Multicenter Perioperative Outcomes Group (MPOG)
PCRC Meeting Notes – Monday, December 14, 2015

Attendees: P=Present; A=Absent; X=Expected Absence

P	David Adams, MD - Vermont	**P**	Sachin Kheterpal, MD – U Michigan
P	Mike Aziz, MD – Oregon	**P**	Tory Lacca, MBA – U Michigan
P	Narendra Balusu	**P**	Ziaul Mannan – NYU Langone
P	Genevieve Bell – U Michigan	**P**	Michael Mathis, MD – U Michigan
P	Joshua Berris	**P**	Karen McCarthy - Vanderbilt
P	Daniel Biggs, MD – Oklahoma	**P**	Nino Miletic – NYU Langone
P	Pam Bromley – Cleveland Clinic	**P**	Bala Nair, PhD – U of Washington
P	Swamy Bachu	**P**	Shu-Fang Newman – Univ of Washington
P	Ken Bullard - Colorado	**P**	Laura Oliver
P	Mary Coppola	**P**	Nathan Pace, MD – Utah
P	Curt Carl, MD - Sparrow	**P**	William Paganelli, MD – Vermont
P	Germaine Cuff, MD – NYU Langone	**P**	W. Pasma - Utrecht
P	Mark Dehring – U Michigan	**P**	Ron Pleas – Oregon
P	Alexander Friend, MD –Vermont	**P**	Leif Saager, MD – Cleveland Clinic
P	Greg Giambrone, MS – Weill Cornell	**P**	Rita Segelman-Noguera – Cleveland Clinic
P	Michael Godbold, MD – U Tennessee	**P**	Simon Tom – NYU Langone
P	Steven Hart - Utah	**P**	Christian Ian Tope – Weill Cornell
P	Mona Hitchcock - Beaumont Dearborn/Taylor	**P**	Kevin Tremper, PhD, MD – U of Michigan
P	Shelley Housey, MPH – U Michigan	**P**	John Vandervest – U Michigan
P	Chayawat 'Yo' Indranoi (Tennessee)	**P**	Kevin Wethington - Utah
P	Cameron Jacobson (Utah)	**P**	Deborah Yoshihara – Univ of Wisconsin
P	Leslie Jameson, MD - Colorado	**P**	Chad
P	Shirley Johnson-Rogers - Beaumont	**P**	Sriram – Memorial Sloan Kettering
P	Samir Kendal – NYU Langone	**P**	Swati - Yale

Ground Rules for PCRC:

1. Each protocol must have specific testable hypothesis with data available in MPOG data structure
2. People requesting specific data elements must also supply that data type to MPOG. If you don't submit that data type currently, then you can't get that type of data type out. However, if you have a co-investigator from another site that does supply that data, then you can ask for that type of data. The reason is so someone on the research team understands the limitations of each data element being requested and used
3. To ensure that there is not a lack of clarity about what the status of the proposal is, each proposal will get the following overall decision at the end of each presentation and discussion
    a. Accept with minimal or no changes required
        i. E-mail revision to PCRC
    b. Accept with moderate changes required
        i. Represent at a future PCRC
        ii. E-mail Revisions to PCRC
    c. Revise and reconsider at future meeting
    d. Reject

4. Meeting will be recorded to be shared later with members of MPOG via the MPOG website. There were no objections to this via the members that were on the call.

Meeting Minutes

1. This call is a repeat of last year's November call about billing data, but in more detail.
2. We have reconfirmed at this year's executive meeting that billing data is now a part of the minimum data set.
    a. Without this data:
        i. PIs cannot submit research proposals.
        ii. BCBSM money is at risk.
    b. International sites are excluded from this requirement.
3. Professional fees
    a. Need one anesthesia base CPT code per procedure.
        i. If getting the surgical CPT codes is not additional political work, also include them.
    b. Give time of day for date of service if available. The time of day is helpful for case matching when more than one case for a patient occurs on the same day.
    c. It's fine to fill columns with NULL, but fill as many columns as you have data available from the billing system.
        i. Don't infer information, i.e. don't fill in operation id column if that data is not coming directly from the billing system.
    d. Only use MPOG matching algorithm so comparing apples to apples. Don't implement your own matching algorithm.
    e. Must have DOS, CPT code, global patient id (MRN)
        i. If billing system has AIMS patient id, matching script will use AIMS patient id as backup.
    f. Questions
        i. What about operation ids for cases that are not operations?
            1. Don't fill the operation id if unavailable. Case matching is done on date of service with anesthesia start.
        ii. Are we only pulling professional fees?
            1. There are two separate extracts to be done, one for professional billing and one for hospital discharge data.
        iii. Will our billing software (PPM) populate the staging table?
            1. No, this will be a manual process to be done by a programmer.
        iv. I don't see a column for procedure modifiers. Are they excluded?
            1. There is a separate staging table for procedure modifiers. However, they are not required as we have the data being represented elsewhere.
        v. How do we populate the AIMS billing tables?
            1. There is a set of standard scripts MPOG provides to move data from the staging tables to the AIMS billing tables. These scripts are available on website under Technical Downloads (Scripts and Utilities: Staging Extract Scripts). **However, these scripts will be patched by Friday. We will send these scripts to everyone when the patch is completed.**
4. Hospital Discharge data

- a. Often found in UB-04/CMS 1500 billing forms.
- b. These codes are needed for risk adjustment for ASPIRE/QCDR measures.
- c. This data gives us length of stay data and may provide discharge disposition.
- d. Please include ALL encounters, not just OR encounters. This includes ED admits and clinic visits.
- e. ICD-9 formatting
    - i. Do NOT convert to numeric (541 is different from 541.00), treat as text.
        1. Be aware that Excel will convert these codes to a numeric format automatically.
    - ii. Don’t strip leading and trailing zeros (this can make codes ambiguous, i.e. 054.10 (herpes) vs 541 (appendicitis)).
    - iii. Don’t strip leading ‘V’s.
    - iv. Don’t impute decimals, MPOG can safely impute as long as we also have leading and trailing zeros.
- f. We don’t want monetary information. This is good to communicate when requesting access to the data at your institution since it is sensitive data.
- g. Questions
    - i. How should we filter codes to include in the staging tables?
        1. Please pull all HB/HSB data (Epic) for each patient.
        2. Do not filter on patients. Patient filtering will happen in matching scripts (unmatched patient codes are not imported into the AIMS_Billing tables).
            - a. If you were to filter billing codes to only include MPOG patients, you would need to retrospectively pull billing data into the staging tables each time a patient is included in MPOG for the first time.
        3. For date filtering, start from one year prior to the AIMS go live date.
    - ii. Our problem lists are not of good quality. How should we handle this?
        1. We are not pulling the problem list. This data is what the hospital has used for compensation and therefore should be of good quality.
    - iii. Should we be pulling in line item charges?
        1. There are often separate tables for overall discharge codes vs line item charges. Please only pull overall discharge codes. Don’t include line item charges (e.g. gauze, catheter).
    - iv. What should we list as the data source for office visits?
        1. Office visits can be labelled as hospital discharge. This is unintuitive, but technically correct.
    - v. Do we need date of service for non-surgical encounters?
        1. We only need admit/discharge dates. Only include date of service where available.

5. General Questions
    - a. How does this interact with the SSIS package?
        - i. The SSIS package is not involved. Data will need to be manually inserted into the MPOG database.
6. We can’t write extract for you, but can assist with any issues.