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Dr. Liam Rose: Today is a, like I said, was mentioned it’s a question and answer session. So I’ll be giving a 20-minute or so presentation, just some background on VA community care data but what we’re really hoping is that this will be a bit more of an office hours style question and answer session. So I really, really encourage you to use that question box that Maria mentioned. Send in your questions and we’ll do our best to answer them and discuss them. There’s a ton of questions about community care data out there some of which we know, some of which we don’t. So we will do our best to answer and tell you what we do know at this point in time. Very happy to be joined by Todd Wagner, Erin Beilstein-Wedel, and Jeanie Lo who are probably some of the world’s experts in the most recent round of VA community care data so that’s very exciting to be able to say, to share what we know regarding VA community care data.

Dr. Todd Wagner: Thanks, Liam. And I’ll monitor the chatbox as your presenting I’ll do my best to answer questions there as they come up or interrupt you as they come up.

Dr. Liam Rose: Perfect. I also asked Erin and Jeanie to do the same. Thank you.

Dr. Todd Wagner: Got it. Thank you.

Dr. Liam Rose: Okay. Sorry. So quick acknowledgments and disclosures; these are not the views of VA or other organizations. They don’t ask me for my opinion.

So just I’m going to give a quick overview. And we’re going to talk about utilization outcomes. And then hopefully the majority of this will be questions and answers. So again please send those in. Especially if you started working with it and you’re interested and you have some questions, doesn’t matter how specific we’ll try and triage them because we have a team here working on it.

So prior to Fiscal Year 2015 VA has always had some form of community care. There were a couple of different names for it. There was Fee Basis, purchased care, non-VA medical care. They did it for things where it was either urgent; the person could not get to a VA or VA just didn’t offer it. One example of that that’s very traditional you know any OBGYN was not done at VA. We just did not have the capability for it. But there’s also a bunch of other things; acute inpatient care. There’s always been community nursing home care. They’ve always had these contracts with outside providers for nursing home care. Home-based care, a lot of different things that they’ve contracted out. So 2014, that was about 11% of everything.

This changed a bit in 2015. There was the Veterans Choice Program that came into play. Congress allocated about 10 billion for this. And this paid for Veterans to get care outside of the VA, this was put into play because of long wait times. Especially down in Arizona. So you were eligible if you had a long wait time, a long driving distance, or any particular hardship. Basically if you had access issues they were trying to get, to expand your access to outside VA care then VA will pay for. So there’s a wait-time qualification cut off and there was a mileage cut off and there was also this hardship, which is kind of a wild card.

This was greatly expanded with the MISSION Act. This came into play June of last year. This establishes this whole network of VA community care, VCCP, new permanent discretionary community care program. And they estimated about 640,000 VA-enrolled Veterans are going to seek care this way. We think it’s going to be much higher given the initial data although the studies are coming out slowly about this. So roughly speaking about a third of VA-enrolled Veterans already access community care under Choice which was the, previous to June 2019. We don’t have great data on what’s happening since last June. Hopefully that will change soon.

So this is just like an overview of what the criteria were and have been over time. So from way back when the eligibility criteria was just not, if it wasn’t feasibly available and that was very nebulously defined. But then with the Veterans Choice Program this became a little bit more codified so there was, for those years it was unable to schedule a VA appointment within 30 days and that was the wait times part. And live greater than 40 miles from the nearest VA facility. This got expanded fairly substantially with the MISSION Act. So then there was, there are new wait time, excuse me, new wait time and distance requirements that are slightly more. And there’s some of these others that are wild cards. So the Veteran resides in a state lacking full-service VA, cannot provide Veteran with care meeting specified quality standards, and best medical interest. These are nebulous to define that we don’t have a specified VA quality standard yet. It may happen soon but we’re not sure.

So these are the different types of networks. And this is pretty relevant for any studies that might span these periods. So this makes it a bit difficult especially if you have a study that you’re thinking about doing that might say take the last 10 years of data for non-VA care. Where there were very different implementations of what it meant to get non-VA care. So in the old times before Choice there was a lot of individual contracts where, say your local VA would have a contract with a certain state nursing home or a local nursing home and they would maintain that contract. Preauthorization was required and each VA had their own criteria for it. And then claims had to be authorized within 6 years, so that’s a very long time. The Choice program was, changed this a bit. Now we’ve moved to two third-party administrators, TPAs primarily. The two are TriWest and Optum formerly United. And these third-party administrators are supposed to coordinate and create a provider network. But there was significant challenges with this delayed payment of claims. And as you’ll see this is kind of a theme with VA community care data. A lot of these programs are implemented without much thought in terms of how the data’s going to work. And in some cases especially with Choice this actually led to harm for Veterans who were sent to collections because the data were not getting into the VA system and they weren’t getting, and the providers weren’t being paid so they were sending them into collections. MISSION tried to help this out but it’s still a bit iffy in some ways because now there’s six different networks facilitated by TPA contracts. But you could still have your individual local contracts. And the quality standards are not, as I mentioned, they’re not yet there. The claims are supposed to be within six months and the payment is supposed to be within 30 days or 45 days if it’s a paper bill. Whether these are holding true is an empirical question that I think has yet to be answered.

Okay so there’s a couple of these terms that are good to know that may come up in your work. Clinical care referral authorizations, the clinical care network, CCN, clinical care reimbursement system. These are all just terms of how VA is tracking where someone goes and whether they’re going to a person, I’m sorry, a provider within the TPA Network. So most work is going to focus on the reimbursement, the claims. So this is when a Veteran is authorized to go to a non-VA provider. The non-VA provider sends a bill to VA and VA pays this bill.

And this is how VA has come about to be tracking this. Historically there were a couple different ways that VA was looking at these non-VA care that was paid by VA. You might be familiar with the Fee Basis system, this is the oldest one. and then we also had SFS, FBCS excuse me. And so what they’re trying to do is put everything in this new tool called the Program Integrity Tool. This is a product that was not intentionally bought for this purpose but it has been what it’s being used for. And now it is supposed to be taking all non-VA paid care and aggregating it together. I shouldn’t say aggregating, storing it in the same place there’s no aggregation. And all of this gets put in CDW, there’s a PIT, there’s PIT tables for researchers to access. We should mention though that as far as I know right now there is no guarantee that you’re going to capture everything in PIT despite this nice-looking diagram. So I think the current protocol for studies that involve all non-VA care is to also look in FEE tables in CDW, along with PIT. There’ll obviously be a lot of duplication but making sure there that you’ve, if you’re really interested in making sure you’ve captured the full extent of an individual’s non-VA care that is paid for by VA check in both, because there may be some loss between the two.

Dr. Todd Wagner: Liam, can I add a point on this slide.

Dr. Liam Rose: Yes, yes.

Dr. Todd Wagner: So one thing is that to note that there’s a whole team of people in the PIT office that are working on the left-hand side of the data here and trying to make these data aggregated and linked. Researchers in VA don’t have access to that data. What we have access to is just this Mirror that’s on the other side of this blue dotted line. There’s a separate person who is responsible for getting that Mirror established and in some cases the variable names are not the same. So that does create some problems and we’ve just, we’ve been building a relationship with the PIT office so that we can clarify how we’re using some of these variables because we’ll go back to them and say can you help us with this variable? And they’re like, we don’t know that variable. Well it’s just the way it’s been translated for our Mirror. So there’s a little bit of challenge in translation here. Thanks.

Dr. Liam Rose: Yeah so a little bit of a challenge is an understatement. There’s a lot happening here that is difficult to figure out. If anyone on the call has tried working with this so far.

So I think it’s worth making the point that these are very different data. If you’re someone who’s used to working with VA data and you’re just venturing into non-VA data that VA has paid for. With care provided in the VA the patient is seen and the provider will just enter these services and then this data is uploaded into CDW and we can see it the next day. With care provided outside VA it’s much more like a non-VA dataset, it’s a claims dataset. So the patient is seen, the services are entered into the provider’s medical record whatever they’re using, and then they have a billing team that reviews it and sends a bill to the TPA, the third-party administrator, then this data gets into PIT, the claim is adjudicated and it’s reentered into PIT. So this makes it very difficult to compare directly across CDW and PIT. Because they’re, this whole concept of a claim does not really exist within the VA walls.

So just to give an idea of the schema and the content. The structure is that it follows the medical billing process. So if you’ve worked with Medicare data it’ll be much more similar to that. There’s an institutional claim form, this is the bill that goes to facility. And there’s a professional claim, this is individual providers and ambulatory surgery centers, surgical centers. So this is not connected to standardized CDW. Obviously in CDW we don’t have separate bills for VA and VA employees, that’s not how it works in VA. So this is quite different. So the DIM tables, if you’re familiar with this in the SQL language, they’re in the NDim schema for PIT. And then one big thing is that you will need real SSN access to link back to the rest of CDW. You don’t necessarily have to do it with real SSN but you do need to have, to link it together you need access to the SVeteran table which is in CDW and that has real SSN so you’ll, if you’re doing this for a research project you’ll need to make sure that you have real SSN access when you’re doing your DART application. So in there we have adjudicated claims, accepted or rejected both are in there so you have to, we’ll have to filter those out. There’s Veteran and non-Veteran care, obviously CHAMPVA and things like that are also in there.

This is just a real quick example, very small example of some of the problems we see. So this is from, this is a fake claim obviously but it’s based on an example of an inpatient stay. Where in the institutional claim we’ll see many, many rows of claims. But if you look over on the right-hand side here you’ll see that they’re, all of them are charge amount or zero except for the last one which we think is room and board. So one of our star programmers has a theory that it goes for inpatient claims they put it all under room and board even though there’s all these other revenue codes in here. So this makes it pretty difficult. You need to be able to filter out the denied and unpaid claims because otherwise you’ll be overcounting by quite a lot. And even then you have to be extra careful that you’re only looking at the things that are actually being paid for. This particular example comes from a matched dataset that the programmer was looking at where he was taking some examples from the FEE tables and matching it to the PIT tables. So he knew beforehand what amount, dollar amount he was looking for. He was looking for $16,700. Without that it gets a bit tougher but you can see that some of these will have many, many rows including they’ll say that this wasn’t paid or this was denied or it’s in submission or that it’s not current. All these things get put into the PIT dataset and it’s up to us to filter them out which makes it quite difficult.

So for documentation, not good for the most part but we’re working on it. As Todd mentioned HERC and CHOIR where Erin is, is working with the community care team including with the PIT program office to formalize documentation and trying to get something out to researchers that’s usable. We have an internet and intranet sites that are updated pretty regularly. Shout out to Sam for doing this pretty regularly. We try to keep it updated as things change. As Todd mentioned these data can change very fast, there can be new variables that show up and we’re not sure what they mean. So we’re trying to keep it as up to date so that it reflects our current knowledge on the topic as best as we know. So you know if you find something that you don’t agree with on this page absolutely send us an email and we’ll try and work with you and try and figure out what the discrepancies are. There’s also some metadata documentation, you can get this through VIReC CDW documentation. This, just kind of shows yeah metadata what fields are in there and exist. Oh. Uh-oh. Sorry.

Okay. So PIT variables of interest. A couple, this is just obviously it’s a much, much bigger dataset. I just, we just thought we’d share some that you think probably you’re going to need for sure. I have a star on this because they’re subject to change and you probably will need more. So this, there’s dates. For dates you’re going to need the statement from and to dates and the service dates for the professional. And then procedure codes, those go under the PIT procedure code SID. Those are, can be stacked ICD or CPT so that makes it difficult. You have to be pretty generous with your regular expressions your RegEx searches. There can be some, where there’s supposed to be periods and there’s no periods, that kind of thing. Some of them have an extra letter at the end. So you definitely have to be generous with your first data pull in terms of you know trying not to miss anything. There’s diagnoses, again this is admitting PIT diagnosis code SID. For the institutional and then you can go back to the NDim tables to get that linked up. And then for professional there’s professional claim diagnosis.

Providers. Providers is a bit of a tough one. There’s attending providers, operating providers, and rendering providers. So this differs by institutional and professional claims. So looking for all of those you can pull out who was doing this. There are NPIs, National Provider Identifier for all of them. But the information related to the NPI is not all there. So you can get some of it. Total charges for payments along with paid amounts and amount paid, VA paid amount. Those are separate in the institutional and professional claims. And then some of these flags for what’s going on with that claim are really important. So like current flag, pay flag, claim status you’re definitely going to need those to figure out whether the claim that you’re looking at is the one that was paid and it goes with the service.

Again this is how you can link back to some of these things. Patient/provider identifiers you have to go to SVeteran as I mentioned. That SVeteran has SSN, real SSN, so you’re going to need real SSN access to do this. And then you can connect that back to SPatient. The authorization this is to connect claims together. It’s worth noting that all authorizations were reissued on June 6, 2019 which was the start of the MISSION Act. So they don’t continue beyond that date and there’s new ones all for that date, keep that in mind. You can connect the PIT claim information to FBCS and you can also connect the PIT provider to NPPES, that is a Medicare held dataset which has national provider information. And there’s also PPMS which is a VA product that’s fairly new where they’re aggregating all the contracts and all providers that are providing services to Veterans through VA community care. Are there really no questions so far? Okay. Again, very much encourage everyone to give questions.

Dr. Todd Wagner: Nothing so far.

Dr. Liam Rose: Okay. So some opportunities and challenges. The location and type of provider, like I said there’s multiple provider fields and many are missing. I’ve personally been working on this one. PPMS is promising but difficult to work with because it’s a contractor. We’re trying to figure out how you can maybe get it in CDW where this has more addresses and things like that for where the provider is. Finding a lot of duplicates in that one too unfortunately as providers move from multiple office groups. And there’s detailed information about the service. Some of the CPT modifiers are missing, that’s pretty tough because that’s a big deal in terms of what actually went on, yeah, that’s a tough one especially if you’re looking for something very specific. If you’re doing a study on something very specific you don’t want to be mixing up modifier A verse modifier B or not having a modifier, something like that. Mixed procedure codes, as I mentioned. And missing diagnosis qualifiers.

Dr. Todd Wagner: Hey, Liam.

Dr. Liam Rose: Yeah.

Dr. Todd Wagner: I’m just going to jump in with one nuance about why modifiers matter so much. So if someone’s coming in and let’s just say it’s for ambulatory surgery they might be having a pre-op visit. And so if there’s no modifier, you could have a modifier that says this is the pre-op visit for this surgery. But if there’s no modifier and you’re wanting to track complications that stem from the surgery you might start your timing too early. Let’s say they come in a week prior, that means if you’re doing 30-day follow-up period you’re only going to really have 23 days of follow-up. And so it does create challenges if you’re looking at things like, like quality and complications. It also creates challenges if you’re looking at costs because a pre-op visit is much cheaper than a surgical visit. Thanks.

Dr. Liam Rose: Yeah, definitely. So, I’m being pretty general but a lot of these things you can run into depending on what your study is about. And then another one is, there’s also some missing authorization IDs. So that can make it difficult to link back. For example, if a Veteran had a primary care visit within VA and then was referred out, trying to link those two together can be difficult because of the authorization ID and then also the lag between the appointment and data availability. It’s going to be much slower than CDW.

Okay. So really briefly again just building a cohort. There’s different ways of doing this. A study I’ve been working on has been really focused on particular procedures so having to go through the ICD and CPT codes very carefully. And looking at, you know what, like I said a very generous search for what could possibly be one and then trying to weight out the duplicates. You could also go by diagnosis or location or types of providers. This is all information that’s available but again probably a lot of duplicates and you have to be very careful with that.

So limitations, most of which I’ve already put in. The data are not well documented, as one example member ID holds the social security number but the social security number does not. Data can change very rapidly, the data are very messy. Like I said the ICD and CPT procedure codes are stacked in one variable which is, makes it much harder to do some of these searches that you’re used to in other datasets. FEE and FCBS schema are still in CDW and possibly some encounters may not end up in PIT. I think it’s especially key to check FEE still for a more complete picture. And this really depends if your interest is more hey I want to know who’s using Choice or who’s using MISSION verse who’s using all non-VA. Because like I said a lot of older FEE things were just long-standing contracts between VA and a facility. For example, a nursing home. Where it’s not really a Choice or a MISSION piece. It’s just that’s what that VA uses for their nursing facilities, and it happens to be a private care, privately held facility rather than a VA held facility. So it really depends on your interest for your study there.

Okay. So we have plenty of time and I really encourage questions. I can, I have a few more slides to keep talking but I’d really prefer people talk, to do this. I mean a lot of this material can be found elsewhere. So we have some of the best experts in the world in this, on the call right now. So that’s not to intimidate you. I really think with this topic in particular there’s no such thing as a too simple or too dumb of question. So throw them out there.

Dr. Todd Wagner: Yeah. Thank you so much, Liam. And we’ll wait to see if those come up. The other thing just to note is we’ve built a relationship now with the PIT program office. So every two weeks we’re going to have a conversation with them about, they’ll update us about new updates on the PIT side and we’ll send them questions. So if you stump us, so you’re sort of stumping the chump, we’ll get answers to you through the PIT program office. All right. So questions are flying in.

Dr. Liam Rose: Great. Thank you guys.

Dr. Todd Wagner: Or, or they just opened the floodgate, because they’re just like. So do you want to read these or do you want me to read them for you, Liam?

Dr. Liam Rose: All right. My question is\_

Dr. Todd Wagner: Yeah so the first question is, is it possible to identify under what eligibility criteria the Veterans qualified for community care in? Is it wait time versus distance?

Dr. Liam Rose: I think, my understanding of the answer to that question is not really. I think there, wasn’t there a variable for, if it’s supposed to be there, but then a lot of them are just going to be put under best medical interest.

Dr. Todd Wagner: There’s also this database that they had that was tracking this, but they were, it was a real-time database and they were overwriting it. So historically if a person was distance but then now had a need in the most recent, the need would jump over and take, and would write out the distance. So it, it wasn’t perfect.

Dr. Liam Rose: So I think for now the answer\_

Dr. Todd Wagner: So I think most people\_

Dr. Liam Rose: Sorry.

Dr. Todd Wagner: Sorry, go ahead.

Dr. Liam Rose: I think the answer is mostly no at the moment.

Dr. Todd Wagner: Yeah. And I think most people who are using this are kind of compute this themselves versus use other databases. But that might be an area where, as people research this we’ll learn more. So, wondering if there are tips or best practices to use Fee Basis and PIT together in order to capture all community care from certain years and eliminate any overlap between Fee Basis and PIT? So the term that the PIT folks use and other folks use is ingesting. So I have this image of a snake eating a mouse. And so as programmers have looked at, for the most part when you look at more recent data being Fiscal Year ’19 it’s pretty much complete. The ingestion’s there, we’re at like 98% but you have to be a little bit careful and you have to go back and forth. Especially if you’re looking at earlier years. I suspect if you’re looking at Fiscal Year ’16 it’s going to be particularly challenging to figure out where IDs split. Do you have anything to add on that Liam?

Dr. Liam Rose: Yeah so we’ve been looking at ’18 and what we’ve done basically is just, this is specific to us because we were interested in particular procedures, is to look and see, basically just do it in parallel. I don’t have any better answer than that other than to match on the procedure date, match on the procedure itself, and match on the person. And it’s actually not too difficult to match from FEE to PIT. The issue is really if it’s not there. So matching from FEE to PIT is generally just a matter of person. As you would match anything in CDW.

Dr. Todd Wagner: Great. There’s a question about NPIs that someone said Rachel posted about previous data. So if you’re familiar with this Medicare data, this NPPES data, it’s a provider enumeration dataset that can change and changes over time. But it’s also a very large dataset. It’s like four gigabytes. So in theory you could update this dataset every month to look at changes in providers and providers can move and so you would then want to continually update that. I think there has been efforts in VA to try to capture that data once a year. But even that’s imperfect because it’s taking up so much space. In fact I think it depends a little bit on if you’re looking at a specific set of providers. But otherwise it’s very hard to do that in real-time.

Dr. Liam Rose: So if the question is, is there NPI available in PIT? The answer is yes. The question is, is there missing information on these NPIs in PIT? Also yes. So the answer, the purpose of NPPES or PPMS these provider datasets is to complete the missing information in PIT. My, our most recent is that 25 to 30% of NPIs in PIT don’t have further information on it except for the NPI. So you’d have to go outside PIT to match. NPPES is a good resource because it’s free and the vast majority of providers that accept Veterans will also accept Medicare patients. PPMS is a newer resource, hard to use. So that, but it does have information on VA-specific providers that are contracted with VA either through TriWest or Optum or other.

Dr. Todd Wagner: Yeah. Another benefit of the NPPES dataset if you haven’t used it before is two things; one is it has a taxonomy of the clinician type. And so if you’re particularly interested in honing in on specific types of providers, let’s just say you’re looking at occupational therapists you can do that with specific occupational, these typology codes. You can also look at, for example, mental health providers, specific specialized mental health providers you could do that. The other very cool thing with NPI and NPPES is you can identify their location where they render care. That’s where they provide care, that’s the terminology. And so we’ve done some GIS mapping and the folks, our collaborators in Salt Lake City have done GIS mapping so you can see where patients actually went to get care. And you can map it all using this NPPES dataset. So there’s another question for us here, is it possible to identify under what eligibility criteria the Veterans qualified, ope we answered that one, sorry. Too many questions. Is historical FEE data being loaded into PIT? That’s sort of the ingestion question. Yes they are. Do we expect at some point it will no longer be Fee Basis? I think that that is coming quickly down the road. So Sharon you were the one asking that. And we do expect, I know that some of the work that Ciaran had done with the GeriPACT team had looked at births, I believe. And showed that most of it was now ingested.

Dr. Liam Rose: I think FBCS is also, has a sunset date right?

Erin Beilstein-Wedel: Hopefully this year.

Dr. Todd Wagner: Almost all of them do now.

Dr. Liam Rose: This year. Oh yeah.

Dr. Todd Wagner: Yeah. That was Erin.

Erin Beilstein-Wedel: Yes.

Dr. Todd Wagner: Hey Erin.

Dr. Liam Rose: Okay\_

Dr. Todd Wagner: So\_

Dr. Liam Rose: Sorry.

Dr. Todd Wagner: Go ahead.

Dr. Liam Rose: Adam’s asking if we’ve looked into the accuracy of the PIT diagnosis code version variable. I have not. Has anyone else?

Jeanie Lo: No.

Erin Beilstein-Wedel: I haven’t looked into its accuracy.

Dr. Todd Wagner: And the theory is that the people would be miscoding stuff. So you clearly see if you take all claims that are linked to a specific PIT authorization code, Adam. You do see that there are some things that shouldn’t be there. Now it’s not clear whether it’s the misuse of the authorization key or miscoding. So when we looked at cataracts for example we pulled all these other records and we saw that some people who are getting this authorization key had a colonoscopy. I would suspect that that colonoscopy was not associated with that cataract but it could be that there’s two problems and we just don’t know which is which. We assumed that the problem was with the authorization key. And then there’s of course the chance\_

Erin Beilstein-Wedel: Also, the CX are, I’m sorry go ahead.

Dr. Todd Wagner: No I was just going to make a joke that of course maybe it is true. That the cataract and the colonoscopy were [unintelligible 35:49]. Go ahead Erin.

Erin Beilstein-Wedel: The CX are also procedure-based they’re not diagnosis-based and so there’s probably less checking happening on the diagnosis that’s being read and compared to the procedure codes.

Dr. Todd Wagner: Got it. We have a question for the group, can you talk a little bit more about the difficulties identifying the location and type of provider. For example, if you wanted to look at utilization of community urgent care centers or distance from the community care provider to the Veteran home.

Dr. Liam Rose: Yeah, so urgent care’s slightly different because there’s a dedicated office for urgent care. The difficulty is that if you look in PIT and you go and say okay where are, you just take a list of all the NPIs that have provided service there’s a provider schema 30% or so of them are missing their information. It’ll say NPI but it’ll be missing. So this is why we’re talking about these extra datasets to try and gather the information on where is this provider. The other 70 or so percent will have like an address and what type of provider is it and what do they serve. Like it’ll say like oh this is a physical therapist, this is their address, this is what they do. But if it’s missing then you’re kind of out of luck so that’s why we’re looking at some of these other datasets. Really encourage people to look at Megan Vanneman’s work with Todd of course, looking at how they were able to merge in the Medicare NPI information to do some of the mapping about where it is. As far as urgent care, very new, obviously that’s a new benefit from June 2019. I don’t know a tremendous amount how to get that data in particular except for the people that work in that office.

Dr. Todd Wagner: All right. So here’s the next question I’m going to read it stylistically. What do you mean CPT codes and ICD’s are stacked? And then, and what is the best way to search for them?

Dr. Liam Rose: Yeah so\_

Dr. Todd Wagner: Yes. This is not something that most programmers would want to see set up this way, right. So this is, this creates definite challenges. How have you guys dealt with that?

Dr. Liam Rose: Yeah, so shout out to Eli Lovelace at Pittsburgh for doing a good job with this. Basically we directed to do a very generous RegEx if-else to search. So there, ICD procedure codes is not all, it’s not like there, there’s a separate for diagnosis and procedure but the ICD if you want to look at the ICD procedures as long as with CPT then they’ll be together. So it’s just very large exercise of gathering everything and then deduplicating. I don’t have a better more streamlined workflow than that.

Dr. Todd Wagner: Erin, do you want to say anything? You’ve done a fair amount of work trying to source through these procedure codes.

Erin Beilstein-Wedel: I mean I do similar things that Liam does. You just have to really look at what you’re pulling and see if it makes sense. And sometimes it’s helpful to go look at some of the, the V-FSC [phonetic] reports to get an idea for how many surgeries or procedures you should be expecting.

Dr. Todd Wagner: Yeah, that’s a great comment. So we often have been working so far with clinicians who are experts in the area both on our cataracts side and our knee surgery side. And in both cases when we bounce ideas or you know here’s what we’re pulling for years and they’re like yeah, no that’s not right. So you can get a sense on what the clinician does even though as a data analyst or a health economist you might say that sounds legitimate to me, is that they can push back on you. Elizabeth asks a question about costs. Are there new information on the costs of care between VA and community care providers? Good to see you Elizabeth or hear from you. We’re continuing to work on that. There’s a couple things that you can do when you work on the PIT side is first off every line item is just an encounter. So you have to identify all of the encounters that are associated with this, or that’s, I’m using a lot of encounter terms. You have to identify every claim and so there’s a lot typically of professional FEE claims that are with every encounter. So let me be, example, so if you go in for a cataract you’re going to have, the ophthalmologist is going to do the cataract but there might be an anesthesiologist who comes in to do anesthesia there can be other professional services. They might have different claims that are more than just the 66982 or 66984 CPT code and so you have to pull all those together and come up with what’s sort of the bundle of services that are the costs. So we said hey this is great we’ll use this authorization key we’ll start pulling all these bundles and then you have to figure out okay so do we included the colonoscopy that I just mentioned. That probably we thought that shouldn’t be part of that eye bundle. And so then you had to go back and figure out, develop a method for pushing those out or excluding those. And then there’s two other costs that you have to include and we’re still trying to work through these. One is the cost of running the Office of Community Care. And so we can see those data now so we have a sense on how much it costs for an Office of Community Care. Those data should then be spread onto the individual patient claims otherwise you’re missing a large chunk of the money. And then the third one is the third-party administrator fees. And we’re still trying to figure that out. So we’ve got our contact who’s helping us try to source that and link that. So great question, we’re not there yet.

Dr. Liam Rose: Just to be clear. Third-party administration fees mean the fees that the contractors charge VA on top of whatever service, it’s a lot.

Dr. Todd Wagner: Yep. Here’s a question, is anyone looking to separate data fields where the searches are more thorny, like with CPT codes?

Dr. Liam Rose: Separate. I’m not sure.

Dr. Todd Wagner: I’m not sure I fully understand the question.

Dr. Liam Rose: Yeah sorry. If you could rephrase that one we’ll get back to it.

Dr. Todd Wagner: Yeah. So do you have suggestions on the best way to identify different types of care such as emergency care department visits or nursing home stays? That is a great question.

Dr. Liam Rose: Yeah. So in theory it should be pretty easy to just go to who the provider was and see. So if you go and say like hey this person went and it was a nursing home provider then you can be pretty confident that’s what it was. Other than that there’s no like variable that very easily identifies what each thing is as far as I’m aware.

Jeanie Lo: Could you use like PIT bill type code?

Dr. Liam Rose: I haven’t used that one.

Dr. Todd Wagner: So there are, so here’s the key. So people are spoiled on the VA side with clinic stop and treating specialty. And with those two variables on the outpatient/inpatient side respectively they can come up with these mutually exclusive categories of, sort of what type of care; was it primary care, was it emergency care, nursing home care, and so forth. Even if you’re working with Medicare data that is much harder to do. Because what you’re really limited with are procedure codes and a procedure could be done anywhere, right. It can be done in specialty care, it can be done in primary care, it’s much harder to link those. And there have been efforts and even supported by CMS known as BETOS codes, these were the Berenson-Eggers Type of Service codes that we’re trying to come up with categories or typologies and Jim Burgess and some folks in Seattle have pushed that to include the physician type in there as well. Unfortunately CMS no longer supports BETOS codes. So you’re sort of in this tricky world trying to figure out is it specialty care, is it primary care where do those differ. And sometimes even if you pull in the NPI it’s not entirely clear what type of care is this. That’s a really tough question in many regards. Anyone else want to add anything to my answer, before, it was like a dismal answer that doesn’t answer that.

Erin Beilstein-Wedel: I guess like I would suggest for emergency care and nursing home care, I think that you should probably look at the provider and the CPT and the location of care and start there. And kind of see what you get.

Dr. Todd Wagner: Yeah, the other thing that you\_. Yeah and Erin points out one of the cool things you can see is you can see ambulance visits too. And so you could, say for example, a person showed up by an ambulance and you would assume then that that was some sort of emergency care. Awesome, thank you. We’ve been looking at 2002 to 2016 and it’s likely that I’ve just been struggling due to user ignorance. I think we’re all there with you so don’t worry about that. So we’re all just trying to figure out how and you’ve got a large timeframe so it’s particularly challenging when you’re spanning these years especially the 2016 year. Because that’s the year where they’re getting PIT online, it was originally set up for auditing and fraud detection. They’re getting PIT up online to run all these Choice claims through them and it’s particularly challenging that year. So here’s a question that is, are community care contracts available for public consumption?

Dr. Liam Rose: In theory. Like you want, it depends what you mean by public consumption. Can you look at the contracts and the bid? Yes. That’s like with, you can like scroll through it. They’re very long contracts with like, I forget what the service is called but it’s the one with Congress where they have you know all the contracts. And there’s a couple different websites that aggregate all federal contract deals. But like are we saying like specific providers? No, not exactly. And if you mean public consumption by non-VA then no. PPMS is supposed to have all the contracts that VA holds with providers including TriWest, Optum, anything else you could imagine, with DoD, with Indian Health Service, all those other contracts are all in there but that is not a public product that is a VA, they need VA access for that.

Dr. Todd Wagner: There’s another question, I’m going to jump in here because it gets back to this issue of categorizing care. So Michelle brings up this question of, there is this thing called a category of care variable. So when a person requests a consult for non-VA care there is a set of actions that get put into place that are essentially authorizations and consults and there’s a category of care variable. And the last time I looked, Erin do you remember how many, it was like 120 different categories, 170 different categories? Somewhere in that ballpark.

Erin Beilstein-Wedel: Yeah, somewhere in there. Yeah.

Dr. Todd Wagner: And we had great hopes of using that to identify what kind of care and started to do these like mutually exclusive categories and we were going to use a, sort of a data approach to figure out where we should start analyzing the data first. And we were using 2016 data and we realized there was no way to link from the referral and authorization to the paid claim. So we’ve been told that that has been fixed so in theory you could go back and link from a paid claim to the authorization to say, so the authorization was for ophthalmology and here we have the paid claim for cataract. And so that might be a way. But what I don’t know is what happens if the authorization is put in for something and it gets changed partway through. I don’t know if it actually gets changed on the PIT side too. So that might require some work if you’re trying to thread across these datasets. And if you recall Liam had a slide where he talked about the CCRA and the CCRN I think is what the other one is. But there’s these different datasets. One is authorizations and we are looking at the paid claims’ version of it. Anything you guys want to add on the category of care of the linking across these databases. And that’s a shout out to Michelle who’s in Iowa City who is also working with us on the PIT office team and was on the call last week, so thanks.

Dr. Liam Rose: Okay, I’ll take this one from Paul real quick. So the question is, it is my understanding the VA MISSION Act is intended to streamline all the VA purchase of care programs not just Choice into a single program. How has this goal been implemented at VA? For instance, are claims still being handled locally at VAMCs or are all claims processed via CDW/PIT? So CDW/PIT are just data dumps. But the spirit of the question, yes they’re not handled locally. They are handled by the Office of Community Care who has greatly expanded their workforce and now deals with the, any claim that is coming from outside VA walls. I don’t know if we have full time to go into it but basically these, the MISSION Act is streamlining it in the sense that they’re building these networks through these third private party providers. The two primary as I mentioned are TriWest and Optum. Not sure how’s it gone, kind of iffy. TriWest gets confused with TRICARE too much. Still people being sent wrong bills occasionally but yeah they’re trying to get that all centralized around the Office of Community Care and these third-party administrator companies, very large insurance companies.

Dr. Todd Wagner: And the date that you should keep in mind is June 6, 2019. That’s the date when all prior authorizations were closed and all new authorizations were set up through the MISSION Act. So if a patient was midstream on authorization that authorization was closed and a new one was open. And the reason for that was to try and to make sure that the MISSION Act databases would be the single source of all of these versus trying to have ones that thread back all the way to earlier systems.

Dr. Liam Rose: So this question\_

Dr. Todd Wagner: I have yet to\_

Dr. Liam Rose: Sorry.

Dr. Todd Wagner: So I have yet to look at the data to figure out is that going to create sort of problems for researchers but keep that in mind. Sorry, go ahead Liam.

Dr. Liam Rose: This is a different one only slightly related. So for, so should you pull information from FBCS, PIT, and blank for complete picture of Choice seen in community care? This depends slightly on the year. For the most recent data I think it’s only PIT and FEE. The further you go back the more sources you’re going to have to look into. So FBCS, if you’re in 2016 FBCS, FEE, and PIT. And before 2016 PIT’s not really helpful. Yeah. There’s another question about struggling to find\_

Dr. Todd Wagner: We’ve got\_

Dr. Liam Rose: \_NPIs for some of the Rad/Onc CPTs. Yeah I don’t have a tremendous amount of information if the NPI is missing, I have not encountered that yet.

Dr. Todd Wagner: All right. So here’s a great question by Doug and he asks, are you able to describe the distribution of time between time of service and the date the claim is available in PIT? Now if you remember going back to the slide where Liam showed the different programs over time there was this thing with the old FEE and FBCS where they had six years to submit a claim. And Mark Smith who used to work at HERC and left a number of years ago, had done some work basically showing you had to wait two years to get 95% of all claims that were paid in a fiscal year. We do believe that it’s better now. It’s hard to know what we’re exactly missing. But the way that we studied this last year was on a project with Jeanie and Erin, we took all cataracts and we looked at claims by calendar month. And the thought being if there was long lags even short lags you would see large drop-offs for the more recent calendar months. As you approached sort of real-time, if you would. And what we, we were looking at data that was sort of six months in arrears and it looked pretty uniform. I mean there was stochastic change each month to month but it wasn’t like a huge drop off in time. So the data do look like their getting in there more rapidly. But I don’t have any good handle on, is there a best practice to say please wait three weeks or please wait six months. But I think you have to be aware if you’re using data in real-time is that those data are going to be changing. Here’s one for you Liam or others. For procedure codes there is a column called the procedure code version that identifies ICD-9 versus CPT HCPCS, are you saying not to trust this column?

Dr. Liam Rose: Yes, so that was Adam’s question. I don’t know about that one. I haven’t tried to use it. But I would love to know the answer.

Dr. Todd Wagner: Yeah maybe it fixes everything, right.

Dr. Liam Rose: Yeah. So if anyone ever has any information I highly encourage them to publicize it widely. If they could feel they have any information on the accuracy of it, Listserv, wherever else.

Jeanie Lo: I haven’t used that.

Dr. Liam Rose: Sorry, Jeanie.

Jeanie Lo: Sorry. Oh I said I haven’t used that variable that often to Sharon’s question, but I don’t have any evidence to not trust it.

Dr. Liam Rose: Okay. That’s a good start.

Dr. Todd Wagner: Here’s a question for you guys, hello Vanessa here I’ve been working on understanding the whole picture with PIT, FEE, Choice, PPMS, et cetera. I understand PPMS is relatively new. Do you know if PPMS is filling out to include more details and information on providers? And when suggested to use MPPS and PPMS for information is that a currently recommended workaround or is PPMS expected to be encompassing as the program develops?

Dr. Liam Rose: So NPPES is a public dataset. So that’s nice. PPMS is available behind, with access to like a Microsoft Dynamics account and it’s really annoying to use. But it has a ton of information about the providers including you know contract dates, all that kind of stuff that would be relevant to a VA setting. I don’t know if there are plans to make it available in CDW or not. Okay. I’m sorry I’m not sure where we are in these questions.

Dr. Todd Wagner: Thanks, Liam. Yeah thanks. There’s a lot of questions I’m just trying to go through them myself. That was very helpful. I will admit that I do love using Medicare data like the PPES dataset or NPPES dataset when I can because I know that other researchers are familiar with it. And so it makes it much harder when I’m writing a paper or doing research and I’m using a dataset that’s nearly procured in VA and other people haven’t used it and so it becomes a little bit harder to know what exactly is in that dataset and sort of internal validity of that data. I realize I should’ve started flagging these questions as we were answering them but I didn’t so it’s requiring me to go through all the questions. I think we’re getting through most of the questions though, this is good.

Dr. Liam Rose: Is PIT updated\_

Dr. Todd Wagner: And if we’ve missed your question please, please write in again. We’re almost to the top of the hour anyway so. But hopefully people found this helpful.

Dr. Liam Rose: Is PIT updated every night? Um, as far as I know yes. But that doesn’t mean that the data, like you said that’s not really the issue. The issue is it coming in via claims. In the sense that you have a service today but the provider might not send a bill for a month or two, it gets to VA, it gets adjudicated, and then it shows up. So it’s not really an issue of when PIT is updated it is an issue of when the service comes in, sorry when the bill comes in and is paid and then uploaded into PIT which is a bit of human and a bit of data.

Dr. Todd Wagner: And just to say I know that we’re getting close to the top of the hour so thank you Liam for running this. I know there’s a lot of interest out there. And then if there’s questions or you feel like we didn’t answer your question please let us know. And the hope is that over the longer run as more researchers get to use these data we’ll build a community of knowledge. And that community of knowledge will sort of help everybody do this a little bit easier and faster so that we can get through this.

Dr. Liam Rose: So this Winifred’s [phonetic] question, if we use the FEE schema without including PIT to find inpatient/outpatient utilization in 2018 and ’19 how much care would be missing? My answer would probably be the majority of it. I think, right?

Dr. Todd Wagner: Sorry what’s her question?

Erin Beilstein-Wedel: I can’t see that question. Can you see it?

Dr. Liam Rose: I have it on the screen. It’s if we use the FEE schema\_

Dr. Todd Wagner: Oh!

Dr. Liam Rose: \_without including PIT.

Dr. Todd Wagner: Yeah I think you’d miss a good chunk too.

Dr. Liam Rose: I would say the majority but I’m not sure. Okay. Well it’s at the top of the hour. I know Maria has to give us a quick blurb but I’ll stay around for a few extra minutes to answer anything I missed. Also you can email us, HERC@va.gov.

Maria: Hi. We do have a few extra minutes. If anybody has to sign out right now just please submit the survey back. We appreciate and count on your feedback. And I’m going to bring it back Liam.

Dr. Liam Rose: Okay. So here’s actually an interesting question. Is data missing in PIT from the translation to the Mirror, internal error, or is data missing the original claims, external error, and VA pays anyway? Maybe a little bit of both but the particular data that we were concerned about is the internal error. There may be something missing about the translation to the Mirror in CDW versus what the program, the PIT, Office of Community Care office is seeing for their operations work. We answered that one. Is category of care still being used by OCC? Did we answer that?

Dr. Todd Wagner: Yep. That’s the one on the authorization time that I was talking about.

Dr. Liam Rose: Yeah, this is Sharon’s question and Adam’s question about the procedure code version. Did that one.

Dr. Todd Wagner: Well I think we got them all or at least attempted to, so if they will email us back.

Dr. Liam Rose: Okay. Like I mentioned HERC@va.gov for questions. My personal email is Liam.Rose@va.gov. And also encourage people to use Listserv for all it’s worth to help each other out. Like I said everyone is working pretty hard on this but it’s still a lot of unknowns and hopefully getting better by the day in a lot of ways. So thank you guys for joining and for sending in your questions. And also big, very, very thankful for Jeanie, Erin, and Todd for participating and helping out.

Dr. Todd Wagner: Thanks, Liam.

[ END OF AUDIO ]