. The bigger issue is the chronic
12 conditions, the hospitalizations.

13 Quite frankly, I think we should
14 go on with the questions. We have had some
15 good discussion. Whatever our answers are
16 will be our answers. And there is no right
17 answer, so unless somebody disagrees, could we
18 go forward, please? Okay.

19 MR. AMIN: That's two moderate,
20 three low and one insufficient.

21 CHAIR WEINSTEIN: Next question.
22 For outcome measures, which we don't have any,

1 is there any evidence-based risk adjustment
2 strategy or rational data support no risk
3 adjustment stratification?

4 I don't know if outcome measures
5 is the right term there. I think the question
6 they are really asking is there an evidence-
7 based risk adjustment strategy?

8 MS. WILBON: Right.

9 DR. RATLIFF: Can I ask a question
10 of the developers? How do your clinical
11 superiority levels relate to your relative
12 risk adjustment or your risk adjustment
13 methodology referring specifically to S-10.1
14 from page 31 of your PDF?

15 DR. DUNN: Sure. So the -- I
16 touched on this a bit before this. The
17 severity of risk levels that are assigned to
18 the episode, are they simply on the MSDRG for
19 the admission that the replacement happened
20 within?

21 And each of those MSDRGs map to a
22 -- let me open exactly that table. I said,

1 for example, a major joint replacement, an
2 MSDRG for a major joint replacement, a
3 reattachment of the lower extremity without a
4 major complication, comorbidity, is assigned
5 to Severity Level 1. No episodes with that
6 MSDRG for the inpatient stay. They got a
7 Severity Level 1.

8 On the other end of the spectrum,
9 a bilateral multiple major joint procedure of
10 lower extremity with major complications and
11 comorbidity go to Severity Level 4. And then
12 the other DRGs fell in between.

13 So the DRG will -- assignment will
14 trigger the severity of the episode and then
15 that will give it, you know, a Level 1, 2, 3
16 or 4. And then that's what you will see on
17 that S-10 table. Did that help?

18 DR. RATLIFF: So understood.

19 DR. DUNN: Okay.

20 DR. RATLIFF: What's your risk
21 adjustment then? Maybe there was a lot of cut
22 and pasting from like a CHF model on your risk

1 adjustment method. How does that actually go
2 into like your output with regards to your
3 procedural efficiency? I don't see how these
4 two things relate at all.

5 DR. DUNN: Yes, so the, you know,
6 general approach to creating an overall risk
7 adjusted measure, so think of the assignment
8 of severity level to risk assessment. So
9 taking the results of that severity level
10 assignment using observe to expected ratio
11 approach, that's where the risk adjustment is
12 happening.

13 So the expected results for a
14 physician is based on their mix of knee
15 replacement episodes and hip replacement
16 episodes by severity level, as well as the
17 experience of their peers.

18 DR. RATLIFF: The problem with
19 what you have is, you know, if you were more
20 specific of doing a knee with some comorbidity
21 adjustments, this all seems to be for another
22 project. It's not to criticize you, but it is

1 a little bit not addressing specifically the
2 knee in the dialogue here with comorbidities.

3 Obviously, knee patients can have
4 CHF or diabetes and all those kinds of things,
5 but the text does not read as if it was done
6 for this particular diagnostic group.

7 MS. PAXTON: Well, it seems like
8 there is a lot of opportunity to apply more
9 sophisticated risk adjusted model considering
10 the work that has been done in this area.

11 CHAIR WEINSTEIN: Other comments?
12 Okay. We will take a vote here.

13 MR. AMIN: That's five low and one
14 insufficient.

15 CHAIR WEINSTEIN: Next question.
16 Are performance results reported? Do they
17 identify differences in performance or overall
18 less than optimal performance? Some
19 discussion?

20 MS. WILBON: So just a quick --
21 again, this one is about whether or not they
22 have demonstrated that the methods for scoring

1 an analysis of the measure identify
2 statistically significant and practically
3 meaningful differences.

4 CHAIR WEINSTEIN: I'll just say I
5 found this very complicated. Just it's hard
6 to follow and even harder for me to explain.
7 So no offense, but I believe it's fantastic
8 work, but I found it very complicated,
9 personally. Other comments? Are you waiting
10 for somebody? Okay. Still waiting?

11 MS. WILBON: So is the sentiment
12 here that the complexity of it makes it
13 difficult to discern whether or not the score
14 would -- are discerning meaningful -- or you
15 are able to discern meaningful differences
16 based on what is submitted? Is that kind of--
17 does that reflect the scoring?

18 MS. O'NEILL: Well, just to try to
19 read what the feedback would be to the
20 physician and figure out what is clinically
21 significant, you know, I mean, it tells
22 something about utilization measurement, but

1 it doesn't really tell you in that given case,
2 given a particular outcome, that you have
3 applied the right resources. It just kind of
4 counts resources.

5 CHAIR WEINSTEIN: Next. How are
6 you doing? Okay?

7 MS. WILBON: We're doing okay.
8 We're doing okay.

9 CHAIR WEINSTEIN: This is on
10 multiple data sets. Again, the resources by
11 which they use to get their analysis,
12 basically, they used their own data, which is
13 large and quite varied, I'm sure, with 50
14 million lives or whatever. So that's the
15 question, correct?

16 MS. WILBON: This is one of those
17 that ends up being a not applicable, because
18 they are actually only -- yes, they are
19 actually only suggesting or specifying the use
20 of one type of data, which is administrative
21 claims data.

22 So if they were suggesting like

1 chart review and admin claims data and
2 clinical data, then this would be kind of the
3 multiple data source thing, so that would be
4 NNA. Yes.

5 CHAIR WEINSTEIN: Next. Validity,
6 what is the overall level of validity from the
7 things we have talked about, specifications,
8 validity testing, risk adjustment,
9 identification, statistically significant
10 meaningful differences and for getting the
11 multiple data sources?

12 MR. AMIN: That's one moderate and
13 five low.

14 CHAIR WEINSTEIN: Disparities of
15 care. Do you want to clarify this for us
16 again, because -- how we should be
17 interpreting this? Because I don't think a
18 lot of these things are done either, so, but
19 I may be misinterpreting those.

20 MR. AMIN: The intent of this
21 criteria is to say that if there are
22 disparities that are identified in this

1 particular area of focus for the measure, we
2 want to ensure that those disparities are not
3 simply risk adjusted away, but they are
4 actually stratified, so that's the intent of
5 what this criteria is looking to measure.

6 MS. WILBON: So to provide a
7 little bit more guidance, if you look in --
8 under the importance criteria, specifically
9 submission items IM-2.4 and 2.5, if in that
10 section they are saying there are disparities
11 with this particular focus area, but then when
12 they go and develop the measure and you get
13 measure results, they are not addressing them,
14 you know, kind of to make that connection.

15 If you are saying there are
16 disparities, but why aren't you -- or how are
17 you addressing those if you have identified
18 them is the --

19 MR. AMIN: And just to add a
20 little bit more on that, keep in mind the last
21 portion of this criteria which says that if
22 there is some data justification for why the

1 stratification is not necessary or feasible,
2 then just keep that in mind that it's not
3 actually possible considering the data that is
4 available.

5 CHAIR WEINSTEIN: Yes, let me
6 suggest that there are references to disparity
7 with stratified populations, whether it is
8 Hispanic or non-whites and I don't think they
9 had stratified or addressed it.

10 So I'm just -- that's my own
11 opinion, but others should speak up.

12 MS. SINNOTT: The data is not
13 there. There is no race/culture data
14 generally available in commercial data.

15 CHAIR WEINSTEIN: In their data,
16 correct.

17 MS. SINNOTT: In any commercial
18 data.

19 MS. O'NEILL: Also, I don't know
20 if this is entire true, but I think it's
21 largely true that the disparities come on the
22 point of surgical decision making, not on the

1 resource use after the surgery -- surgical
2 decision has been made.

3 Although, there is some variation
4 in pain treatment, but I think most of the
5 disparities would be evident prior to getting
6 to this PEG episode.

7 CHAIR WEINSTEIN: From the federal
8 data, Medicare data, there is data that we
9 have published multiple times on disparities
10 and I think you are right. Once you get to
11 that, the rates are different across different
12 groups, ethnic groups. The rates are very
13 different.

14 And I think in fairness to them,
15 they don't -- they didn't stratify it. They
16 don't have it, as you suggest.

17 DR. RUBIN: It did include a
18 reference, not in the document, but he
19 reference refers to that box of higher rate
20 mortality, readmission and wound infection
21 effort prior to major knee replacement
22 compared to whites.

1 MS. WILBON: So just to --

2 DR. RUBIN: And the statistical
3 analysis, NA.

4 CHAIR WEINSTEIN: Yes.

5 DR. RUBIN: You know, so.

6 MS. WILBON: Yes.

7 CHAIR WEINSTEIN: I just didn't
8 think they addressed it, so I -- but if
9 somebody thinks they did, please, speak up,
10 because I think it's important. I would
11 change my mind then, because if I'm
12 misinterpreting this or Ingenix speak up.

13 Did you do this and we are missing
14 it?

15 DR. DUNN: Well, it's not part of
16 the measure methodology, so there is no risk
17 adjustment. I think someone had mentioned the
18 factors which recognize race or ethnicity or
19 some other attribute like that.

20 If the user wanted to stratify to
21 do analysis by that and they had that
22 information, they could do that, but, you

1 know, there was no intent to include that as
2 a risk factor and adjust it out of the
3 measure.

4 CHAIR WEINSTEIN: So, NQF, are you
5 satisfied that they didn't do it, because they
6 didn't think they needed to?

7 MS. WILBON: So the criteria
8 allows for them to either build it into their
9 measure or provide a rationale for why it is
10 not feasible. So if that's the case, if they
11 -- if it's not in their data, then they should
12 provide a rationale for why it's not in the
13 data.

14 CHAIR WEINSTEIN: Could I ask, is
15 it in your data or not, just for my
16 clarification?

17 DR. DUNN: No. It's not in. I
18 think someone mentioned it's not usually
19 available as part of the information of
20 commercial health problems.

21 CHAIR WEINSTEIN: Just for the
22 record, that's why they didn't do it.

1 DR. DUNN: Actually, back to the
2 point is maybe I'm splitting hairs here, I
3 think if you risk adjust -- include it in the
4 risk adjustment, then the ability to assess
5 disparities goes away. I'm not sure you want
6 to do that.

7 CHAIR WEINSTEIN: About
8 stratifying and not risk adjusting.

9 DR. DUNN: Yes. Okay. So looking
10 at the results, that way if someone had that
11 information, they could certainly do that
12 using this measure.

13 CHAIR WEINSTEIN: Which we have
14 done on CMS data, yes.

15 DR. DUNN: Okay.

16 MS. O'NEILL: So we're saying,
17 one, because we have a rationale for not doing
18 it?

19 DR. RATLIFF: Microphone.

20 MS. O'NEILL: Are we saying that
21 this is high because we have a rationale for
22 not doing it?

1 MR. AMIN: Okay. 2C references S-
2 10.2 and so if we -- if you felt that there
3 should be justification, the justification was
4 provided in 10.2 or from what we have heard
5 today. So if you believe the justification is
6 sufficient, I would vote as such.

7 MS. BOSSLEY: You want them to go
8 back at some point and put it in the form, so
9 it's there? Yes.

10 MR. AMIN: We have one high, three
11 low and two insufficient.

12 CHAIR WEINSTEIN: They have been
13 testing this at various places, so people are
14 using it, just FYI. Does that make it good or
15 bad? I don't know.

16 Available to the public, is that
17 happening, Ingenix? At this point, I assume.

18 DR. DUNN: I'm sorry, available to
19 the public in terms of the actual reports?

20 CHAIR WEINSTEIN: Yes.
21 Performance results is what the question is
22 asking.

1 DR. DUNN: There is one
2 organization who uses these procedure episodes
3 for knee and hip who do designate surgeons and
4 I believe that information is available to
5 members of that health plan, you know, the --

6 CHAIR WEINSTEIN: Is that the --
7 who is that or you're not allowed to say or
8 what?

9 DR. DUNN: I would rather not
10 without asking their --

11 CHAIR WEINSTEIN: Okay.

12 DR. DUNN: -- permission here.

13 CHAIR WEINSTEIN: Fine. So but it
14 is available in some way, so that helps us
15 answer the question.

16 DR. DUNN: Right. That's at least
17 one instance.

18 CHAIR WEINSTEIN: Okay.

19 DR. DUNN: Correct, yes.

20 MS. SINNOTT: Would you clarify --
21 oops, sorry. I'm looking at page 40. You
22 list a long list of users of ETGs and the

1 ERGs. Are any -- is any one of these using
2 this particular measure as a stand-alone
3 measure?

4 MS. ZIELINSKI: This is Cheri.
5 The answer to that question is as a stand-
6 alone measure, no. I mean, our --

7 CHAIR WEINSTEIN: We didn't get
8 the vote, I don't think. Okay.

9 MR. AMIN: That's four moderate
10 and two low.

11 CHAIR WEINSTEIN: Did submitted
12 information demonstrate that results produced
13 by the measure are meaningful, understandable
14 and useful for information for quality
15 improvement and public reporting or credible
16 rationale presented?

17 MS. SINNOTT: And I want to
18 clarify again that this measure, as a stand-
19 alone measure, has not been used for any
20 quality improvement activities, correct?

21 DR. DUNN: Well, maybe defined
22 internal, you know, quality improvements, for

1 example, looking at the results and reaching
2 out to a physician or a group of physicians
3 for discussion. Is that -- would that qualify
4 as quality improvement?

5 MS. SINNOTT: Yes, it would. But
6 I'm referring to this measure as a stand-alone
7 measure, not as part of a performance profile
8 for a physician.

9 DR. DUNN: And so that's just a
10 composite, for example.

11 CHAIR WEINSTEIN: What was that
12 response?

13 MS. WILBON: As a composite.

14 DR. RATLIFF: Microphone.

15 MR. AMIN: Can you repeat that,
16 please?

17 CHAIR WEINSTEIN: Can you repeat
18 your answer, please?

19 DR. DUNN: Oh, sure. I was
20 actually trying to clarify the question. I
21 may have answered it at the same time. So
22 there are organizations who will take results

1 for orthopedic surgeons, for example, and talk
2 with physicians who are, you know, somewhat
3 different than the norm, based on these
4 measures on resource use.

5 And some of that discussion could
6 be triggered by an overall result looking
7 across all the episodes, these episodes and
8 others, that are included in that provided
9 overall result.

10 But that discussion will -- or
11 that provider will get to the level of looking
12 at individual episodes, like knee replacements
13 and hip replacements for discussions around,
14 you know, opportunities.

15 Is it all only -- is the whole
16 discussion only focused on these episodes? I
17 would say probably rarely. It's probably part
18 of a general discussion and performance around
19 these episodes will surface during that.

20 CHAIR WEINSTEIN: Thank you.

21 MR. AMIN: That's three moderate
22 and three low.

1 CHAIR WEINSTEIN: Are the data and
2 result details maintained such that the
3 resource use measure, including clinical
4 construction logic, for defined unit of
5 measurement can be, I hate this one, broken
6 down to facilitate transparency and
7 understanding?

8 MR. AMIN: It's two moderate and
9 four low.

10 CHAIR WEINSTEIN: Next. Are the
11 required data that is -- routinely generated
12 and used during care delivery? Do you want to
13 tell us something?

14 MS. WILBON: Yes. So again, these
15 next two criteria are, again, remember we are
16 just talking about admin data and the ability
17 for them to be generated in routine care and
18 whether or not they are electronic, which is
19 the following criteria, available
20 electronically.

21 MR. AMIN: That's five high and
22 one moderate.

1 CHAIR WEINSTEIN: Are the required
2 data elements available in electronic health
3 records or electronic sources, which is claims
4 data? Is what you mean here. If not, is it
5 credible -- one of the things I want to
6 understand is the claims data from United, in
7 this case, versus other claims.

8 So would CIGNA have the same or is
9 this unique to them or something?

10 MS. WILBON: I don't think so.

11 CHAIR WEINSTEIN: Yes, I don't
12 either, but I'm just asking for clarification.

13 DR. DUNN: Yes. This is Dan.

14 CHAIR WEINSTEIN: You didn't see
15 anything you need that would exclude others
16 from using this. Kind of -- I have --

17 MS. O'NEILL: No. I think -- I
18 mean, the only -- there is -- what you don't
19 even want to know about is the platform
20 behavior. I mean, there is stuff that happens
21 in organizations, based on their own quirky
22 software and historical evolution of their IT

1 systems. But it is all pretty standard.

2 CHAIR WEINSTEIN: That would be
3 important in usability, which we are not to
4 yet, but you think it's feasible?

5 MS. O'NEILL: Yes.

6 CHAIR WEINSTEIN: Yes.

7 MS. O'NEILL: And I think that we
8 are using it.

9 CHAIR WEINSTEIN: Okay.

10 MS. O'NEILL: By the way.

11 CHAIR WEINSTEIN: Did we all vote?

12 MS. WILBON: No.

13 CHAIR WEINSTEIN: We will vote
14 again?

15 MS. WILBON: Yes.

16 MR. AMIN: That's six high.

17 CHAIR WEINSTEIN: Are
18 susceptibilities to inaccuracies, et cetera,
19 unintended consequences due to inaccuracies,
20 errors and the ability to audit the data items
21 to detect such problems identified?

22 So I guess, to me, are these data

1 elements susceptible to inaccuracies? I mean,
2 any time you are taking data from one place
3 and putting it in the claims data, they are
4 all susceptible to those kind of things. I
5 don't know what the error rates are, but any
6 other discussion about that?

7 MS. O'NEILL: I guess the only
8 other concern I have is kind of in the
9 unintended consequences arena is from their
10 description, if a complication does occur, it
11 is identified as an element to their risk
12 adjustment as opposed to being kind of tracked
13 as a complication.

14 And to me that's kind of washing
15 it out. I mean, it's not having diabetes
16 ahead of time is a risk. Having pneumonia
17 afterwards isn't a risk. It's a complication.
18 And from their description it sounds like it
19 would be treated like a risk.

20 DR. DUNN: Yes. This is Dan.
21 That's -- that wasn't correct. It's our
22 fault. You know, the only sort of risk driven

1 elements of this are the MSDRGs. The pneumonia
2 would not trigger additional risk for these
3 episodes.

4 MS. PAXTON: Would you be able to
5 clarify what those DRGs or those risks without
6 multiple complications?

7 DR. DUNN: Correct. That is it's
8 in one of the tables. If the -- you know, all
9 of the major joint replacement, knee or hip
10 replacement DRGs some without, you know, MCC,
11 some with MCC.

12 MS. PAXTON: The complications
13 could be potentially embedded within those
14 DRGs?

15 DR. DUNN: I believe that those
16 are present on admission complications. Is
17 that correct? I think those would be
18 beforehand.

19 MS. PAXTON: Admitting DRGs?

20 DR. DUNN: Yes. Complicating
21 factors beforehand.

22 MS. O'NEILL: So one of the things

1 you mention is the problems with small sample
2 size. And, in particular, when you isolate
3 one of these conditions that orthopedic
4 surgeons, for example, use, you refer to the
5 fact that it is easier to make an assessment
6 of physician performance when there are
7 multiple conditions in a panel, rather than
8 measuring a single condition like this measure
9 does.

10 Have you a recommendation on the
11 minimum number of episodes on which a
12 physician should be measured or the
13 performance measured?

14 DR. DUNN: Well, in terms of
15 measurement, you know, all these measurements
16 are based on, at least our specifications,
17 comparisons with peers. Then the question
18 becomes is -- you know, how do you assess
19 whether a difference observed is statistically
20 significant? You can, you know, put some
21 weight on it and sample size will be, you
22 know, part of that determination.

1 So our recommendation on related
2 to sample size is to use confidence intervals
3 to support that comparison with a benchmark or
4 with peers. You know, and if you look at the
5 -- whether the tradeoff between sample size
6 and statistical significance, you know, it
7 will vary on application, depending on the
8 physician or the, you know, peer group you are
9 looking at.

10 You know, you probably need, you
11 know, 30 or more episodes or higher to get
12 something that's statistically different,
13 unless the provider is very different from
14 their peers.

15 I can't give you a recommendation
16 on precise sample size, but, you know, just in
17 the ballpark of what ends up being, you know,
18 sort of the typical distribution.

19 MS. SINNOTT: Right. I'm just
20 thinking most of a smaller health plan. For
21 example, you know, how many patients with
22 total knees are done in a year in a health

1 plan of 200,000 or 300,000 people? And then
2 how many of those are actually done by a
3 single provider? That's where the question
4 comes in.

5 CHAIR WEINSTEIN: And 90 percent
6 of knees are -- people doing knee replacements
7 do less than 10 a year.

8 DR. DUNN: And that is a valid
9 comment on challenges with these measures.

10 MR. AMIN: That's two moderate and
11 four low.

12 DR. DUNN: Can I ask a question?
13 Okay. Are the intent of the endorsements tied
14 to a specific unit of measurement, that, you
15 know, individual surgeon versus practice
16 versus delivery system? Could the answer to
17 this question depend on, you know, the level
18 you are applying the measure at?

19 The feasibility of this is
20 difficult at the individual surgeon level.

21 But if you start rolling up --

22 CHAIR WEINSTEIN: Yes. First of

1 all, I don't want to comment on the
2 endorsement by NQF. They should comment
3 themselves. But I think what we are trying to
4 do is understand the usability -- feasibility,
5 excuse me, across different domains.

6 And at the individual surgeon
7 level, any of these things are very difficult
8 if the person, him or her, only does, you
9 know, five of these, how valid is the measure?
10 But you could imagine over a few years of use,
11 potentially, that that could get better.

12 There is no secret that -- you
13 know, and I think we have just finished this
14 study showing that you have to do -- I think
15 people who do more than 100 tend to do much
16 better. And that may not be the cutoff. I
17 might have this data wrong, but it's a number
18 like that.

19 And people who do less have more
20 complications and more problems. You are
21 going to -- you know that from your database
22 already, quite frankly, because you have years

1 of data on similar providers over time.

2 That wasn't a requirement of this
3 collection process to make a determination of
4 supporting this -- your measure, to my
5 knowledge. So --

6 MS. O'NEILL: Yes, also the
7 reporting that was included was on the
8 individual physician level, so we didn't see
9 a sample practice or a health system report,
10 so maybe we are making an assumption that
11 that's what the reporting format was going to
12 be.

13 DR. DUNN: And then --

14 MR. AMIN: I would just add --

15 DR. DUNN: I think --

16 MR. AMIN: Sorry, go ahead.

17 DR. DUNN: No, go ahead, Todd.

18 Really quick, you know the early focus of our
19 responses are on the measure itself, rather
20 than how it would be reported.

21 But my assumption is it would
22 apply at all the different levels, that makes

1 sense.

2 MR. AMIN: So the only thing --

3 DR. DUNN: Including -- go ahead,
4 sorry.

5 MR. AMIN: I'm sorry. It's hard
6 to read. I can't see it. So the only thing
7 that I would add from NQF, this is true in
8 speaking, is that the measure would be
9 evaluated based on the level of analysis that
10 was chosen by the measure developer. So what
11 you chose on 11.3, the level of analysis on
12 page 32, so the Committee should evaluate
13 these criteria based on the multiple levels
14 that were specified.

15 So this measure could be applied
16 at multiple levels, clearly, at the facility
17 or the health plan level or at the population
18 level, but it is also specified for clinician
19 at the individual level.

20 So it would be endorsed for use at
21 that level. So, thus, this -- all these
22 criteria and, you know, obviously, the more

1 specific the unit of analysis, the more issues
2 of like 4C would become more important to
3 evaluate.

4 So I guess the answer to the
5 question that you had posed is that the
6 evaluation would depend on the level of
7 analysis that was chosen for endorsement,
8 since it would be endorsed for use at the
9 individual clinician level.

10 DR. RATLIFF: And their primary
11 outcome measure is an individual clinician.
12 Now, here in S-11.3, they give a level of
13 analysis going from the individual physician
14 to like the universe. But what they are
15 giving us in this outcome measure is
16 individual physician data. So I think that's
17 what we focused on as we approached this
18 measure.

19 CHAIR WEINSTEIN: You would think,
20 John, that if they could do it at the
21 individual level, you could roll it up at any
22 other level. That's -- I think that's their

1 assumption. Yes. So, okay, can we vote?

2 MR. AMIN: That's one high, four
3 moderate and one low.

4 MS. WILBON: So do you want to
5 take a quick break then?

6 CHAIR WEINSTEIN: Sure. We will
7 take a quick break.

8 MS. WILBON: So we are going to
9 take about a 10 minute break, for those on the
10 phone. And we will be starting with the ABMS
11 measure for 1585, episode of care for simple
12 non-specific lower back pain, when we come
13 back.

14 CHAIR WEINSTEIN: An easy one.

15 MS. WILBON: At about 2:25.

16 (Whereupon, at 2:17 p.m. a recess
17 until 2:23 p.m.)

18 CHAIR WEINSTEIN: The first
19 question.

20 MS. WILBON: So let me just check.
21 Is there anyone from ABMS on the phone? I
22 know we are running a little bit behind.

1 DR. MANHEIM: Yes, Larry Manheim
2 again.

3 MS. WILBON: Okay.

4 DR. MANHEIM: Todd is no longer
5 here, but I'm here.

6 MS. WILBON: Okay. Great.
7 Thanks, Larry. Do you mind giving us just a
8 brief overview of the measure before we start
9 discussion?

10 DR. MANHEIM: Okay. So again,
11 it's resource use and processes shared with an
12 episode of care for what we define as simple
13 non-specific lower back pain. This is
14 triggered by an initial ambulatory care visit
15 for non-specific lower back pain defined by
16 our diagnoses.

17 It is a three month episode.
18 Again, similar to -- we talked about
19 radiculopathy. We also include prior 14 days,
20 not for office visit, but in case there were
21 lab or imaging done prior to the first visit.

22 An episode only begins if there is

1 no lower back pain diagnosis, trigger
2 diagnosis within 90 days prior to the initial
3 visit. It has to be a 90 day gap. And also,
4 individuals with a radiculopathy diagnosis
5 during the measurement period or during the
6 prior year are excluded from consideration
7 here.

8 And we allocate to physicians
9 based on the same method as I talked about for
10 radiculopathy. It goes to a physician and has
11 to have 70 percent E&M visits and, otherwise,
12 it goes to more than one physician or
13 physicians that have 30 percent or more E&M
14 visits during the episode, otherwise, it goes
15 to no physician.

16 CHAIR WEINSTEIN: Any questions by
17 anybody? Okay. Are you ready to go, sir?
18 The pressure is on, sir.

19 Is this a high impact area?

20 MS. WILBON: That was six high.

21 CHAIR WEINSTEIN: Was data
22 submitted that demonstrated considerable

1 variation in delivery of care? If somebody
2 has a comment, speak up, otherwise, we will
3 just keep voting.

4 MS. WILBON: Again, six high.

5 CHAIR WEINSTEIN: Is the purpose
6 objective a resource use measure in the
7 construct for resource/cost clearly described?

8 MS. WILBON: We have five high and
9 one moderate.

10 CHAIR WEINSTEIN: Are the resource
11 use service categories that are included in
12 the resource use measure consistent with and
13 representative of the conceptual construct
14 represented by the measure?

15 MS. WILBON: That's two high and
16 four moderate.

17 CHAIR WEINSTEIN: Is the measure
18 precisely specified so that it can be
19 implemented consistently?

20 MS. WILBON: So we do need a
21 little bit of discussion here, just so we have
22 a rationale kind of where you are going with

1 this one.

2 CHAIR WEINSTEIN: Anybody want to
3 speak up?

4 DR. RATLIFF: Well, this is a -- I
5 think -- can you go back to the question, sir,
6 please?

7 MS. WILBON: Yes.

8 CHAIR WEINSTEIN: This is a tough
9 one to specify. It isn't that they didn't do
10 a good job and I was just -- as I was
11 answering that question, I was looking back at
12 the inclusion/exclusion criteria and I think
13 they did a really good job. I just think it
14 is a tough one, so I was probably a little
15 less positive, only because I know how hard it
16 is.

17 I think the measure does a really
18 good job around specificity, so I think they
19 were precise. But any other comments?

20 DR. RATLIFF: I think this is a
21 real grab bag diagnosis. And I think a lot of
22 different pathologies get lumped into a lumbar

1 DDD and I think they do about as good a job as
2 you could hope for in parsing out that patient
3 population.

4 MS. O'NEILL: I guess this is a
5 technical question.

6 CHAIR WEINSTEIN: Microphone.

7 MS. WILBON: Microphone.

8 MS. O'NEILL: If this is a
9 technical question about have they specified
10 it, then they technically specified it, is it
11 -- maybe we are all jumping to the clinical
12 appropriateness of the specificity.

13 CHAIR WEINSTEIN: Well, the
14 problem I got into is there is other overlying
15 diagnoses sometimes and they have all the
16 drugs. I mean, more drugs than I can imagine,
17 which is -- this population sees all the time.
18 But is it the primary problem? Is it a
19 secondary problem?

20 And I'm not sure that is addressed
21 well. That was my -- I mean, --

22 MS. O'NEILL: Yes.

1 CHAIR WEINSTEIN: -- I wasn't
2 criticizing, but we all see these patients
3 that have secondary gain issues that have home
4 issues, that have work issues and back pain
5 ends up to be the diagnosis that gets them
6 into this episode. It's not their fault, but
7 that's how I was doing it.

8 MS. O'NEILL: And there were some
9 exclusions of things that are pretty common
10 findings radiologically, for example. There
11 were some exclusions that, to me, wouldn't --
12 shouldn't be exclusions, but maybe that's a
13 different question.

14 MS. WILBON: So I think that comes
15 up probably more so in 2(b)(1), which we will
16 get to in just a second. But here if you guys
17 are comfortable with the way that it is
18 written, that someone could follow it, that
19 someone could take that piece of paper, hand
20 it to a programmer and say, you know, program
21 this measure for me, that that is, as it is
22 written, clear enough to do that is basically

1 what we are asking.

2 CHAIR WEINSTEIN: I think May Kay
3 captured it though.

4 MS. WILBON: Okay.

5 CHAIR WEINSTEIN: We are taking
6 what is probably really clear from an
7 implementation algorithm to say no matter how
8 clear it is, it's going to be a problem
9 potentially.

10 MS. WILBON: Okay. Okay.

11 CHAIR WEINSTEIN: Why? Why what?

12 MS. WILBON: It sounds like
13 everyone is comfortable with the way that it's
14 -- it's a difficult topic, but based on it
15 being difficult, that they did a good job, but
16 it wasn't quite high.

17 CHAIR WEINSTEIN: We like this.

18 MS. WILBON: But that some of the
19 issues that pertain to the actual
20 specifications will come up in 2(b)(1), which
21 we will discuss.

22 CHAIR WEINSTEIN: Yes.

1 MS. WILBON: Does that kind of --

2 CHAIR WEINSTEIN: Yes.

3 MS. WILBON: Okay.

4 MS. O'NEILL: Thank you.

5 MS. WILBON: Thank you.

6 CHAIR WEINSTEIN: Does the
7 reliability testing demonstrate that the
8 results are repeatable producing the same
9 results time and time again in the same time
10 period and that the measure score is precise?

11 I don't know that I have that
12 precision issue in this. Does somebody want
13 to comment on that?

14 DR. RATLIFF: I think it's a
15 similar issue to the first group.

16 CHAIR WEINSTEIN: Yes.

17 DR. RATLIFF: They didn't do
18 reliability testing.

19 CHAIR WEINSTEIN: Yes. So do you
20 understand that?

21 MS. WILBON: Yes.

22 CHAIR WEINSTEIN: Okay.

1 MS. SINNOTT: Only face validity
2 is --

3 CHAIR WEINSTEIN: Microphone.

4 MS. SINNOTT: Oh, I'm sorry. Only
5 face validity is reported. And reliability of
6 the physician scoring isn't reported, either.

7 MS. WILBON: Right. So just to --

8 CHAIR WEINSTEIN: It's in process.
9 This isn't done yet.

10 MS. SINNOTT: Right.

11 MS. WILBON: So just I think this
12 is very similar, that testing information that
13 was meant for this measure is very similar to
14 other measures. So if everyone is comfortable
15 with that, I don't think -- unless there is
16 something new particular for this condition
17 focus that would need to be brought up. I
18 think it would be covered. Okay.

19 So that's one moderate, two low
20 and three insufficient.

21 CHAIR WEINSTEIN: What is the
22 level of overall reliability and testing?

1 Again, we run into the same issues. We
2 thought that there was some good
3 specifications, but the reliability testing
4 isn't there. So that's why you are going to
5 see the votes you are going to see, whatever
6 they are.

7 MS. FANTA: So we have one
8 moderate, three low and two insufficient.

9 CHAIR WEINSTEIN: And, you know, I
10 think we all just want to congratulate the
11 people who have been doing these things,
12 because we are going to run out of here when
13 we are done sometime or they will leave the
14 phone, but we all, as a Committee, want to
15 express our appreciation to Ingenix and ABMS
16 for this incredible work. This is really hard
17 work. And we applaud that.

18 And our comments in no way want to
19 discredit that or be seen in any other way.
20 So just to get that on the record.

21 Are the measure specifications
22 consistent with the evidence?

1 MS. O'NEILL: What evidence?

2 MS. WILBON: And again, this is
3 not that -- evidence should actually like the
4 intent or the focus of the measure. So again,
5 evidence is a little misleading. We didn't
6 paraphrase that well.

7 CHAIR WEINSTEIN: Well, but what
8 do you want us to answer?

9 MS. WILBON: So we are asking if
10 the measure specifications, as the measure is
11 written, is it consistent with what they said
12 the intent of the measure was? And what the
13 focus of the measure of that particular
14 condition is and what they are intending to
15 measure.

16 CHAIR WEINSTEIN: Can we revote,
17 Sarah?

18 MS. FANTA: Yes, revote.

19 CHAIR WEINSTEIN: Start -- yes,
20 because I --

21 MS. FANTA: Oh, sure, yes.

22 CHAIR WEINSTEIN: I used the word

1 consistent with the evidence.

2 MS. WILBON: Yes.

3 CHAIR WEINSTEIN: Thank you.

4 MS. FANTA: Go ahead.

5 CHAIR WEINSTEIN: Who is going to
6 make sure that question is interpreted the way
7 you said versus what we are answering?

8 MS. WILBON: It's actually on here
9 correctly, which is what we are going by.

10 CHAIR WEINSTEIN: Okay.

11 MS. WILBON: So it's just a slight
12 -- it's just the slide that's wrong, let's
13 assume.

14 MS. FANTA: So we have one high
15 and five moderate.

16 CHAIR WEINSTEIN: Does the
17 validity testing demonstrate that the measure
18 data elements are correct? Does validity
19 testing -- you know, we run into the same
20 problems again. So we can vote. Do you want
21 to say something, Mary Kay?

22 MS. O'NEILL: Just, at some point

1 time, we have to say that in this cadre of
2 patients, what things are called and, as you
3 have pointed out, what the actual underlying
4 driving diagnosis may be, it has the highest
5 degree of variability.

6 Maybe not in every clinical
7 situation, but one of the most -- I mean, it's
8 the one area where I think if you gave a bunch
9 of reasonably trained clinicians the same
10 batch of patients and even coming up with the
11 right diagnostic code, it would be a pretty
12 big grab bag, you know. So it's hard to get
13 the right data in here.

14 MS. SINNOTT: And you have to give
15 them all the same, what's it called, billing
16 sheet with the diagnosis at the bottom, you
17 know.

18 MS. O'NEILL: Correct.

19 MS. SINNOTT: Or whatever.

20 CHAIR WEINSTEIN: Well, the
21 problem is some people use the same code for
22 all of these patients independent of what the

1 diagnosis might be. I mean, it's just -- we
2 all understand.

3 MS. FANTA: The results were one
4 moderate, three low and two insufficient.

5 CHAIR WEINSTEIN: Are exclusions
6 supported by the clinical evidence or analysis
7 of frequency and distribution? Is information
8 about impact of exclusions for patient
9 preference transparent?

10 MS. O'NEILL: Could I just --

11 CHAIR WEINSTEIN: Yes.

12 MS. O'NEILL: -- clarify in this
13 90 day episode, am I correct to read that any
14 patient that has a fusion in the 90 days is
15 excluded?

16 DR. MANHEIM: Any patient that has
17 a fusion in the prior period is excluded.

18 MS. O'NEILL: But not in the
19 episode?

20 DR. MANHEIM: Right.

21 MS. O'NEILL: Okay.

22 DR. MANHEIM: As long as they

1 don't have a diagnosis one -- of a
2 radiculopathy diagnosis.

3 MS. O'NEILL: Okay.

4 DR. MANHEIM: You know, because
5 that may be thrown out because of that.

6 MS. O'NEILL: Okay.

7 DR. RATLIFF: As some of your
8 exclusion criteria you list active cancer,
9 which seems pretty reasonable, because you
10 want to look at back pain, not people that are
11 coming in with pathologic fractures. But then
12 you exclude melanoma, which not infrequently
13 goes to the spine, but more importantly,
14 prostate, which loves going to lumbar spine
15 and is going to give you a little back pain.

16 So it's going to confound your
17 data that following this exclusionary
18 criteria, you are going to be bringing in
19 prostate cancer meds to the spine along with
20 your Workman's Comp patients who have like
21 isolated low back pain episodes.

22 So I don't understand that aspect

1 of your exclusionary criteria.

2 DR. MANHEIM: Oh --

3 DR. RATLIFF: Look at that.

4 DR. MANHEIM: -- so what you are
5 saying is --

6 DR. RATLIFF: I don't understand
7 why you then say active cancer (excluding
8 melanoma, skin), prostate and CLL. Like why
9 exclude prostate? Why do you want to have
10 prostate cancer patients included for a low
11 back pain measure?

12 CHAIR WEINSTEIN: Do you
13 understand his question? It's pretty
14 specific. You say cancer, but you exclude
15 some cancers.

16 MS. SINNOTT: Exclude from the
17 exclusion.

18 MS. WILBON: Right.

19 CHAIR WEINSTEIN: Yes.

20 DR. MANHEIM: Right.

21 CHAIR WEINSTEIN: It doesn't make
22 sense.

1 MS. WILBON: Maybe they meant
2 including.

3 DR. MANHEIM: I'm looking at it
4 and I may --

5 DR. RATLIFF: It's on page 13 of
6 your PDF, Step 3 of your criteria, the first
7 paragraph there.

8 DR. MANHEIM: So diagnostic codes
9 to identify active cancer treatment.

10 CHAIR WEINSTEIN: But then you say
11 excluding certain types of cancer. Why would
12 you exclude them? I think what you are giving
13 is examples of cancer you would include
14 potentially.

15 DR. RATLIFF: Agreed.

16 DR. MANHEIM: Right, right. From
17 what I'm looking at, I should be following
18 what you have, I don't see that.

19 CHAIR WEINSTEIN: Yes, it's --

20 DR. MANHEIM: I believe that --

21 CHAIR WEINSTEIN: -- an error, I'm
22 sure --

1 DR. MANHEIM: It's an error.

2 CHAIR WEINSTEIN: -- in what was
3 written.

4 DR. RATLIFF: If it's an error,
5 they consistently make it at multiple
6 different points in the document.

7 CHAIR WEINSTEIN: Yes.

8 DR. RATLIFF: Whenever they talk
9 about like excluding --

10 CHAIR WEINSTEIN: Yes. You are
11 exactly right.

12 DR. RATLIFF: -- cancer, active
13 cancer patients.

14 CHAIR WEINSTEIN: The other thing
15 they did, they say patient had fusion or other
16 back surgery or fracture. I assume that
17 includes osteoporotic compression fractures,
18 which are very common cause of back pain?

19 DR. MANHEIM: The diagnoses are
20 listed and I would have to look at that.

21 CHAIR WEINSTEIN: So those are
22 important points that we just brought up that

1 you need to resolve.

2 DR. MANHEIM: Right.

3 CHAIR WEINSTEIN: Okay.

4 MS. SINNOTT: I'm sorry, is
5 pregnancy in here as an exclusion?

6 DR. MANHEIM: Pregnancy, I believe
7 is --

8 CHAIR WEINSTEIN: It's not listed.

9 DR. MANHEIM: -- not listed. It's
10 not in here. I know there was discussion and
11 it was decided not to include it as an
12 exclusion.

13 CHAIR WEINSTEIN: Another good
14 point, I think. It's hard enough to do this
15 with including those. The Committee is
16 recommending you make the changes that we have
17 recommended in your model or clarify that this
18 is an error in the printed version that we
19 have --

20 DR. MANHEIM: Right.

21 CHAIR WEINSTEIN: -- versus your
22 model.

1 DR. MANHEIM: So exclude
2 pregnancy, don't have the restrictions and on
3 active cancer, if that's not an error, you
4 know, just written therein. In any case, we
5 have to correct that.

6 CHAIR WEINSTEIN: And compression
7 fractures.

8 DR. MANHEIM: Right.

9 CHAIR WEINSTEIN: Which maybe it
10 says or fracture, so I'm just not sure. But
11 you are talking about surgeries there, so I'm
12 not sure.

13 DR. MANHEIM: Yes. So we will
14 need to check that.

15 MS. SINNOTT: And what about
16 trauma?

17 DR. MANHEIM: Trauma is, I
18 believe.

19 DR. RUBIN: It's in there. I
20 think it's in there.

21 MS. SINNOTT: As expressed as an E
22 Code. Well, the question is whether you want

1 to include motor vehicle accidents in the non-
2 specific, might I say, mechanical low back
3 pain?

4 CHAIR WEINSTEIN: You get into
5 this whiplash kind of stuff, too, you know,
6 back pain.

7 DR. RATLIFF: If you're going to
8 start excluding motor vehicle accidents, why
9 don't we exclude like Workman's Comp and other
10 like work-generalized accidents? And I see
11 what you are saying, but it can quickly like
12 broaden out and suddenly your measure doesn't
13 mean anything to your patient population.

14 MS. SINNOTT: Well, but if I'm a
15 Workers Comp carrier, I want -- I don't want
16 to exclude the Workers Comp injuries, right?

17 MS. O'NEILL: Yes, most of this
18 database would not have Comp data, I don't
19 believe, but they would have personal injury
20 cases is what you are saying. And, obviously,
21 they would be excluded if they were major
22 trauma by the other exclusionary criteria, but

1 not minor trauma.

2 MS. SINNOTT: I'm just going back
3 to the, you know, original exclusions from the
4 back pain, the boat, which was, you know,
5 inflammatory, spinal arth --

6 CHAIR WEINSTEIN: Spinal
7 arthropathy.

8 MS. SINNOTT: Thank you. And
9 motor vehicle accidents and pregnancy and
10 cancers and things like that.

11 DR. MANHEIM: Whether we would
12 actually know whether it was a motor vehicle
13 accident or even Workman's Comp from the data,
14 I'm not sure.

15 CHAIR WEINSTEIN: Well, the other
16 thing is in your -- in the radiculopathy one--

17 DR. MANHEIM: Yes.

18 CHAIR WEINSTEIN: -- you also, we
19 missed this, but, included the cancers there,
20 too. So I think it's an error. And I think
21 your list of exclusions are a little bit
22 better around some of these things we are

1 talking about right now, so you might --

2 DR. MANHEIM: Right.

3 CHAIR WEINSTEIN: -- try to --

4 DR. MANHEIM: Look at both of them
5 and make sure they are both correct.

6 CHAIR WEINSTEIN: -- look at those
7 and make sure that they are making sense with
8 your physician panel. And I would ask that
9 you submit a revised list to NQF that matches
10 your model and/or if your model has got these
11 in them, it's a problem. So there is some
12 work that needs to be done that NQF needs to
13 know about by these things we are bringing up
14 now, because --

15 DR. MANHEIM: All right. We will
16 do that.

17 CHAIR WEINSTEIN: -- it
18 invalidates or weakens your model by not
19 addressing these issues, in both cases.
20 Anybody have other comments about that? Okay.

21 So are exclusions supported by the
22 clinical evidence or analysis of frequency and

1 distribution? Is information about impact of
2 exclusions for patient preference then
3 apparent? The same issues we have had before.

4 NQF, will you let us know that
5 they have done that?

6 MS. WILBON: Yes.

7 CHAIR WEINSTEIN: Yes.

8 MR. AMIN: That's three moderate
9 and three low.

10 CHAIR WEINSTEIN: Risk adjustment
11 for resource use measures is the evidence-
12 based risk reason based here? I assume.

13 MS. WILBON: Yes. Let's check the
14 wording here. Yes, so the risk adjustment
15 should be based on patient clinical factors or
16 evidence about those clinical factors that
17 influence the measured outcome of resource
18 use. Obviously not based on factors of
19 related disparities and care and that the risk
20 adjustment factors are present at the start of
21 care and have demonstrated -- that they have
22 demonstrated adequate discrimination and

1 calibration of the model.

2 CHAIR WEINSTEIN: Any comments
3 from the group?

4 DR. RATLIFF: The same content to
5 me as the first model.

6 CHAIR WEINSTEIN: Say it again.

7 DR. RATLIFF: The same content as
8 the initial model from ABMS. The same issues.

9 CHAIR WEINSTEIN: Thank you.

10 MS. O'NEILL: Jim, I -- this may
11 just be completely impractical. I note in the
12 risk adjustment model they have got some major
13 psych diagnoses, but they don't have any, you
14 know, anxiety disorder, any of the more normal
15 psych diagnoses, which is a risk factor in
16 this group. And maybe that's because the data
17 is too hard to get.

18 CHAIR WEINSTEIN: Okay. Let's
19 vote on this one.

20 MR. AMIN: It's three moderate and
21 three low.

22 CHAIR WEINSTEIN: One of the

1 things I just want NQF to know is in their
2 page 22, while the latter is straightforward
3 around risk adjustment, caution is warranted
4 as the risk adjustment equations were derived
5 from a population that may be different from
6 the population to which the measure is being
7 applied. That's why I said low.

8 I don't know what that means. Can
9 you guys explain that?

10 DR. MANHEIM: Right. What it
11 means is that the coefficients were derived
12 from existing data and an alternative to just
13 taking the coefficients that we used is to re-
14 estimate it, the variables we have, within
15 someone's given population.

16 CHAIR WEINSTEIN: Okay. Thank
17 you. Are performance results reported? Do
18 they identify differences in performance or
19 overall less than optimal performance? So we
20 all talked about this before.

21 MS. WILBON: The same one?

22 MS. WILBON: Right. So this

1 criteria reads should be that the data
2 analysis demonstrate that methods for scoring
3 and analysis of the specified measure allow
4 for identification of statistically
5 significant and practically meaningful --
6 practically and clinically meaningful
7 difference of performance.

8 CHAIR WEINSTEIN: Are you okay,
9 Elizabeth? Do you need some more help? Are
10 you reading the answers for us?

11 MS. FANTA: We have three
12 moderate, two low and one insufficient.

13 CHAIR WEINSTEIN: Thank you. If
14 multiple data sources methods specified, do
15 analysis demonstrate that they only used, you
16 know, the one data source? So are we going to
17 answer this? I thought this was one we
18 skipped.

19 MS. WILBON: Yes, it is.

20 CHAIR WEINSTEIN: Okay. Validity.
21 What is the overall, based on the different
22 measures, validity of this?

1 MS. FANTA: We have three
2 moderate, two low and one insufficient.

3 CHAIR WEINSTEIN: Disparities. Is
4 it the same issues that we have talked about
5 before?

6 MS. FANTA: One high, two low and
7 three insufficient.

8 CHAIR WEINSTEIN: I'm going to
9 have these questions memorized by the end of
10 this. Sad. Tell us when you are okay. Are
11 you okay?

12 MS. WILBON: Yes. So just for the
13 Committee's information, what I'm doing is
14 kind of for consistency sake, I realize that
15 over the course of a day, you know, people get
16 tired and there is -- that we are rating kind
17 of the same issues, the same across the
18 measures, particularly from the same
19 developer, so I'm just kind of checking back
20 to ratings to make sure that they are
21 consistent.

22 So they have been consistent, up

1 to this point. Although, I would like to --
2 not to call anybody out, but whoever rated
3 this high, if they could just -- the previous
4 rating for this same criteria for the other
5 ABMS measure was one low and five
6 insufficient.

7 So we ended up with this one with
8 one high, two low and three insufficient. So
9 I just kind of want to get a feel for where
10 people were on that.

11 DR. RUBIN: So I was the outlier.

12 MS. WILBON: Okay.

13 DR. RUBIN: And part was the
14 statistical analysis. I really was looking
15 for a not applicable, I guess, and just
16 referenced back to my initial evaluation from
17 this. But it's not part of the risk
18 adjustment and so maybe I should have thrown
19 it back to four. That seems to be a marked
20 discrepancy, but --

21 MS. WILBON: Yes.

22 CHAIR WEINSTEIN: It's okay.

1 Whatever you --

2 MS. WILBON: It's okay.

3 CHAIR WEINSTEIN: -- think.

4 DR. RUBIN: It's the only time
5 I've been an outlier.

6 MS. WILBON: As long as you -- as
7 long as we have a justification and we can
8 kind of rationalize it, that's fine.

9 CHAIR WEINSTEIN: So do you want
10 to change your vote?

11 DR. RUBIN: No, that's okay.

12 CHAIR WEINSTEIN: You're okay?

13 DR. RUBIN: Yes.

14 CHAIR WEINSTEIN: Good. Okay.

15 Are you okay?

16 MS. WILBON: Yes.

17 CHAIR WEINSTEIN: Next.

18 Usability. Are the measure performance
19 results reported suitable to report to the
20 public at-large, national, da, da, da, da. Is
21 there evidence?

22 MS. FANTA: Two moderate, three

1 low, one insufficient.

2 CHAIR WEINSTEIN: Usability. Did
3 sufficient -- did submitted information
4 demonstrate that results produced by the
5 measure are meaningful, understandable and
6 useful for quality improvement, public
7 reporting, etcetera?

8 MS. FANTA: The results were one
9 moderate, four low and one insufficient.

10 CHAIR WEINSTEIN: That's on
11 usability. Are you okay? Do you need
12 something answered?

13 MS. WILBON: Yes.

14 CHAIR WEINSTEIN: Because we want
15 to make sure you are --

16 MS. WILBON: I just -- so for the
17 ABMS measure, 1586 on the lumbar
18 radiculopathy, for this -- this is 3(a),
19 correct?

20 DR. RATLIFF: Yes.

21 MS. WILBON: Okay. The vote was
22 that everyone voted insufficient. So I just

1 kind of want to point that --

2 DR. RATLIFF: One thing for the
3 discussion there --

4 MS. WILBON: -- point out some --

5 DR. RATLIFF: -- to make the same
6 kind of -- I think I can answer your question.

7 MS. WILBON: Okay.

8 DR. RATLIFF: The thinking on a
9 point there, the point we brought up, it was
10 they had funding from Robert Wood Johnson.
11 They noted the measures had been tested for
12 usefulness or interpretabilities. When we
13 discussed, I guess, 1586, we sort of made the
14 point that this was a process. We didn't
15 really have the data yet.

16 CHAIR WEINSTEIN: I also think
17 this diagnosis has much more specificity to it
18 with the right criteria than low back pain
19 does. So I think there is a difference.

20 MS. WILBON: Okay.

21 CHAIR WEINSTEIN: That we have
22 tried to represent in this.

1 MS. WILBON: Okay.

2 CHAIR WEINSTEIN: Do you need more
3 help with that?

4 MR. AMIN: No, that's good.

5 MS. WILBON: That's okay.

6 CHAIR WEINSTEIN: Okay. Is this
7 the next one, sir? I thought we did this one?

8 MS. WILBON: We did. But just
9 clarify it. Yes, go ahead, just show it.

10 DR. RATLIFF: So I guess what I
11 take home from the Committee is that even with
12 the data, we still think this is going to be
13 low?

14 MS. WILBON: I --

15 DR. RATLIFF: Because of the
16 patient population, because of the diagnostic
17 criteria?

18 MS. WILBON: Yes.

19 DR. RATLIFF: Because of the
20 uncertainty involved.

21 MS. O'NEILL: And I think even
22 more than the, you know, trying to evaluate

1 the resource utilization of a bunch of people
2 doing decompression laminectomies or whatever
3 for a peer group comparison, how many
4 resources you use to manage people that come
5 in under these diagnostic labels is
6 unbelievably hard to evaluate, if you don't
7 have outcome data.

8 I just don't even know what you,
9 in this group, are measuring hardly, because,
10 I mean, maybe somebody sees somebody once and
11 doesn't like these kind of patients and they
12 don't see them again. Maybe that's the best
13 thing for some of these guys, but you know
14 what I mean?

15 It's just too much of a grab bag.
16 And I think this is absolutely where you would
17 want to have an outcome.

18 CHAIR WEINSTEIN: Does that answer
19 your guys' questions, NQF personnel, who are
20 whispering? Share your feelings with the
21 group.

22 MS. O'NEILL: I'm saying this and

1 I'm going to go to the airport and you guys
2 can talk about what crazy things I said.

3 MS. WILBON: Stir the water and
4 then run.

5 MR. AMIN: So the discussion on
6 the previous ABMS measure was around the O to
7 E ratio and whether the information was giving
8 you enough detail to be able to tell a
9 difference, to be able to discern a difference
10 between different providers. Does that
11 sentiment carry onto this measure?

12 MS. O'NEILL: I would just say, I
13 mean, when you are looking at resource use
14 expected and observed around a procedure and
15 you are doing it around the management or the
16 non-surgical or conservative management or
17 maybe not so conservative management of the
18 people with the same group of complaints, not
19 even the same diagnosis necessarily, but of
20 symptom complaint, which back pain is not a
21 diagnosis, it's a symptom complaint, and to
22 say what you would observe versus what you

1 would expect, unless you are looking at really
2 large numbers, you would need to have how many
3 resources you need to get to a certain outcome
4 with a cohort of patients before you can tell
5 if you are doing enough, too little, too much.

6 You know, I mean, I don't know how
7 you -- what yardstick you would be using
8 really.

9 CHAIR WEINSTEIN: Is that helpful?

10 MR. AMIN: Yes, it is.

11 CHAIR WEINSTEIN: All right.

12 MR. AMIN: Thank you.

13 CHAIR WEINSTEIN: Is this the next
14 one, Sarah?

15 MS. FANTA: Yes.

16 CHAIR WEINSTEIN: Are the data and
17 result details maintained, such that the
18 resource use measure, including the clinical
19 and construction logic for a defined unit of
20 measurement can be broken down to facilitate
21 transparency?

22 MS. FANTA: The results are one

1 high, two moderate and two low.

2 CHAIR WEINSTEIN: Feasibility.

3 Are the required data routinely generated and
4 used during data care delivery?

5 MS. FANTA: Four high and one
6 moderate.

7 CHAIR WEINSTEIN: Are the required
8 data elements available in electronic records?

9 MS. FANTA: Five high.

10 CHAIR WEINSTEIN: Are
11 susceptibilities to inaccuracies, errors or
12 unintended consequences in the ability to
13 audit the data items to detect such problems?

14 The problem with this is the
15 specificity of these diagnoses or the lack
16 thereof, so people tend to use different
17 codes, maybe even for the same patient if they
18 saw him on two different days, is one of the
19 issues you may see in some of the responses
20 here versus the other radiculopathy one.

21 Still waiting?

22 MS. FANTA: One moderate, three

1 low and one insufficient.

2 CHAIR WEINSTEIN: Do you need some
3 clarification, Sally?

4 MS. WILBON: Go ahead.

5 MR. AMIN: I guess the question
6 that the team is thinking about is whether
7 that is a concern with administrative data
8 broadly applicable to any measure or this is
9 particular to this topic area, because --

10 CHAIR WEINSTEIN: Yes, that's what
11 I was trying to give you a clarification
12 expecting this response.

13 MR. AMIN: Okay.

14 CHAIR WEINSTEIN: In this
15 particular diagnosis, the Time 1, Time 2
16 diagnosis in the same patient may be very
17 different, unlike the others. A hip fracture
18 is a hip fracture. A knee replacement is a
19 knee replacement. A disc herniation with
20 radiculopathy is pretty clear.

21 MR. AMIN: Okay.

22 CHAIR WEINSTEIN: But back pain,

1 today it's back pain, tomorrow it's back pain
2 from a different one of these codes. So it
3 isn't that the data isn't there. It's the
4 reliability of using the same code for the
5 same patient at different times. Over time I
6 think it would change.

7 MR. AMIN: Thank you for that
8 clarification.

9 CHAIR WEINSTEIN: Is that okay,
10 Sally?

11 MS. TURBYVILLE: It's interesting.

12 CHAIR WEINSTEIN: Yes, true,
13 unfortunately. Unless my colleagues feel
14 differently? No.

15 DR. RATLIFF: I see no
16 nomenclature for this just we don't have a
17 good language for describing these conditions,
18 so you are stuck with that, with a measure
19 like this, those administrative data for back
20 pain.

21 CHAIR WEINSTEIN: Can the data
22 collection strategy be implemented? Is this

1 measure already operational? So that answer
2 is no. So it's not ready to be implemented is
3 the way I would sort of look at it.

4 MS. WILBON: Right. So it doesn't
5 -- okay, that's fine.

6 CHAIR WEINSTEIN: Who are we
7 missing here?

8 MS. FANTA: Two low and three
9 insufficient.

10 CHAIR WEINSTEIN: This next one is
11 going to be actually pretty easy, I think.
12 We'll see what the group thinks.

13 We're not taking a break.

14 MS. WILBON: Oh, we're not?

15 CHAIR WEINSTEIN: We're going to
16 keep going.

17 MS. WILBON: Oh, okay. We are
18 just taking a five minute mind break.

19 (Whereupon, at 3:06 p.m. a recess
20 until 3:07 p.m.)

21 MS. WILBON: Is there someone from
22 Ingenix still on the line?

1 CHAIR WEINSTEIN: Are you prepared
2 to talk about the next measure, because some--

3 DR. TARKO: That's it. Dan Dunn
4 will be doing that.

5 CHAIR WEINSTEIN: Is he there?

6 MS. WILBON: So the next measure--

7 DR. TARKO: Right here.

8 MS. WILBON: -- we are discussing
9 is No. 1603, which is the ET-based hip and
10 pelvic fracture measure. If some one could
11 just give us a brief overview of the measure
12 before we --

13 CHAIR WEINSTEIN: Yes, and could
14 you clarify? To me, this is about hip
15 fractures, because pelvic fractures, the
16 terminology, I just want to be clear because
17 your literature reveals -- is talking about
18 hip fractures pretty much.

19 So the word pelvic in there is
20 interesting to me.

21 DR. RATLIFF: My interpretation of
22 this is just hip.

1 CHAIR WEINSTEIN: Yes.

2 DR. RATLIFF: Why are we saying
3 hip fracture? When I was filling this out, I
4 don't know about anybody else --

5 CHAIR WEINSTEIN: Me, too, but
6 they keep -- they have the terms here, so I
7 just want to be clear, because pelvic fracture
8 is a whole other ball game.

9 MS. WILBON: Yes.

10 CHAIR WEINSTEIN: Not that it
11 doesn't occur in the elderly, but -- okay. We
12 are ready to have you tell us.

13 DR. TARKO: Well, we're waiting
14 for Dan Dunn. He'll be here in a second.

15 CHAIR WEINSTEIN: He will be here
16 what?

17 MS. WILBON: Dan Dunn is going to
18 be on the phone.

19 CHAIR WEINSTEIN: Oh.

20 DR. TARKO: We're getting him
21 right now. He'll be right here.

22 CHAIR WEINSTEIN: Yes, we're

1 waiting on him not happily. Well, we do have
2 other jobs. We're ready to go, Sarah.

3 MS. WILBON: We are just going to
4 go ahead and go and then when Dan gets on the
5 phone, we will ask him any questions as they
6 come up.

7 DR. TARKO: Okay.

8 MS. WILBON: Okay. Thanks.

9 CHAIR WEINSTEIN: I just do want
10 to clarify this is about hip fractures. And
11 I would eliminate the word pelvic for right
12 now, unless I hear otherwise from Ingenix.

13 DR. ROBERTS: Are we sure that's
14 what they meant?

15 CHAIR WEINSTEIN: That's why --

16 DR. ROBERTS: Because if the
17 pelvic --

18 DR. TARKO: That would have been--

19 DR. ROBERTS: -- is all the way
20 through there that needs to be removed.

21 CHAIR WEINSTEIN: That's what I'm
22 asking. Can you guys answer that question?

1 DR. TARKO: It was our
2 understanding that it was hip and pelvic
3 fractures, so I'm here in Tom Lin's stead, but
4 that was our understanding it was including
5 pelvic fractures as well. That was our error.

6 CHAIR WEINSTEIN: Yes, but did you
7 include --

8 MS. WILBON: I'm sorry, can you --

9 CHAIR WEINSTEIN: -- codes for
10 pelvic fractures or just hip fractures?

11 DR. TARKO: We did include codes
12 for pelvic fractures.

13 MS. WILBON: I'm sorry, can you
14 tell me your name? Who is talking right now?

15 DR. TARKO: It's Howard Tarko.

16 MS. WILBON: Oh.

17 DR. TARKO: I'm a medical director
18 here.

19 MS. WILBON: Okay.

20 DR. TARKO: I'm here in Tom Lin's
21 stead. He was called away on some personal
22 emergency.

1 DR. RATLIFF: Bringing in like a
2 pelvic fracture --

3 MS. SINNOTT: But am I correct
4 that the ETG --

5 DR. RATLIFF: -- that's different.

6 DR. TARKO: Dan Dunn is calling in
7 now.

8 DR. DUNN: Yes, hello, Dan Dunn
9 here, also.

10 MS. SINNOTT: So the ETG says
11 close fracture or dislocation by hip and
12 pelvis, so it is an ETG classification,
13 correct, for hip and pelvis fracture?

14 DR. DUNN: Yes.

15 CHAIR WEINSTEIN: Can you show me
16 your inclusion criterion? Just for whatever
17 reason -- because the codes they have here on
18 25, ETG does provide methodology to deal with
19 this case where code will shift.

20 You know, for example, concurrent
21 renal transplant. For hip fracture there were
22 26 diagnosis codes which would cause an

1 episode of hip/pelvic fracture to shift to an
2 episode of joint degeneration.

3 So I'm confused. This is really
4 important.

5 DR. RATLIFF: You know, I mean,
6 it's cracked. I mean, if you look at their
7 Excel spreadsheet where they go through the
8 diagnosis codes that they are including, they
9 are including --

10 CHAIR WEINSTEIN: Which page is
11 that, John?

12 DR. RATLIFF: This is their Excel
13 sheet S-5_DD, that is included in the package
14 of information that came with 1603.

15 CHAIR WEINSTEIN: Oh.

16 DR. RATLIFF: That's fracture
17 ilium and fracture ischium, a pelvic fracture
18 with the disruption of pelvic circle. Closed
19 fracture part of the pelvis. So I think we
20 were all thinking standard hip fracture.

21 CHAIR WEINSTEIN: Yes.

22 DR. RATLIFF: But they are

1 including like a lot more.

2 DR. ROBERTS: A sacral
3 insufficiency fracture compared with an
4 interstroke anterior hip fracture.

5 CHAIR WEINSTEIN: That's why I
6 asked the question right up front, because
7 these are like apples and oranges and treated
8 very differently in very different episode
9 groupers. And so if this is -- then it is
10 probably -- we need to decide whether we can
11 include this or not the way it is designed.

12 Hip fracture is a very common,
13 very meaningful important measure unto itself.
14 When you get into pelvic fracture, it's a very
15 different problem. They are usually stress
16 fractures. They are not talking about trauma
17 here, I'm sure, I hope. I shouldn't be sure
18 about anything.

19 But unless the Committee feels
20 differently, I think you really have to
21 disentangle those things.

22 MS. SINNOTT: Am I correct that

1 NQF requested a measure for hip and pelvis --
2 felt pelvic fracture as a single entity?

3 MS. WILBON: It wasn't necessarily
4 that we were asking for it in a single entity.
5 I know the way that it was listed on the call
6 for measures in hip/pelvic, but if they had a
7 separate measure for hip fracture and a
8 separate measure for pelvic fracture we would
9 have taken that as well, I think. It was just
10 a matter of semantics.

11 CHAIR WEINSTEIN: Well, this is a
12 core question to whether we can actually
13 answer this effectively.

14 DR. TARKO: The way that the
15 measure was specified, I'm trying to find the
16 actual statement, was there are some
17 classifications which the episode treatment
18 groups called condition statuses. And the
19 condition status -- there is a condition
20 status factor called femoral neck fracture and
21 one for pelvic fracture.

22 And it was understood that that

1 would be the set of codes used in terms of
2 defining the measure. The subset of the
3 episode treatment group.

4 CHAIR WEINSTEIN: Are these the
5 codes?

6 MS. WILBON: Yes.

7 CHAIR WEINSTEIN: Yes. Can I?

8 MS. WILBON: Sure. Go ahead.

9 CHAIR WEINSTEIN: Just for a
10 second. Can you scroll? Can you scroll?

11 MS. WILBON: You can scroll.

12 MS. SINNOTT: In the beginning of
13 the measure information --

14 CHAIR WEINSTEIN: You get into
15 unspecified derangement of a joint,
16 unspecified -- site unspecified. A lot of
17 these codes open fracture of an acetabular.
18 You can't compare these things. Those are
19 night and day problems. Much more morbidity,
20 much more complex surgery.

21 Hip fracture by itself has a 30
22 percent one year mortality uncomplicated.

1 MS. WILBON: So, Dan, or whoever
2 else is on the phone, can you guys give a
3 rationale for -- does this ETG exist in this
4 way or was it combined in some way in response
5 to the call or are they --

6 CHAIR WEINSTEIN: Open fracture.

7 MS. WILBON: -- separated? Maybe
8 if you can just give us some context as to how
9 this evolved or how you have it in your system
10 currently?

11 DR. DUNN: Yes, this is Dan. I'll
12 take a shot. And again, I apologize Tom isn't
13 able to be here, but I'll do my best. So
14 there is an ETG. I think if -- someone
15 described which is called closed fracture or
16 dislocation by hip and pelvis.

17 So that's the general
18 categorization. You know, what we did is go
19 into that ETG and identify those episodes
20 where there was evidence of those two
21 conditions status that somebody mentioned,
22 fracture femoral neck and pelvic fracture.

1 So the episodes that find their
2 way into the spinal measure specification are
3 the subsets of episodes in that broader ETG
4 where there is the indication of the, you
5 know, fracture of femoral neck or pelvic
6 fracture.

7 CHAIR WEINSTEIN: Yes, but this is
8 a hard one. You understand the problem. A
9 lot of your codes like the 800 codes, you
10 know, open fracture of an acetabular is so
11 different. Multiple open pelvic fractures
12 with disruption of the pelvic circle, that's
13 diastasis.

14 I mean, I can see the
15 transcervical fracture, which is not a femoral
16 neck fracture being included actually. I can
17 see the mid-cervical fracture. I could even
18 see an intertrochanteric fracture, a
19 pertrochanteric fracture, but a lot of these
20 pelvic things you can't put them in the same
21 grouper.

22 DR. DUNN: Maybe that's how -- do

1 you have access to a table that's in the S-8--

2 CHAIR WEINSTEIN: Is this it?

3 DR. DUNN: -- spreadsheet and it's
4 called "Condition Status to DX Code Map." I
5 don't know if this would help the discussion,
6 but that would give you the diagnosis code,
7 but not for the specific subset that we are
8 pulling out.

9 CHAIR WEINSTEIN: Well, this is
10 even more confusing. Closed fracture of the
11 shaft of the femur, closed fracture of the
12 lower end of the femur, closed fracture of the
13 lower epiphysis of a femur which would be in
14 a child.

15 DR. DUNN: Yes. I'm sorry, the
16 only one that I'm referring to here are the
17 ones with fracture of the femoral neck, which
18 is -- starts with that 70326 condition status
19 or the 70328 coded fracture, but in the 820
20 range.

21 CHAIR WEINSTEIN: So you are
22 including just the 70326s?

1 DR. DUNN: And the 70328.

2 CHAIR WEINSTEIN: Yes, but when
3 you get into the 328s, you get into the pelvis
4 fractures and acetabular fractures and ilium
5 fractures and disruptive pelvic ring
6 fractures. These are very different injuries.

7 DR. DUNN: And then the strategy
8 then is -- maybe again clinically this -- you
9 still -- it doesn't make sense that the risk
10 adjustment methodology would recognize those
11 two differently.

12 DR. RATLIFF: When I interpreted
13 this, I think I just mentally read it as like
14 a hip fracture.

15 CHAIR WEINSTEIN: Well, that's
16 what I was thinking, but --

17 DR. RATLIFF: But you are clearly
18 correct --

19 CHAIR WEINSTEIN: -- I asked the
20 question -- yes.

21 DR. RATLIFF: -- it's not just a
22 hip fracture. It's a pathologic fracture of

1 the femur from systemic malignancy is open
2 pelvic fractures. It's a vast array of
3 different injuries.

4 CHAIR WEINSTEIN: If this is the
5 way it has been done, I don't think we can
6 effectively measure this.

7 MS. WILBON: Okay.

8 DR. DUNN: Actually --

9 MS. BOSSLEY: So I think it would
10 be helpful for you to at least talk through
11 the important piece, because I'm seeing hip
12 fractures discussed in the importance piece,
13 but not the pelvic piece, the pelvis.

14 CHAIR WEINSTEIN: Yes, they are
15 all important.

16 MS. BOSSLEY: So I think --

17 CHAIR WEINSTEIN: But the hip
18 fracture is so common.

19 MS. BOSSLEY: Right.

20 CHAIR WEINSTEIN: There is a half
21 a million in a year.

22 MS. BOSSLEY: Which is where I

1 think they were able to get the data on it.

2 CHAIR WEINSTEIN: Yes.

3 MS. BOSSLEY: But so I think it
4 would be helpful to have you rate the
5 importance piece and then I think we should
6 probably have you, at least, discuss the
7 scientific acceptability, because the
8 precision of the specifications deal with this
9 issue as well.

10 CHAIR WEINSTEIN: Yes, that's what
11 I'm -- because all their writings are about
12 hip fractures.

13 MS. BOSSLEY: Right. I think
14 that's what I would do. And then maybe let's
15 have you stop, because I don't know that you
16 can go beyond that. What we may have to do is
17 talk to Ingenix and make sure that this was
18 truly the intent, because they have the person
19 that would typically answer this question is
20 not available.

21 And then if we need to get you
22 back on a phone call to finish the discussion,

1 why don't we do that?

2 CHAIR WEINSTEIN: Perfect.

3 MS. BOSSLEY: Does that seem
4 reasonable to --

5 CHAIR WEINSTEIN: Perfect.

6 MS. BOSSLEY: -- staff, too?

7 CHAIR WEINSTEIN: Is somebody
8 reading this differently than me, including
9 the Ingenix people? Because maybe we are
10 misinterpreting what you meant to do. Okay.
11 So let's --

12 DR. DUNN: This is Dan. I'm
13 sorry. Yes, I can't help you here.

14 CHAIR WEINSTEIN: Don't worry
15 about it, Dan. It's not a problem. We're
16 going to figure it out, but we just want to
17 make sure we do the right thing.

18 So I think Heidi's suggestion is
19 the right one.

20 MS. BOSSLEY: Yes. So, Dan, we
21 will give you -- they will give you some
22 guidance. They are going to go through

1 importance and some of scientific
2 acceptability, so you can talk to Tom when he
3 is available, get back to staff and then if we
4 need to reconvene the TAP to look at more, we
5 will.

6 DR. DUNN: Okay. Thank you.
7 Sounds good.

8 CHAIR WEINSTEIN: Okay. So if it
9 is hip fracture, which can be an
10 intertrochanteric, femoral neck,
11 pertrochanteric, it's a big problem. You
12 know, it's a big cost. It has a lot of issue
13 around comorbidity issue, complications, so do
14 you want us to actually grade this, Heidi?

15 MS. BOSSLEY: I think it would be
16 helpful.

17 CHAIR WEINSTEIN: Okay. Okay. So
18 from an impact point, can we all agree --

19 MS. WILBON: Well, I just have a
20 procedural question.

21 MS. BOSSLEY: Yes.

22 MS. WILBON: Because I'm a little

1 bit confused now myself --

2 MS. BOSSLEY: Yes.

3 MS. WILBON: -- admittedly. Are
4 they going to be evaluating this as if it is
5 as submitted or as if they are just evaluating
6 hip fracture? Because --

7 MS. BOSSLEY: No. I think they
8 have to --

9 CHAIR WEINSTEIN: We're talking
10 about the fracture.

11 MS. BOSSLEY: -- submit it as --
12 evaluate it based as it is submitted, because
13 from the sounds of it, that's actually what
14 they intended to do, if we are understanding
15 them correctly.

16 CHAIR WEINSTEIN: The first part
17 of this we can answer so many questions,
18 because they are written about the variance
19 and the issue is really written around hip
20 fracture, all the papers they are quoting.

21 MS. WILBON: So but the measure --

22 CHAIR WEINSTEIN: But the

1 methodology by which they did the measure is
2 not valid.

3 MS. WILBON: But the title --

4 DR. RATLIFF: But when they went
5 back to do their summary --

6 MS. WILBON: -- I mean, let me
7 look at the intent here quickly. Let me just
8 see if that is -- because I think this is
9 where it might be --

10 DR. RATLIFF: Their summary data
11 answers the first question.

12 MS. WILBON: -- confusing is where
13 the title says one thing, their intent says
14 one thing, but then the specifications say
15 another. So I just want to make sure as we go
16 through this that we are all on the same page.

17 DR. RATLIFF: Even as we look at
18 the first question, like relevance, importance
19 of this, they talk pelvic fractures as being
20 how they looked through their own database to
21 get their charge discrepancy.

22 So again, even answering the first

1 question like you are asking us to do, we are
2 still opening a grab bag --

3 CHAIR WEINSTEIN: You know, Heidi,
4 could I make a suggestion?

5 DR. RATLIFF: -- that is filled
6 with crackers.

7 MS. BOSSLEY: Sure.

8 CHAIR WEINSTEIN: It's just
9 because I think it will be confusing for
10 everybody.

11 We can do this by phone. This
12 isn't a hard one to do. I would rather get
13 the clarification and do it the right way,
14 then start down a path that is going to get us
15 all mixed up and not be adequate for you.

16 MS. BOSSLEY: That's absolutely --
17 we are fine with that, too.

18 CHAIR WEINSTEIN: Okay.

19 MS. BOSSLEY: And it is perfectly
20 fine. So I think the question would be is
21 does Ingenix have enough information to know
22 what they need to, you know, clarify?

1 CHAIR WEINSTEIN: Well, we can
2 talk to them by phone, too.

3 MS. BOSSLEY: Yes, yes, exactly.

4 CHAIR WEINSTEIN: Because the
5 right person is not here.

6 MS. BOSSLEY: Right.

7 CHAIR WEINSTEIN: And so why don't
8 we do that the right way? And we are familiar
9 enough with this, you could put these
10 questions on a monkey survey, we could all do
11 them together or whatever.

12 MS. WILBON: Survey monkey, you
13 are close. You are close. So then team, do
14 you guys have a good idea of -- as Jim said,
15 we can have a conversation off-line about what
16 needs to be clarified and what maybe needs to
17 be disentangled or what have you.

18 Do you have an idea about what
19 maybe to follow-up with Tom with about, at
20 this point?

21 DR. DUNN: Yes. This is Dan.

22 Yes, thank you. And, yes, we will -- we are

1 probably going to need to touch back with you
2 to clarify, but I think I know where to start
3 now.

4 MS. WILBON: Okay. Great. So we
5 will circle back with you tomorrow or Monday
6 and kind of touch base. I'm not sure when Tom
7 will be back, but we can touch base and figure
8 out when to have that discussion.

9 DR. DUNN: Okay. That sounds good.

10 MS. WILBON: Okay.

11 DR. DUNN: Thank you.

12 MS. WILBON: Thanks, Dan.

13 DR. DUNN: Okay. Take care. Bye.

14 MS. WILBON: Bye.

15 CHAIR WEINSTEIN: Are you okay,
16 Heidi?

17 MS. BOSSLEY: Oh, yes.

18 CHAIR WEINSTEIN: Because I really
19 think it's the right thing to do.

20 MS. BOSSLEY: Yes, that's fine.

21 CHAIR WEINSTEIN: Okay, yes.

22 MS. WILBON: Okay. So that said,

1 that actually thus ends --

2 CHAIR WEINSTEIN: A record.

3 MS. WILBON: Yes. So we are going
4 to open it up for public comment. We are
5 going to open it up for public comment.

6 Is there anyone on the phone who
7 would like to make a comment to the TAP before
8 we close?

9 Yes, Operator, can you just make
10 sure that all lines are open, at this point,
11 so if anyone wants to speak, they can do so
12 freely?

13 OPERATOR: Yes, all the lines are
14 open.

15 MS. WILBON: Okay. Thank you. Is
16 there anyone there who would like to make a
17 comment? Okay. Anyone in the room?

18 CHAIR WEINSTEIN: Thank you for
19 all your help. And again, I want to iterate
20 for the Committee how much we appreciate the
21 work of ABMS and Ingenix. This is incredible
22 work that is really important, really, really

1 important, at this time.

2 So thank you and I hope you take
3 our comments as just being complimentary and
4 helpful.

5 MS. WILBON: And I would like to
6 thank Dr. Weinstein for leading the group
7 today and everyone for, you know, traveling
8 near and far to get here to discuss the
9 measures. And we appreciate your work.

10 And we were hoping to not have to
11 do any follow-up, but, obviously, things
12 happen, so we will communicate with you by
13 email as much as possible. And if it warrants
14 another phone call, we will, you know, get
15 that arranged for some time later this summer.

16 So again, thanks to everyone and
17 feel free to call me or email me with any
18 questions or things that come up and we will
19 keep you informed.

20 Great. Anyone? Okay. Thank you.

21 (Whereupon, the Technical Advisory
22 Panel Meeting was concluded at 3:27 p.m.)

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In the matter of: Bone/Joint Technical Advisory Panel

Before: NQF

Date: 07-07-11

Place: Washington, DC

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Court Reporter

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