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All That Wheezes Is Not Asthma

by David Sand, MD, MBA, FACS
Corporate Medical Director, Permedion

These words spoken by Chevelier Jackson, the father of modern bronchoesophagology, ring as true today as they did nearly a century ago. As we focus in this issue on Pediatric Asthma, it is important to reflect on the old adage: "When you're in Texas and you hear hoof beats, don't think of zebras!" Well, depending on the age of your patient, there *are* some additional fairly common diagnoses to consider.

In the newborn and infant age group, some of the most common causes of airway noise are gastroesophageal reflux disease, laryngomalacia, tracheomalacia, vocal cord paralysis, and airway compression from congenitally aberrant great vessels. Other less common causes include laryngeal clefts and tracheoesophageal fistula. While it may seem the differentiation between small and large airway noise should be easily made, in real-life with a tachypneic infant and frantic parents it's often more difficult than you would think!

In fact, in many cases of upper airway obstruction there may be reactive lower airway abnormalities as well. The history will be your greatest ally in these cases. Some questions to consider: does the airway noise occur with or after feeding?; only in certain positions?; constantly or only when the child is upset?; has it been present since birth?; is the cry normal, husky, or breathy?

As with many of the differential diagnoses presented in this article, the ability to make the

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Pediatric Asthma Study Shows Room for Improvement

Asthma is one of the most common chronic diseases of childhood. An estimated 4 million children under 18 years old in the United States have had an asthma attack in the past 12 months, and many others have "hidden" or undiagnosed asthma. Asthma is the most common cause of school absenteeism due to chronic disease. Even though asthma cannot be cured, it can almost always be controlled. For this reason, the American Lung Association and the National Heart, Lung, and Blood Institute have chosen childhood asthma as one of their top priorities. The better asthma and its treatment are understood, the better it can be controlled.

In collaboration with the Ohio Department of Job and Family Services (ODJFS), Permedion developed and coordinated the *Pediatric Asthma Study* to determine if Ohio Medicaid pediatric recipients with asthma are receiving treatment according to the National Asthma Education and Prevention Program (NAEPP). The recipients were stratified according to the geographic location in which they lived. Recipients residing in one of the 13 counties where the Enhanced Care Management program was available were designated the ECM eligible group and all remaining were designated the



non-ECM eligible group.

These comparison statistics enable healthcare providers to recognize good performance and potential problems. Providers can use this information to develop benchmarks to improve performance monitoring and service to Medicaid pediatric consumers.

The eligible population included non-institutionalized Ohio Medicaid patients, 20 years old and younger, who had a physician claim for a visit between July 1, 2002 and June 30, 2003 with a primary diagnosis of asthma. A random sample of 560 visits was selected from this population. Of the 560 records requested, 446 were produced for study analysis.

The average age for recipients in ECM counties was 11 years old; non-ECM 10 years old. Males represented 73% of the ECM sample and 62% of the non-ECM sample. The ECM sample contained 66% African American and 33% Caucasian recipients. The non-ECM sample contained 73% Caucasian and 27% African American recipients.

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MAJOR FINDINGS

Twelve quality indicators provided the focus of this study. The table summarizes the results.

The study showed that 72% of the patients in ECM counties used asthma medications, compared to 67% in the non-ECM counties. The ECM population had significantly lower rates of asthma medication use compared to the Agency for Healthcare Research and Quality statistics of 87%, which included both children and adults.

Patients in ECM counties had an asthma-related hospitalization rate of 66 per 1,000 children, which was significantly higher than the 37 per 1,000 hospitalization rate in non-ECM counties. Nationwide, hospital rates for people (children and adults) with persistent asthma are 38 per 1,000.

Patients in ECM counties had an asthma-related emergency department (ED) visit rate of 290 per 1,000 children,

Results Summary	ECM	Non-ECM
Diagnosis of asthma	1,761	816
Use of appropriate medications	72%	67%
Hospitalizations	66 ¹	37 ¹
Emergency department visits	290 ¹	154 ¹
Influenza vaccine	23%	20%
Lung assessment	97%	95%
Pulmonary function testing	26%	15%
Claim data accuracy	88%	88%
Patient education	71%	61%
Treatment plan	94%	96%
Maintenance episodes	51 ²	48 ²
Flare-ups	15 ²	10 ²

1. per 1,000 people per year
2. per 1,000 members per month

which was significantly higher than the 154 per 1,000 visit rate in non-ECM counties. Nationwide, ED visit rates for children (0 to 18 years old) with persistent

asthma are 173 per 1,000.

Twenty-three percent of the patients in ECM counties and 20% in non-ECM counties received an influenza vaccination within a year of the selected visit. Nationally, about one-third of asthmatic patients receive a flu shot.

Medical records revealed that the lung assessment rate was slightly higher for the ECM group (97%) compared to the non-ECM group (96%). However, only 26% of the patients in ECM counties had a PEF or FEV1 within the study period, with 15% of patients in non-ECM counties having one of these tests.

This study found that 71% of the patients and/or parents in ECM counties and 61% in the non-ECM counties had asthma education documented in their medical records. Education was defined fairly liberally and included such things as

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CODING CORNER Pediatric Asthma

In this issue of the Coding Corner, we provide information on the causes and risk factors of **Pediatric Asthma**. The ICD-9-CM code assignment range for asthma is (493.00 - 493.92).

Definition – Asthma is a chronic condition involving lungs in which narrowing of the passages from the lungs to the nose and mouth leads to difficulty breathing. These changes commonly occur in response to changes in the environment including weather, allergens (such as dog or cat dander, mold, or dust), foods, or respiratory infections (i.e., colds).

Causes and Risk Factors – Asthma is a disease of the respiratory system. It is commonly found in children, although it can also occur in adults.

Among children, asthma is a leading cause of hospitalization, chronic disease, and school absenteeism. In recent years, there has been a worldwide increase in the number of children with asthma. This trend has been linked to environmental factors, including air pollution.

Children with asthma may be able to breathe normally most of the time. When they encounter a trigger, however, an attack can occur. Common asthma triggers include tobacco smoke, dust, pollen, exercise, viral infections, animal hair/dander, mold, and changes in the weather.

Signs and Symptoms – The child with asthma may need to use the muscles around the chest to help with

breathing. Wheezing and coughing are also important signs that can occur during an attack, or even when a child is feeling well. A persistent nighttime cough is one common sign of asthma, even in children without symptoms.

Prevention – There is no foolproof method to prevent asthma attacks. The best way to minimize the number of attacks is to follow the asthma plan that you develop with your doctor and to eliminate triggers (especially cigarette smoke). When families take control of their home environment, asthma symptoms and exacerbations can be significantly decreased.

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Ohio Medicaid Hospital Billing Update

Important changes are being made to the Ohio Medicaid Hospital Billing Instructions for hospital claims with dates of service on or after October 1, 2005. Changes have been made in accordance with the National Uniform Billing (NUBC) guidelines. A summary of the changes follows:

Type of Admission Code

Valid values for hospital claims are '1' through '5'. Values '6' through '8' will no longer be valid. Ohio Medicaid will no longer require Type of Admission '3' to be used on claims for services requiring precertification, or Type of Admission '2' on claims excluded from precertification. Type of Admission '2' and '3' should be used in accordance with NUBC guidelines to indicate Urgent and Elective admissions, respectively. For claims for services requiring precertification providers must continue to enter the precertification number in the Treatment Authorization field. Condition Code 'AN' should be used to report claims excluded from precertification when the services would otherwise require precertification.

Source of Admission Code

Valid values for Ohio Medicaid hospital claims are '1' through '8', and 'A'. Source of Admission '4' should be used to indicate a transfer from a hospital (both DRG ad DRG exempt). Source of Admission '6' should be used to indicate a transfer from another health care facility (other than a hospital or SNF). Source of Admission 'A' may be used to indicate a transfer from a Critical Access Hospital.

Patient Status Codes

Valid values for hospital claims are '01' - '09', '20', '30', '43', '50', '51', and '61' - '66'. Patient Status code '09' is valid only for outpatient claims. Patient Status code '62' should only be used when transferring to a free-standing rehabilitation hospital.

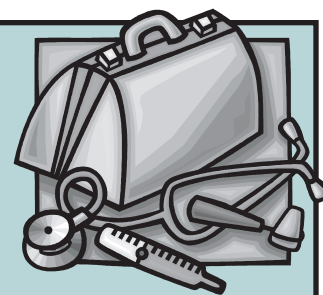
Medicare Part A Changes

Reimbursement for Medicare cost sharing for inpatient services will be limited to the lesser of (1) the sum of the coinsurance, deductible, and co-payment, or (2) the amount Medicaid would reimburse for the services (Medicaid maximum allowed amount) minus all prior payments. Due to the policy change for inpatient Medicare crossovers, hospitals will now be required to report all prior payments, including Medicare payments, on all inpatient crossover claims submitted directly to Ohio Medicaid.

Please refer to the Ohio Health Plans' provider Web site for updates to the Ohio Administrative Code rules, HHTLs, billing instructions, and EDI Companion Guides as they become available. These can be found at: <http://jfs.ohio.gov/ohp/provider.stm>.

Please direct any questions on information contained in this article to the Bureau of Health Plan Policy, Hospital Program Unit, at (614) 466-6420.

Medical Director dialogue



Permedion is pleased to announce the appointment of David J. Sand, MD, MBA, FACS as its new Corporate Medical Director. Dr. Sand is no stranger to the Permedion family and has been an independent medical reviewer for many years.

Born and raised in the Philadelphia, Pennsylvania area, he received his ScB and MD degrees from Brown University. He returned to Philadelphia for a 6-year residency in Otolaryngology, and continued in solo private practice for the next 12 years, first in Princeton, New Jersey and then in Newark, Ohio. While in practice, he participated in his Academy's Domestic Violence project as one of only about 100 surgeons in the country providing services free of charge to the victims of domestic violence.

Dr. Sand left private practice in Ohio to become Medical Director for Hearing Healthcare Management, Inc. and designed and implemented their first Quality Assurance program, as well as their HIPAA and OSHA compliance programs. During this time, he earned his MBA in Health Care with honors at Regis University in Denver, Colorado, and continued his involvement in patient care in his otology practice on the western slope of the Colorado Rockies.

With a desire to improve the quality of care for populations rather than just one patient at a time, Dr. Sand enthusiastically supports the goals of ODJFS and Permedion. Dr. Sand is a Diplomate of the American Board of Otolaryngology, Fellow of the American College of Surgeons, Fellow of the American Academy of Otolaryngology – Head and Neck Surgery; and a Fellow of the American Academy of Facial Plastic and Reconstructive Surgery. Feel free to contact him by phone at 1-800-473-0802, ext. 3354 or via e-mail at dsand@permedion.com.

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discussion, pamphlets, and demonstrations. As such, this rate seems low considering the importance education plays in managing the disease.

RECOMMENDATIONS

The findings of this baseline study of the quality of care received by the Ohio Medicaid pediatric eligible population with asthma support the following recommendations:

- ♦ Educate providers to give greater emphasis to identifying asthma cases among boys 1-17, women 18-20, and all minorities
- ♦ Encourage providers to prescribe asthma medications to their patients in compliance with NAEPP guidelines
- ♦ Educate providers about the safety of giving the influenza vaccine to asthmatics
- ♦ Encourage providers to perform regular pulmonary function testing
- ♦ Emphasize patient education, develop easy-to-understand materials, and make them available in other languages for non-native English speakers

For more information about this study or to request a copy of the report, please contact Sue Hackett, Permedion's Quality Assessment Service Line Manager, at 1-800-473-0802, Ext. 3374.

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Example

A 10-year-old female patient is seen in the Emergency Room experiencing acute shortness of breath while playing soccer. The patient is a known asthmatic. The physician's diagnosis is asthma.

Code assignment: asthma, unspecified (493.90).

Remember, if the documentation in the medical record is unclear, the coder needs to discuss the diagnosis with the attending physician to ensure proper coding and billing are submitted.

All that wheezes *continued from p. 1*

definitive diagnosis is often only possible in the operating room with rigid ventilating bronchoscopes and telescopes, or radiographically with contrast enhanced studies.

In patients who have been intubated, the possibility of laryngeal or subglottic stenosis should be considered. Force yourself to consider this possibility in patients who have been previously intubated for their asthma. Infants and toddlers are incredibly adaptive – I have seen patients with airways of only 1 or 2 mm in diameter who were able to compensate until they got an upper respiratory infection!

Finally, we all know that children reach a stage where everything they can get their hands on goes in their mouth! Airway foreign bodies take many forms and can lodge in either the upper or lower airways. Patients may present acutely with relentless coughing and respiratory distress, or the aspiration may have been distant and the only complaint may be fever and a slight but persistent cough. The chest exam may be relatively quiet or you may hear "classic" wheezing. The radiographic appearance may be quite variable as well. You may or may not see the object. You may see air-trapping from a ball-valve type foreign body with mediastinal displacement to the side opposite the foreign body, or you may see volume loss and consolidation with a shift toward the side of the foreign body.

So, if your patient doesn't respond to appropriate therapy in the manner you would expect, or returns to the ER time and again with the same symptoms, it may be time to think of other causes of those "hoof beats." REMEMBER: your patient may indeed have asthma AND another problem.

CONTACT INFORMATION

Permedion • Sue Hackett, Project Manager
 • 350 Worthington Rd., Suite H • Westerville, OH 43082 • 614/895-9900 • fax 614/895-6784
 • www.permedion.com • shackett@permedion.com

Ohio Department of Job and Family Services – Office of Ohio Health Plans
 • Debbie Clement, Contract Administrator • 30 E. Broad St. • 27th Floor • Columbus, OH 43215
 • 614/466-6420 • fax 614/466-2908 • www.jfs.ohio.gov

350 Worthington Rd., Ste. H
 Westerville, OH 43082

