CMS Indaba, 27th November 2013

Coding, Pricing and Value in SA Healthcare

Dr Jonathan Broomberg, CEO, Discovery Health
What drives medical inflation in South Africa?

Medical Inflation: 2009 – 2013 May YTD

Drivers of utilisation:

**Demand-side drivers:**
- Adverse selection
- Increased disease burden
- Ageing

**Supply-side drivers:**
- Fee for service system
- Undersupply of doctors
- New technology and procedures
- New hospitals
Examples of demand-side and supply side inflationary drivers

**Demand-side: Increasing disease burden in medical schemes**

- Chronic prevalence has increased by 60% over the last 4 years
- Chronic patients cost 4 x non-chronic

**Hospital claims inflation driven by utilisation and price**

Utilisation leads to an average annualised increase in hospital claims of 2% p.a.

Source: Council for Medical Schemes Annual Reports 2008 - 2012
Utilisation also contributes to higher payments to health professionals

Increase in specialist payment rates

- 14% increase in DH payment per member since 2007 due to utilisation

 Claims paid to doctors (plpm)  DPA tariffs  CPI
Coding plays a critical strategic role in sustainable healthcare funding.

ICD - 10

Enables

- Fair reimbursement for healthcare services
- Monitoring quality of care and outcomes
- Understanding the burden of disease
- Keeping current with new technologies and techniques
- Move to ARMs and effective risk management
- Planning of healthcare needs
- Reliable communication of healthcare data
- Facility management
- Research
- NHI – Public sector
Coding helps to detect fraud and waste

Gentamycin: For middle ear infections, rarely used

- Dr A bills code 3266, 100% of the time
- Peers bill 5% and less

Removal of tonsils

- Multiple providers bill code 1039, 100% of the time
- Peers bill 40% and less

Laryngeal stroboscopy with video capture: code 1118

- Surgeon used code 1118 (Laryngeal stroboscopy) which is used by ENTs
- Estimated savings from one surgeon: ~R1.2m
However there are several challenges in the current coding environment:

- Coding not updated since 2006 to reflect new technologies and practices
- Inappropriate clinical use of coding
- Poor discipline of coding, leading to inaccuracies
- Fraud and code pairing
- Abuse of Rule C workaround

Fee For Service system predisposes to poor coding and misinterpretation of guidelines.
Examples of poor quality coding

- Frequent use of sign/symptom codes instead of confirmed diagnosis codes

- Main conditions treated by an ‘allied’ health professional coded as Caesarean Section deliveries

- 50% (10 000 claims) from one doctor coded to same code: M2550 (Pain in joint, multiple sites)
### Inappropriate clinical use of coding

<table>
<thead>
<tr>
<th>Pr type description</th>
<th>ICD-10</th>
<th>Description</th>
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<tbody>
<tr>
<td>Dietician A</td>
<td>J069</td>
<td>Acute upper respiratory infection, unspecified</td>
</tr>
<tr>
<td>Dietician B</td>
<td>E282</td>
<td>Polycystic ovarian syndrome</td>
</tr>
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<td>Gynaecologist A</td>
<td>J069</td>
<td>Acute upper respiratory infection, unspecified</td>
</tr>
<tr>
<td>Gynaecologist B</td>
<td>A000</td>
<td>Cholera due to vibrio cholerae 01, biovar cholerae</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>S818</td>
<td>Open wound of other parts of lower leg</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>S101</td>
<td>Other and unspecified superficial injuries of throat</td>
</tr>
<tr>
<td>Social Worker A</td>
<td>L600</td>
<td>Ingrown nail</td>
</tr>
<tr>
<td>Social Worker B</td>
<td>L84</td>
<td>Corns and callosities</td>
</tr>
<tr>
<td>Speech Therapist/Audiologist</td>
<td>Z500</td>
<td>Cardiac rehabilitation</td>
</tr>
<tr>
<td>Surgeon</td>
<td>J029</td>
<td>Acute pharyngitis, unspecified</td>
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</tbody>
</table>
Critical to establish organised forum for schemes and providers to negotiate codes and tariffs

Objectives

- Appropriate remuneration for professionals
- Manageable cost impact of changes for schemes and members – no “shocks” to system
- Keep up with appropriate advances in medical practice
- Ensure consistency and accuracy of coding
Key elements of a coding/tariff forum

- Shared leadership and governance
- Agreed, structured process
- Focus on managing:
  - Codes
  - Tariffs
  - Utilisation
Tariff setting must take Scheme affordability and quality into account

Real increases in DHMS expenditure (2008-2012)

- 21.8% Radiology
- 21.0% Specialists
- 18.1% GPs
- 16.9% Pathology
- 16.3% Hospitals
- -0.3% Medicine
- -5.5% Non-healthcare expenditure

CMS data
2008 baseline based on PLPM costs
SA Health Improvement Triangle
Achieving quality of care, affordability and access

- Reduce waste
- Value based payments & innovative payment arrangements

- Wellness programmes
- Integrated patient-centred care and teamwork
- Quality improvement processes

- Embrace technology to improve access
- Electronic health records
- Transparent data on quality of care
There is a global movement away from FFS, towards value-based payments
Significant opportunities to increase doctor remuneration by reducing waste and improving quality

Source: DHMS data

Principal Professional Fee as a proportion of Total Procedure Cost

- Other professional CPE
- Radiology CPE
- Pathology CPE
- Hospital CPE
- Principal Professional CPE
- Principal professional as % of Total CPE
- Average principal professional as % of Total CPE

Source: DHMS data
Collaborate on quality of healthcare

**Patient Hospital Experience Survey**

<table>
<thead>
<tr>
<th>Category</th>
<th>Never and Sometimes</th>
<th>Usually</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>6%</td>
<td>15%</td>
<td>79%</td>
</tr>
<tr>
<td>Responsiveness of staff</td>
<td>11%</td>
<td>23%</td>
<td>66%</td>
</tr>
<tr>
<td>Doctors</td>
<td>9%</td>
<td>29%</td>
<td>62%</td>
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<tr>
<td>Hospital environment</td>
<td>12%</td>
<td>21%</td>
<td>67%</td>
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<tr>
<td>Pain management</td>
<td>11%</td>
<td>14%</td>
<td>76%</td>
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<tr>
<td>Medication information</td>
<td>13%</td>
<td>85%</td>
<td>88%</td>
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<td>71%</td>
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<td>26%</td>
<td>20%</td>
<td>50%</td>
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Since May 2010:
- >150,000 responses
- ~27% response rate

**Best Care Always**

- CLABSI doubles the hospital cost and has 12-25% mortality rate*
- BCA prevented ~1200 infections per year and saved 150-300 lives per year

Source: [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6008a4.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6008a4.htm)
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