Ohio medicaid QUALITY MONITOR

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New Program for Medicaid Consumers

Enhanced Care Management (ECM) is a new program for Ohio Medicaid consumers who are aged, blind, or disabled and have certain chronic illnesses. ECM will provide enhanced care management services for adults with diagnoses of asthma, diabetes, congestive heart failure, coronary artery disease, non-mild hypertension, or chronic obstructive pulmonary disease and for children with asthma. Monthly, ECM members will receive an Enhanced Care Medicaid card that allows them to receive all regular Medicaid fee-for-service benefits. In addition, ECM members can use these cards to receive case management services. An estimated 30,000 Medicaid consumers statewide are eligible for ECM. Participation in the program is voluntary.

As of October 1, 2004, ECM program membership began in Lucas County. Over the next 12 months, the ECM program will be phased in for six urban and six rural counties. During the coming months, ECM outreach activities will take place in Franklin, Cuyahoga, and Hamilton counties, where the program will be implemented in the fall.

For physicians who serve ECM members, the payment is identical to the current fee-for-services system in which the physician provides the service and subsequently bills Medicaid. The ECM program also allows for supplemental monthly payments to physicians who serve as ECM members' accountable primary care providers (PCPs) and includes an opportunity to offer performance incentive payments to PCPs. Correspondence concerning the ECM program is being sent directly to physicians who provide primary care services to Medicaid consumers who are eligible for ECM.

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Retrospective Review Denial Hierarchy Table

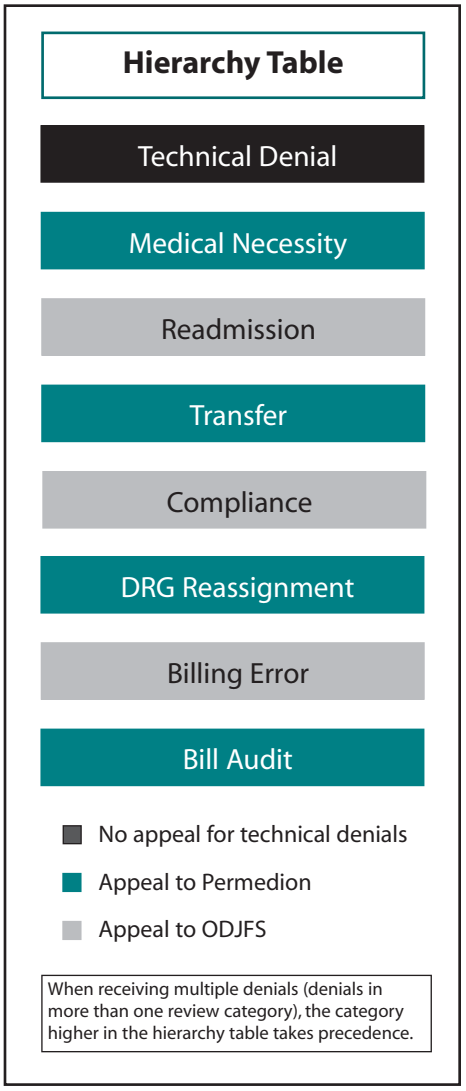
In this issue of the *Quality Monitor*, the Ohio Department of Job and Family Services (ODJFS) and Permedion provide clarification of the hierarchy table used in the Ohio Medicaid Retrospective Review Program. This table will assist hospitals in determining the appropriate channels for the appeals and rebilling processes.

The hierarchy table includes eight review categories. Categories displayed in green are appealed to Permedion; categories in gray are appealed to ODJFS. Technical denials are issued when the hospital does not produce the requested medical record in a timely manner. Technical denials cannot be appealed.

Permedion sends hospitals denial letters on the last business day of the month. Each denial letter contains specific appeal instructions. Only appeals postmarked within 60 days of the original denial notification are processed.

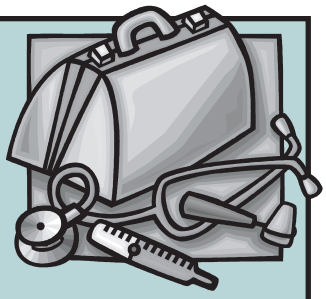
After the appeal process is completed and the denial is upheld, the hospital needs to wait for ODJFS to take back the payment; the hospital can then rebill the account appropriately. This step can take up to 150 days.

The following examples further explain how multiple denials are handled in the retrospective review program and the effects of the hierarchy.



Hierarchy *continued on pg. 3*

Medical Director *dialogue*

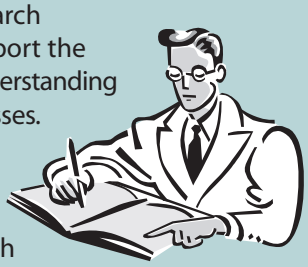


by T.J. Redington, MD
Ohio Department of Job and Family Services

Look for New Clinical Review Criteria!

As part of the utilization management program, clinical review criteria are used to assist in making determinations regarding medical necessity and quality of patient care. In the Ohio Medicaid Utilization Review Program, Physician Developed Criteria (PDC) has been used for the past seven years. PDC was provided to all Ohio Medicaid participating hospitals and is a proprietary digest of over 20,000 clinical parameters linked to diagnoses and procedures. However, it is internally developed and does not afford us the benefits of readily accessible references, web access, and national acclaim. For these reasons, we have been on a search for nationally accepted clinical review criteria with the aforementioned attributes.

After several meetings, demonstrations, and consultations, ODJFS and Permedion have chosen to use Milliman *Care Guidelines*® as the criteria for clinical review. These nationally accepted guidelines are founded on the use of evidence-based research methodology to support the development and understanding of medical care processes. The clinical criteria were developed and are updated on a regular basis with input from health care providers in active clinical practice. Sources of information for all *Care Guidelines* include medical literature and textbooks, nationally recognized guidelines published in all fields of medicine, practice observation, and database analyses.



More information regarding the use of Milliman *Care Guidelines* will be sent to hospitals in the next two months. Our goal is to begin using the criteria for medical necessity and quality reviews sometime during the first quarter of 2005.

Payment for Outpatient Observation Services

Effective October 16, 2003, ODJFS changed the payment methodology for outpatient observation services. Before this change, hospitals were reimbursed for outpatient observation in increments of two hours, using codes X7100 and X7500. Now, ODJFS requires hospitals to assign a severity level to observation services and use the appropriate CPT codes.

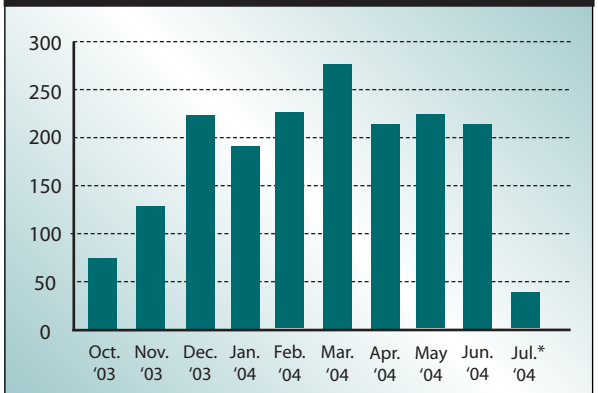
The following CPT codes were added to the outpatient fee schedule in the Ohio Administrative Code rule 5101:3-2-21:

- 99218—initial observation care, per day, low complexity
- 99219—initial observation care, per day, moderate complexity
- 99220—initial observation care, per day, high complexity
- 99234—observation, admission, and discharge on same date, low complexity
- 99235—observation, admission, and discharge on same date, moderate complexity
- 99236—observation, admission, and discharge on same date, high complexity

Further, payments for observation services will be made for up to two consecutive days only. To receive payment for a third consecutive date of service, the patient must have been discharged and, for medically necessary reasons, readmitted as an outpatient.

ODJFS asked Permedion to analyze the outpatient claims in terms of use of these new observation codes. Outpatient claims with dates of service from October 2003 through July 2004 were examined to identify billed observation services using any combination of the above codes for more than two consecutive days. Permedion found 588 stays that met these criteria—that is, there were 588 "stays" representing more than two consecutive outpatient claims for the same patient at the same hospital. Total days of consecutive stays among these 588 stays ranged from three to five days, but 89% of the cases were three days in length.

Observation Stays Exceeding Two Consecutive Days



*Data from July 2004 are incomplete.

These results suggest that providers may not be fully familiar or compliant with the new rules. Further, the results do not appear to reflect a provider learning curve, given that the number of claims billed more than

Observation *continued on p. 4*

Hierarchy *continued from p. 1*

Example 1: Medical necessity and DRG reassignment denials (overturned)

When a case has both a medical necessity denial and a DRG reassignment, the medical necessity denial takes precedence because it is higher on the hierarchy table. If the medical necessity denial is overturned during the appeals process, the DRG reassignment still needs to be rebilled to reflect the appropriate DRG for the account.

Example 2: Medical necessity and billing error denials

When a case has both a medical necessity denial and a billing error denial, the medical necessity denial once again takes precedence because it is higher on the hierarchy table. If the medical necessity denial is overturned during the appeals process, the billing error denial needs to be corrected and the account rebilled as indicated on the denial letter.

Example 3: Medical necessity and DRG reassignment denials (upheld)

When a case has both a medical necessity denial and a DRG reassignment, the medical necessity denial again takes precedence because it is higher on the hierarchy table. If the medical necessity denial is upheld during the appeals process, the account needs to be rebilled as an outpatient/observation stay. The codes from the DRG reassignment letter should be rebilled to reflect the appropriate diagnoses and procedures for this account.

BILLING ERROR DENIALS

When the hospital has a billing error denial (i.e., admission and discharge on the same day or the account should have been observation stay), rebill these accounts from an inpatient stay (with a DRG payment) to an outpatient/observation stay.

READMISSION DENIALS

When the hospital has two accounts for the same patient who is readmitted within one calendar day of the first admission, the two accounts need to be merged into one and one DRG payment will be paid.

MONTHLY REPORTS

A "Hospital Summary of Denials" report accompanies the monthly denial letters sent by Permedion. For cases with multiple denials, an asterisk is placed next to the concern that is lower on the hierarchy table.

In the following example, an asterisk is placed next to the billing error denial because it is lower on the hierarchy table.

Hierarchy *continued on pg. 4*

CODING CORNER

Risks of obesity

In this issue of the Coding Corner, we provide information from the *Coder's Desk Reference for Diagnoses* for ICD-9-CM on the health risks of obesity.

Obesity is defined as a condition in which the body weight of the patient is at least 30% above the ideal weight as seen on standardized weight charts.

There are two general classifications of obesity: (1) exogenous, which is caused by excessive food intake, and (2) endogenous, which is caused by some abnormality within the body, endocrine, or faulty metabolism. Specific endogenous causes of obesity include hypothyroidism, adrenal hyperfunction, and testicular and ovarian hypofunction.

Obesity is coded as morbid obesity (278.01) or obesity unspecified (278.00). Morbid obesity is defined as increased weight beyond limits of skeletal and physical requirements (125% or more over ideal body weight) as a result of excess fat in the subcutaneous connective tissue.

Obesity is epidemic in the United States and puts patients at risk for diabetes, hypertension, and coronary artery disease. Obesity occurs when caloric intake chronically outpaces calories expended as energy.

We usually do not know why persons consume more calories than they expend. However, the following seven factors may contribute to obesity.

1. Social: a person's lifestyle and his or her dietary and exercise patterns play a major role in obesity.
2. Endocrine: metabolic abnormalities (i.e., diabetes mellitus) are usually the consequence rather than the cause of obesity. Thus, endocrine-related obesity is generally exogenous, not endogenous.
3. Psychologic: many obese persons report that they overeat when emotionally upset, but it is difficult to understand the factors linking emotions and obesity.
4. Genetic: it is widely recognized that obesity runs in the family, and genetics play a major role in human obesity.
5. Developmental: Most persons whose obesity began in adult life suffer from hypertrophic obesity, which is related to the increase in size and number of fat cells.

Coding Corner *continued on p. 4*

Observation *continued from p. 2*

two consecutive days have increased to and remained steady at over 200 monthly, as seen in the figure. Hospitals may want to review their billing procedures to ensure that these codes are being appropriately assigned.

Hierarchy *continued from p. 3*

The medical necessity denial takes precedence, pending appeal determinations.

Hospital Summary of Denials

Type of Review	Claim Disagreement Amount
A	$ 0.00 *
M	$ 3,500.00

Definition
A: Billing Error
M: Medical Necessity

* This concern is lower on the hierarchy table

For additional information about the Ohio Medicaid Retrospective Review Program, please contact Peggy Fouty, Permedion Coding Specialist, at 614-839-3369.

Coding Corner *continued from p. 3*

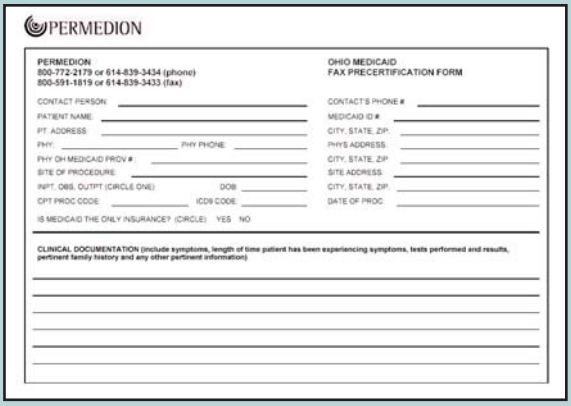
6. Physical activity: decreased physical activity is often cited as a major factor in the rise of obesity.

7. Brain damage: brain damage, particularly to the hypothalamus, can lead to obesity; the final common pathway to caloric balance lies through behavior mediated by the central nervous system.

Fax Your Way to Precertification

The Ohio Medicaid Precertification Center handles requests for precertification of elective inpatient and outpatient surgeries. We would like to remind you of a quick, easy way to request precertification—by fax.

A copy of the **Precertification Fax Form** is included with this issue of the *Quality Monitor.* Simply complete the form and fax it to the Ohio Medicaid Precertification Center at 1-800-591-1819. The request will be processed within one business day. A determination letter will then be sent to the physician's office and the hospital. If typing is easier for you, visit Permedion's website at ***www.permedion.com***. Select the links for **Ohio Medicaid** and **Precert Fax Form (Microsoft Word format)** and save the form to your computer. You will then be able to type in the necessary clinical information for your request.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PERMEDION
800-772-2179 or 614-839-3434 (phone)
800-591-1819 or 614-839-3433 (fax)

OHIO MEDICAID
FAX PRECERTIFICATION FORM

CONTACT PERSON: _____ CONTACT'S PHONE # _____
PATIENT NAME: _____ MEDICAID ID #: _____
PT. ADDRESS: _____ CITY, STATE, ZIP: _____
PHY: _____ PHY PHONE: _____ PHYS ADDRESS: _____
PHY OH MEDICAID PROV #: _____ CITY, STATE, ZIP: _____
SITE OF PROCEDURE: _____ SITE ADDRESS: _____
INPT, OBS, OUTPT (CIRCLE ONE) DOB: _____ CITY, STATE, ZIP: _____
CPT PROC CODE: _____ ICD9 CODE: _____ DATE OF PROC: _____
IS MEDICAID THE ONLY INSURANCE? (CIRCLE) YES NO

CLINICAL DOCUMENTATION (include symptoms, length of time patient has been experiencing symptoms, tests performed and results, pertinent family history and any other pertinent information)

Permedion's website also offers detailed information on the Ohio Medicaid Precertification Program, including the Precertification Manual and information on the procedures requiring precertification. For more information, please call the Ohio Medicaid Precertification Center at 1-800-772-2179.

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