Re-evaluation of the Scope of Cardiac Surgery in COMAR 10.24.17

Key Objectives for MHCC staff

- Support best practices for patient safety
- Reflect best clinical evidence
- Efficient for MHCC to administer
- Support replication of results by others using publicly accessible data sources
- Align with previous approaches to extent possible

Key Process Questions

Approach for Reaching Consensus

1. How do we define the range of codes to evaluate for inclusion in cardiac surgery?
    a. Is there a shorter list of codes that can be the starting point for discussion?
    b. Should each surgeon and/or hospital representative provide a list of codes that he particularly wants to discuss?

    Staff recommends maximizing the time spent at a face-to-face meeting reviewing codes by focusing on groups of codes or determining ahead of time, when possible, codes where there is consensus on how to categorize the code.

2. What is the best way to assure that all members have an opportunity to participate, remain engaged, and receive timely updates of any discussions missed?

    Staff recommends that discussions of cardiac codes by held during fewer, longer meetings, on the weekend if necessary, in order to facilitate an orderly discussion with maximum participation from cardiac surgeons. Staff also recommends supplementing meetings with group email discussions, even though it is less than ideal. Staff would also plan to provide summaries of meetings to all members in a timely manner, if a subset of the CSAC, such as cardiac surgeons, meets to discuss the codes.

3. What is the appropriate way to involve surgeons at hospitals without cardiac surgery programs who want to provide input on the scope of services these non-cardiac hospitals can appropriately deliver?

    Staff prefers not to substantially expand the number of people participating in meetings. However, we could have a few guest speakers at CSAC meetings and encourage more

coordination with current members representing hospitals without cardiac surgery programs and the thoracic surgeons or administrators at their hospitals.

Approach to Defining Cardiac Surgery Using ICD Procedures Codes

4. In October 2015 hospitals began reporting ICD-10 codes on the hospital discharge abstract dataset, the current primary data source for utilization studies and projections. For the utilization projection, the ICD-10 codes will need to be mapped back to ICD-9 codes until all of the data used in the cardiac utilization has ICD-10 codes, approximately six years from now.
    a. Should we define cardiac surgery in the context of ICD-9 codes and only review the corresponding ICD-10 codes where disagreements exists or if it would potentially be useful in better differentiating codes? This approach will still require crosswalking ICD-10 back to ICD-9 beginning in October 2015.
    b. Should we develop a cardiac surgery list based on ICD-10 codes, clinicians judgment, existing crosswalks, and coding experts' experience? A crosswalk to ICD-9 would still need to be developed.

5. Should one or more experts in ICD-9 and ICD-10 coding participate directly in meeting discussions? Would CSAC members be able to coordinate with those individuals outside of the CSAC meetings?

<u>Key Policy Questions</u>

1. Should we continue to have the definitions of open heart surgery and cardiac surgery or can a single definition for cardiac surgery be developed?

   Staff recommends that the term open heart surgery be removed. However, the concept of counting only certain cases for the purpose of evaluating compliance with the volume standards and the cardiac utilization projections should remain.

2. Can ICD-9 or ICD-10 codes alone identify pericardiectomies that can be safely and appropriately performed by a thoracic surgeon at hospitals without a cardiac surgery program? If not, can ICD-9/10 in conjunction with CPT-4/HCPCS be used?

   Staff has already collected operative reports from most hospitals without on-site cardiac surgery that performed the procedure in CY2013 or CY2014. It appears that the situations where a pericardiectomy has been performed involve patients with a mediastinal tumor or lung cancer. Part of the pericardium in these cases is excised and sent to pathology. The amount of tissue removed is greater than a hole 1 or 1.5 cm in diameter, the amount of tissue typically removed (as I understand it) for a pericardial window, when fluid is drained. It was also reported that total pericardiectomies were performed at a hospital without cardiac surgery. Staff believes that it may be helpful for surgeons to review redacted and re-typed reports.

3. Should we consider changing the volume standards, based on changes made to the definition of cardiac surgery and/or the list of procedures that count towards the volume standard?

   MHCC staff would recommend increasing the volume standards if the types of cases that count towards the volume standards increases. The current volume standards are based on recommendations from the Clinical Advisory Group that met prior to development of draft regulations. The basis for the CAG's recommendation was research that linked higher volumes with better outcomes for CABG cases. Historically, the threshold of 200 cases for a cardiac surgery program dates back to the 1970s, based on research linking better outcomes to programs performing higher volumes of open heart surgery. The CAG's recommendation was an endorsement that cardiac surgery programs continue to maintain a volume of 200 or more cases. However, closure of a cardiac surgery program based on the volume of cases performed is only considered when a program performs less than 100 cases annually for two consecutive years.