Ohio medicaid QUALITY MONITOR

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Current quality studies focus on medications

ODJFS and Permedion have developed and are currently conducting three focused quality studies. Selected Ohio hospitals and long term care nursing facilities are collaborating by providing records for these studies.

The **Narcotics Study** addresses adverse drug events (ADEs) causing ED visits and subsequent inpatient stays among patients taking selected schedule 2, 3, and 4 analgesics. In addition to profiling the Medicaid population receiving these drugs, the study will identify the types, frequency, and severity of adverse drug events and estimate their cost. Quality indicators also include appropriate use of narcotics and evidence of practitioner follow-up.

The **Medications in Nursing Facilities Study** aims to describe the medications ordered and administered to the Medicaid population, age 18 and older, who reside in these facilities. Additional analysis will develop patient and facility profiles, including demographics, number of medications, drug therapeutic categories, diagnoses, and ADEs.

The **Disposition of Unused Medications Study** has two phases. The first is a self-reported survey to collect information on current unused meds policies and procedures in nursing facilities. The second phase will define the scope of unused medications in terms of quantity, category, and reason.

These studies are slated for completion by spring 2003. The results will be published in future issues of the *Ohio Medicaid Quality Monitor*.

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PERMEDION

Economic challenges

An open letter from Barb Edwards, Deputy Director, Office of Ohio Health Plans

Ohio faces a serious budget challenge. Since the General Assembly passed the state fiscal year (SFY) '02/'03 budget, the Ohio Department of Job and Family Services (ODJFS) has taken budget cuts totaling more than 20% in order to match lower than expected state revenues. Although these cuts did not affect ODJFS' Medicaid budget for direct care services, Ohio has, and continues to, experience an economic recession that has resulted in a significant increase in Medicaid enrollment by children, families, and seniors in poverty. In response to similar budget challenges, many states have resorted to cutting Medicaid eligibility, services, or reimbursements. Ohio has avoided making such program changes so far.

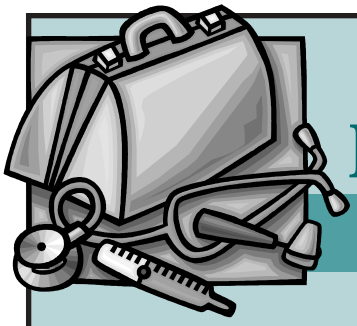
> If Ohio is to avoid or minimize Medicaid program cuts, we must together find cost savings options to reduce Medicaid's spending growth, without threatening access or quality.

However, the budget situation will be even more challenging for the SFY '04/'05 budget, especially given ongoing state revenue projections. Over the past 8 years, on average, Medicaid spending has grown by 9% each year, to over $10 billion in SFY '03. ODJFS Director Tom Hayes recently testified that a 9% annual growth rate for Medicaid would require an additional $2 billion all funds [i.e., both state and federal funding] over the state fiscal year '03 base, or $850 million in new state general revenue funding, for the upcoming SFY '04/'05 budget.

If Ohio is to avoid or minimize Medicaid program cuts, we must together find cost savings options to reduce Medicaid's spending growth, without threatening access or quality. One such option is an acute care management strategy for our consumers who are low income, aged (65 and older), blind, or have a disability (a.k.a. "ABD" consumers).

ABD consumers account for 78% of Medicaid spending, while representing only 29% of the Office of Ohio Health Plans' (OHP) enrollees. In addition, spending for these consumers has increased by 50% on a per person basis over the last 8 years, which is more than double the increase of the children and families population. State and national research suggests that some portion of these expenditures need not occur, and health outcomes would improve

Challenges *continued on p. 3*



Medical Director dialogue

by T.J. Redington, MD
Ohio Department of Job and Family Services

There continues to be some uncertainty about the use of observation status versus direct admission to inpatient status in the hospital. ODJFS defines observation services as "services furnished on a hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient (5101:3-2-02 of the Ohio Administrative Code)."

Based on this definition, the use of observation status should be considered when: the need for inpatient admission is unclear, but is expected to be determined in the next 24 hours; the clinical diagnosis is uncertain, but the diagnosis is expected to "declare" in the next 24 hours; or the patient is expected to be stabilized and released in the next 24 hours.

In contrast, observation status should not be used: for services that are provided only for the convenience of the family, patient, or physician; for preparation and post-care for outpatient diagnostic services (e.g., colonoscopy); for post-operative monitoring during the standard recovery period; or as a standing order following outpatient diagnostic services or surgery.

When a physician finds it hard to decide between admitting the patient and using observation status, I recommend the latter. The reason is pragmatic and financial. A physician can evaluate and treat the patient in an observation setting and admit if needed. However, if the physician first admits the patient, and the admission is found to be medically unnecessary upon retrospective review, the inpatient stay will be denied and payment will be recouped.

The American College of Emergency Physicians has published guidelines for the development of observation units. These guidelines refer to "virtual" observation units whereby the patient

Medical Director Dialogue *continued on back*

How quality concerns are identified, appealed

The Summer 2002 issue of the *Ohio Medicaid Quality Monitor* discussed the claims review and appeal processes related to billing components. In this issue, we address the review and appeal processes from the quality perspective.

The review process

Permedion's claim review process begins with a registered nurse reviewing the medical records against the Quality Screens issued by the Centers for Medicare and Medicaid Services (CMS). If a Permedion nurse reviewer identifies a potential quality concern, the record is reviewed by an Ohio-based peer-matched physician reviewer who may determine that **1)** there is no issue, **2)** the issue has been resolved, or **3)** there is a valid quality concern. When a valid quality concern is found, the physician reviewer assigns a severity level to the quality concern and the hospital is notified through a letter entitled "Preliminary Quality Notice."

Quality Concern Severity Levels
Level 1: Confirmed quality problem with minimal potential for significant adverse effect(s) on the patient
Level 2: Confirmed quality problem with potential for significant adverse effect(s) on the patient
Level 3: Confirmed quality problem with significant adverse effect(s) on the patient

The appeal process

The hospital may appeal the decision within 60 days of the date of the Preliminary Quality Notice. The appeal request should state why the hospital does not agree with Permedion's decision and should include a copy of the medical record and any additional medical information the hospital wishes to provide.

Regardless of whether or not a hospital responds within the 60-day appeal period, a second Permedion physician reviewer is assigned to evaluate medical records of all preliminary quality concerns. If the hospital does respond within the appeal period, the second physician reviewer analyzes the medical record along with any additional information submitted by the hospital. Within 30 days, the second physician reviewer decides if the issue has been resolved or lessened or will confirm the quality determination, and a letter labeled "Quality Concern-Final Decision" is sent to the hospital explaining Permedion's findings.

Quality Concerns *continued on back*

Challenges *continued from front*

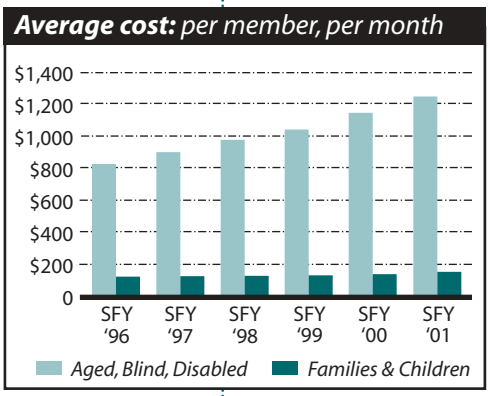
with more effective preventive care and care management with chronic and high cost health conditions.

OHP has initiated a statewide public process to develop an acute care management strategy. Questions for consideration include:

- What contracting arrangements should be used?
- Which ABD consumers to include in the first phase of the program?
- What communities to include in the first phase of the program?
- How can a program adapt to various populations and/or geographic areas?
- How can a program adapt to varying consumer needs and provider availability?
- How best to structure financial payments and incentives to improve outcomes and save money?

As a Medicaid provider, I invite you to participate in this public process. As a first step, please visit www.state.oh.us/odjfs/ohp/news.stm. This web page provides a more detailed overview of the challenges we face and the beginnings of an acute care management proposal. This site also includes two recent presentations made to a House subcommittee that is holding a series of hearings on the Medicaid program [from the web address above, select the link to Ohio's Medical Care Advisory Committee]. I encourage you to review this information and submit your reactions to the office at medicaid@odjfs.state.oh.us and include "Acute Care Proposal" in the subject line.

As part of its public process, OHP has begun meeting with associations representing various provider groups, managed care plans, and consumers. General community forums will be scheduled for late fall. I encourage your participation as OHP will use the information collected to further refine Ohio's acute care management strategy.



Thank you for your continued participation as a Medicaid provider. Collectively, you provide health care to over 1.7 million Ohio Medicaid consumers a year. The direct value to individuals and families, and the indirect value to our communities, is beyond measure.

Sincerely,

Barb Edwards

CODING CORNER

Identifying and coding mechanical ventilation

Recently, Permedion nurse reviewers identified several cases in which mechanical ventilation was billed as the primary procedure when, in fact, the patient was on BiPAP (bi-level positive airway pressure). In this issue, we explain the correct identification and coding of mechanical ventilation versus BiPAP as a primary procedure.

Coding Clinic for ICD-9-CM (3rd Quarter, 1998) indicates that the BiPAP system is a noninvasive ventilation support system designed to augment a patient's ability to breathe on a spontaneous basis. A code from category 96.7, other continuous mechanical ventilation, would not be assigned because patients on BiPAP do not have either the insertion of an endotracheal tube or a tracheostomy as required for the use of that code category. Assign code 93.90, continuous positive airway pressure (CPAP) for both BiPAP and CPAP continuous ventilation. Other types of respiratory assistance not considered mechanical ventilation are intermittent positive pressure breathing (IPPB, 93.91) and continuous negative pressure ventilation (CNP, 93.99).

An example:

A 52-year-old female with a significant history of chronic obstructive pulmonary disease and congestive heart failure presented to the Emergency Room with hypoxemia. The patient had been noncompliant with her medications and her chest X-ray indicated possible infiltrates. She became lethargic and was placed on BiPAP (93.90) for respiratory assistance. Soon after, the patient became uncooperative and refused to wear it. The patient continued to fail, she was made a no code status, and she expired. The hospital incorrectly coded/billed the mechanical ventilation (96.71) and insertion of an endotracheal tube (96.04). In this case, the code for BiPAP (93.90) is the appropriate principal procedure.

Remember, consult the *Coding Clinic for ICD-9-CM* and the *Official Guidelines for Coding* to ensure correct code assignments for diagnoses and procedures.

Quality Concerns *continued from p. 2*

The hospital may appeal the confirmed quality determination by requesting a re-review within 30 days of the date of the Final Decision letter. A third Permedion physician reviewer would then review the medical record and any additional information and would make a final binding determination.

The reporting process

All quality determinations are sent to ODJFS and are recorded. ODJFS refers level 3 quality concerns involving physicians to the Ohio State Medical Board and sends all level 2 and level 3 quality concerns to the Ohio Department of Health (ODH). ODH enters these findings into its ASPEN Complaint Tracking System (ACTS) and forwards them on to the Joint Committee on Accreditation of Health Care Organizations or the American Osteopathic Association, as appropriate. ODH also makes the information available to CMS. If a provider requests a re-review or appeals outside of the deadlines mentioned above, the concerns would have been forwarded already to ODH. However, any revised findings would be sent to ODH, which would make a note of the new findings within the initial entry.

If you have any questions about the quality review and appeal process, please contact Phyllis Alder at 614-895-9900 or palder@permedion.com.

Medical Director Dialogue *continued from p. 2*

may be held in an observation bed in: **1)** the ED; **2)** another outpatient area of the hospital; or **3)** an inpatient unit area. The guidelines provide hospitals the flexibility to design a program that is most appropriate for their facility, while complying with Medicaid guidelines and receiving appropriate reimbursement for the length and level of care provided to their patients.

Improving communication

For matters related to utilization review, Permedion communicates with the person designated by the hospital CEO as the utilization review contact. The hospital utilization contact may receive a record review request, be asked to schedule an onsite audit, receive utilization information, and be informed regarding any changes in the precertification program. When a hospital is involved in an onsite review of medical records, the utilization contact person and the Permedion nurse reviewer also will schedule a completion exit interview.

The purpose of the exit interview is to discuss referrals of medical records with utilization concerns, answer any questions the hospital utilization contact person has about the referrals, and review a list of medical records required to be sent to Permedion within 10 days. If the hospital cannot produce the copy of the medical record within 10 days, a technical denial is issued and the hospital loses its reimbursement for that admission.

At some hospitals, Permedion nurse reviewers may communicate with someone other than the designated utilization review contact person (e.g., health information services) when scheduling the onsite review of medical records and conducting an exit interview. In these instances, the nurse reviewer will request that an additional courtesy copy of the "Photocopying Request for Referred ODJFS Records" be sent via hospital interoffice mail to the hospital's designated utilization contact. The 10-day timeframe to produce the copied medical records remains in effect.

ODJFS and Permedion continuously look for ways to improve communication with hospital utilization review contacts and to close any gaps that may lead to technical denials. If you have questions or comments related to hospital contact communications, please contact Phyllis Alder at 614-895-9900 or palder@permedion.com.

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