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Precertification vs. Prior Authorization: Clarifying the Differences

The terms "precertification" and "prior authorization" are often mistakenly used synonymously by physicians' offices and hospital providers. However, there are significant differences between these terms. Precertification prospectively monitors the utilization of a select group of elective surgical procedures for medical necessity and appropriateness of setting (inpatient vs. outpatient). Prior authorization, while also prospective, is necessary for procedures that are not typically a covered benefit under Ohio Medicaid and for most transplants.

Permedion's website (***www.permedion.com***) provides a convenient link to the Ohio Medicaid Precertification Manual. Follow the links to **Ohio Medicaid** and **Precertification Manual**. This manual contains the CPT codes for surgical procedures requiring precertification and describes exemptions to the rule.

The Ohio Administrative Code details services not typically covered by Ohio Medicaid (rule 5101:3-2-03) and transplants requiring prior authorization (rule 5101:3-2-07.1). In addition, outpatient surgeries that require prior authorization are indicated in Appendix C of rule 5101:3-2-21.

If a procedure is usually not a covered Ohio Medicaid benefit, prior authorization may be necessary. For prior authorization, call the Ohio Department of Job and Family Services (ODJFS) at 1-800-686-1516. If you are scheduling a normally covered surgical procedure, verify the need to obtain precertification by referring to the Ohio Medicaid Precertification Manual or contacting Permedion's Ohio Medicaid Precertification Center at 1-800-772-2179.

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PERMEDION

Developing Quality Indicators

Submitted by Patti Klingel
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Permedion recently attended the 28th Annual Conference of the National Association of Healthcare Quality. Patti Klingel, Director of Quality Management at Bucyrus Community Hospital, was a speaker at the conference. She has published several articles on quality improvement and customer service practices while holding memberships in several local, state, and national quality groups including the National Quality Forum. The following is a condensed version of her presentation: "Developing Quality Indicators."

Quality indicators should reflect an organization's mission, vision, and values as represented in the organization's strategic plan so that the information they generate can be integrated with new strategies, performance improvement, and risk management. By reflecting organizational goals, good indicators provide the necessary data for organizations to assess, monitor, and improve processes and for individual departments to successfully implement process improvement projects.

In selecting an indicator, several factors must be considered. Key business issues that align with the organization's mission, vision, and values and that benefit the customer are prime selection factors. Of course, processes that need to be changed or revised are also important factors. However, understanding the stability of a process should also be considered when choosing an indicator.

It is important to establish the rationale for the indicator and the dimension of improvement, such as efficiency, efficacy, timeliness, or safety. Is the goal to measure an outcome, process, sentinel event, or a percentage of the whole? Is risk or volume part of the rationale?

It is also vitally important that everyone involved understands the measurable information. An indicator statement that is clear and well-defined is critical to any audience. An unambiguous statement could read, "Patients having joint replacement surgery will be given prophylactic antibiotics 60 minutes prior to surgery 100% of the time." The accompanying definition might be, "Prophylactic antibiotics are those medications recommended and approved by the P&T committee to prevent infection in those patients receiving implanted total joint devices. These medications are ordered by a

Quality indicators *continued on p. 2*

Quality indicators *continued from p. 1*

physician and administered not more than 60 minutes before the incision is made."

What appears to be the simplest decision is actually the most complicated one: how to measure the information. The numerator and denominator must be related in order for measurements to be effective. In the example of total joint replacement patients, the numerator may be the number of patients who do not receive the prophylactic antibiotic in 60 minutes over the total number of patients who receive a total joint implant.

Another important decision is who will collect the data and who will see the information. Will the infection control coordinator, quality management, or surgery collect the data? Will infection control, the surgery committee, or other hospital committees review the information? The choice lies with the department that is responsible for changing the process to make the improvements.

Finally, anyone choosing a quality indicator should understand the following:

- Two data points—one measure taken before a process is implemented and one measure taken afterwards—are not enough to determine whether or not a process improved.
- Studying a process is much easier than studying a system.
- Areas that no one is interested in improving should never be studied.
- Essential process improvements should have a definitive beginning and end.

Developing effective quality indicators is a key element in obtaining sound evidence-based information. Evidence-based information leads to accurately measuring healthcare outcomes, utilization, and costs. These measurements are crucial in assessing the effects of healthcare policy and guiding future healthcare policy making to assure and improve the quality of care.

CODING CORNER

Coding different types of congestive heart failure

In this issue of the Coding Corner we provide information from the *ICD-9-CM Coding Advisor* on the different types of congestive heart failure and coding assistance for identifying these diagnoses.

Congestive heart failure is a syndrome of impaired contraction, or power failure (in pumping of the heart), pressure volume overload and impaired filling of the heart.

TYPES OF HEART FAILURE

• **Right-sided congestive heart failure** (428.0) is caused by liver hypertrophy, systemic venous congestion, pitting edema, or ascites due to congestion of fluid behind the right ventricle.

• **Left-sided congestive heart failure** (428.1) is demonstrated by paroxysmal nocturnal dyspnea, cardiac asthma, dyspnea, orthopnea, and/or acute pulmonary edema caused by the collection of excess fluid behind the left ventricle.

• **Low-output heart failure** (428.0-428.1) can be defined as either right- or left-sided congestive heart failure. It may be due to ischemic heart disease, hypertension, cardiomyopathy, or valvular or pericardial disease.

• **High-output heart failure** (428.0-428.1) can develop with anemia, hyperthyroidism, arteriovenous fistulas, beriberi, and Paget's disease.

• **Compensated heart failure** (428.0) describes the state achieved when the heart develops compensatory mechanisms on a chronic basis, such as increased force of contraction, elevated atrial pressures, hypertrophy, and ventricular dilatation.

• **De-compensated heart failure** (428.0) occurs when the heart, even with compensatory mechanisms, is unable to handle the additional workload.

• **Heart failure not otherwise specified (NOS)** is coded 428.9. This is an unspecified code and the coder should make every effort to determine whether a code from the 428.0-428.1 series would be more appropriate.

Coding and reporting of appropriate diagnoses is dependent upon physician documentation in the medical record. If a diagnosis is questionable, always refer to the attending physician for clarification.

The New Medicaid Interactive Voice Response System

Effective October 16, 2003, the Medicaid Interactive Voice Response System (IVR) has been updated to comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements regarding Protected Health Information (PHI).

A personal identification number (PIN) is now required to access client eligibility, claim status, payment status, prior authorization, and provider information. IVR access is available to providers and billing entities. Billing entities are business partners that providers have contracted with to access PHI.

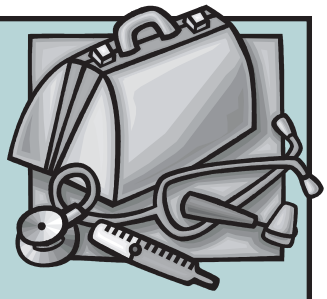
The IVR menu structure changes now incorporate the use of a PIN. To ensure that all phone calls from Medicaid providers are properly routed through the Medicaid IVR, the system has been modified to allow a transfer to a provider service representative. The Office of Ohio Health Plans (OHP) posted an IVR Guide that outlines the new menu options. This guide is available at ***http://jfs.ohio.gov/ohp/bpo/pnms/index.stm***.

Calls made for in-state and out-of-state provider assistance, to the Provider Enrollment Call Center, and to the Prior Authorization Unit will now be answered by the **Medicaid Interactive Voice Response System**.

Medicaid providers are required to administer billing entities' access to PHI via the IVR. This includes PIN administration to grant access, delete access, and reset PINs for your billing entities. In addition, provider finance, patient accounts, and billing departments must be made aware of these changes. Please distribute copies of this guide to each of these areas.

Additionally, on October 27, 2003, the in-state (1-800-686-6108) and out-of-state (614-728-3288) phone numbers for Provider Assistance and the Provider Enrollment Call Center, as well as the Prior Authorization Unit's phone number (614-466-6065) will be answered by the IVR. The IVR phone number is 1-800-686-1516 This enhancement will allow the caller immediate access to information such as payment, eligibility, claim status, prior authorization and procedure code, with no waiting for an available representative.

Medical Director *dialogue*



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

Our overarching objective in the Office of Ohio Health Plans (OHP) is to be a purchaser of value. In some situations this is through a fee-for-service delivery system, in others it is through a managed care plan.

We wish to be data driven and an evidence-based purchaser of quality. OHP is bringing on line a decision support system, which will allow us to profile individual clinics, hospitals, providers, or patients and profile them according to utilization. There are many examples of public and private health plans that use "provider profiles" to influence providers to reach utilization and quality of care benchmarks. Unfortunately, many of the cases that reach the media are portrayed as reducing utilization and limiting access to services. However, there are examples where incentives around provider profiling are created to improve access to preventive health care services and facilitate the use of diagnostic, treatment, and patient education services that are consistent with evidence-based clinical practice guidelines.

The goal of provider profiling initiatives is to improve the quality of care while reducing health care expenditures through the prevention of disease, early detection, and utilization of the most effective treatment plans. It is a tool that facilitates the measurement of targeted health outcomes based on sound scientific and epidemiological methods and evidence based clinical criteria.

As the financing of healthcare assumes a larger importance in the financial well being of the state, the notion of value purchasing is assuming a new imperative in the debate of clinical quality. Strategy one of the OHP Strategic Plan is "to use value purchasing approaches to provide our consumers with a health plan that emphasizes accessibility, network management, quality, and improved outcomes." Provider profiling could be one value-purchasing tool developed by the department to improve the quality of healthcare services while reducing costs.

Hospital-related HIPAA Policy Changes and Updated Hospital Billing Instructions

ODJFS recently published Hospital Handbook Transmittal Letter (HHTL) 3352-03-5, which describes hospital policy and billing-related changes required by ODJFS due to the federally mandated HIPAA. These policy changes became effective for dates of service on or after October 16, 2003.

Also published with HHTL 3352-03-5 are the updated hospital billing Instructions for UB-92 claims. ODJFS updated the hospital UB-92 billing instructions to include changes implemented as a result of HIPAA and other policy updates. With those updates, the billing instructions were also made available electronically online at the same site as the hospital rules and HHTLs. The billing instructions in addition to the hospital rules of the Ohio Administrative Code comprise the hospital provider handbook.

To access the hospital provider handbook go to ***http://jfs.ohio.gov/ohp/bhpp/handbook/index.stm***, select **Ohio Health Plans Provider Handbooks** and **Hospital Services**. Links to the hospital billing instructions, rules, and HHTLs that summarize hospital policy changes (including HHTL 3352-03-5) are provided on the left-hand side.

Questions about the HIPAA changes or updated billing instructions can be made to the Provider Network Management Section, Provider Assistance Unit, 1-800-686-1516.

Permedion's New Ohio Medicaid Precertification Center

"Thank you for calling Permedion, Ohio Medicaid's Precertification Center" is what you now hear when you call for precertification of an Ohio Medicaid targeted procedure. Effective October 1, 2003, Permedion began answering the phone lines for the Ohio Medicaid Precertification Program. Permedion's subcontractor National Health Services, Inc. (NHS), located in Louisville, Kentucky, previously performed the initial precertification review.

The transition from NHS to Permedion will be seamless. The phone numbers, procedures requiring precertification, and process have not changed. The current list of procedures can be found at Permedion's website, ***www.permedion.com*** (Ohio Medicaid, Precertification Manual).

Nurse reviewers Rhondi Seiple, RN, and Maureen Riley, RN, will be performing precertifications at Permedion. Keight Eplin, the new intake coordinator, will open new cases and answer your initial inquiries as needed. Rhondi, Maureen, and Keight have been assisting with Permedion's out-of-state precertification contract for the past two years.

For questions regarding precertification of a procedure, call 1-800-772-2179. Permedion is URAC-accredited and located in Westerville, Ohio.

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