

## Comparing Medicaid Developmental Disabilities Facility and Waiver Programs

As a part of Medicaid's Ohio Institutional Quality and Utilization Management Program, Permedion performs studies to evaluate the quality of care received by Medicaid recipients. These quality improvement studies include evaluations that encompass quality of services delivered, access to care, regulatory impact on care, and recommended changes to delivery systems.

In January 2007, Ohio was one of 31 states and the fourth-largest grantee of the Money Follows the Person Demonstration enacted by Congress as part of the Federal Deficit Reduction Act of 2005. The Office of Ohio Health Plans in conjunction with the "Front Door Stakeholder Group" is working towards a system of long-term care that maximizes choice and promotes community integration. The objective is to expand Ohio's capacity to serve Medicaid consumers with long-term service and support needs in the community.

Ohio Medicaid's current long-term care system is progressing toward greater flexibility in choosing long-term care options. Identification of long-term care needs and the preferences of consumers and family members for non-institutional care could provide important information to help prevent or delay nursing facility placement.

The current study, **The Intermediate Care Facility for the Persons with Mental Retardation (ICFMR) and Waiver Functional Assessment Study**, will provide information on consumers residing in ICFMR facilities and Developmental Centers, or enrolled in the Individual Options, Level One or Transitions

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## Utilization Trends of Medicaid MRI Use

Ohio Medicaid FFS programs spent approximately \$38 million annually on MRI procedures in 2006 and 2007. The overall cost for FFS claims held relatively steady most likely because there had been a transfer of a large proportion of enrollees to managed care plans. However, utilization rates have increased from 77 procedures per 1,000 enrollees in 2006 to 129 in 2007. Again, this trend may be affected by the overall shift from FFS to managed care plans.

As part of the Ohio Department of Job and Family Services interest in understanding utilization patterns for MRI services, this two-step study focused on the medical necessity of the MRI scans performed during calendar year (CY) 2007 and provided information on patients receiving MRIs, the type of practitioners ordering the scans, indications, results, and medical necessity.

Both study steps included MRI procedures performed from July 1, 2007 through December 31, 2007 in an outpatient setting (other than an emergency room). MRI procedures were eligible for inclusion in the sample if a claim for a less intensive diagnostic study, such as an x-ray, CT scan, or ultrasound, was not identified in the six months prior to the MRI. During the six-month study period, there were 30,873 claims for outpatient MRIs, 27,946 of which were eligible for inclusion in the study. The eligible facility cost to Medicaid for these procedures was \$14.5 million. A simple random sample of 480 cases from these qualifying MRI visits was selected for the first step. The second step included physician documentation review of the same 480 case sample.

The first step of the study included review of the MRI records from the provider facilities and identification of the ordering physician. Step 2 of the study included review of the ordering physician's documentation. Both steps required record review of the MRIs for clinical indications as used in Milliman Care Guidelines (2008), evidence-based clinical guidelines that support best practice in imaging and results.



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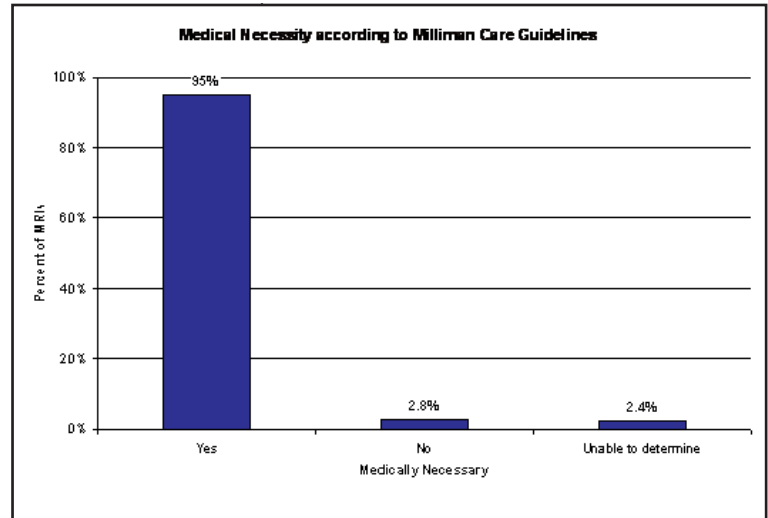
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The average age of the MRI recipients of the study population was 38 years old. Two-thirds were female. This was consistent with the gender distribution of the overall Medicaid fee-for-service population, which is approximately 61% female. Additional demographics are as follows: 76% of services recipients were white, 20% - black, and 2% - Hispanic and other races. The sample population had 65% of recipients in the Aged, Blind, Disabled (ABD) aid program and 27% in the Covered Families and Children (CFC) program. The overall population had a different proportion of aid programs: 43% in the ABD program and 50% in the CFC program. It should be noted that the sample had only recipients without a Medicaid claim for a less intensive diagnostic imaging test within the six months prior to their MRI.

Three quarters of the MRIs were performed as an outpatient in a hospital

versus an imaging center or physician's office. The overwhelming majority of visits included only one MRI. The average number of MRIs per visit was 1.2. The number of MRIs per recipient in the sample ranged from 1 to 4. Approximately 60% of those cases with more than one MRI were for contiguous areas of the spine i.e., lumbar, neck, and chest spines. Neurology/Neurosurgery was the most common ordering physician specialty followed by Family Practice and Internal Medicine specialties.

Of the 505 MRI procedures, 95% were found to be medically necessary according



to the Milliman Care Guidelines, while 3% were not. Medical necessity could not be determined for 2% of the procedures because of lack of documentation. According to the America's Health Insurance Plans (AHIP), 2008, there are studies that show a range of 20% - 50% of high-tech diagnostic imaging fail to provide information that

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## CODING CORNER

# Magnetic Resonance Imaging

In this issue of the Coding Corner, we would like to follow-up on the article "Utilization Trends of Medicaid MRI Use." As a result of this study, we would like to provide some information about the advantages, disadvantages, and risks, of an MRI.

### ADVANTAGES

MRI scanning is one of the safest imaging techniques available. MRI scans can be used to produce images of almost any part of the body and can produce images from all angles. They are especially useful for showing structures made of soft tissue, such as ligaments and cartilage, and organs such as the brain, heart, and eyes. MRI scans have specific advantages over x-rays, as they can:

- provide greater detail when looking at soft tissue
- show the difference between various types of tissue
- show swelling and inflammation
- show the condition of blood vessels and blood flow
- show both three-dimensional and cross-section images on the body

### DISADVANTAGES

There are some disadvantages to getting an MRI:

- the patient needs to remain motionless from 15-30 minutes, up to 1 hour
- scanners are very noisy, you will be given headphones to block out

the noise

- for some people, they may feel claustrophobic
- scanners are affected by movement, so you cannot move

### RISKS

An MRI is considered a very safe procedure. Although the magnetic field created by an MRI scanner can cause certain types of metal within the body to move, everyone having a MRI scan is taken through a detailed checklist before their scan to make sure that it is safe for them to have one. Apart from the effect on metal within the body, there are no known negative effects of being exposed

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improves patient diagnosis and treatment and may be considered redundant or unnecessary. Additional literature by Stein (2003) and Picano (2004) suggests that one-third of imaging procedures may be inappropriate. Managed Healthcare Executive (2008) stated that WellPoint, a managed care plan in Indianapolis, targeted physician offices' imaging services and realized a denial rate of 2% which appears to be more in line with this study's findings. However, any comparison with these studies and this current Ohio Medicaid fee-for-service study should be made with caution. The 2007 study period for the current study was during the transfer of the CFC aid groups to the Medicaid managed care programs. ABD recipients who are generally known to be less healthy and may be more likely to need high technological radiology made up 65% of the study sample.

Edlin's article in the Managed Healthcare Executive (2008) indicates that there is increasing growth of providing imaging services in physician offices. The physicians receive payment for the technical and professional components of the service. Edlin fears that this trend may lead to referrals by physicians to facilities in which they have a financial interest. However, the Ohio Medicaid MRI Study revealed that only 0.4% of the ordering physicians were diagnostic radiologists. Diagnostic radiology physicians are most likely to receive payment for the technical and professional components of MRIs. As previously mentioned, less than 25% of the MRIs were performed in an imaging center. Given these factors, and the current Ohio Medicaid fee-for-service population and pricing structure for MRIs, it is very unlikely that financial incentive is a reason for any overutilization.

However, it would be reasonable to perform another focused study to determine which specific types of MRIs were most likely to be medically unnecessary and if cost effective, target them for precertification review. Review of the MRIs should be centered on medical necessity using Milliman guidelines and appropriate physician documentation. This additional information would assist in providing more details and opportunities for education regarding utilization of MRIs for the Ohio Medicaid FFS population.

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to the magnetic field and radio waves of an MRI scan. Some MRI scans require the injection of a special dye into the body. Allergic reactions to this dye are possible, but rare, and can usually be treated immediately.

In summary, MRI scans are usually performed as an outpatient procedure, with no overnight stay in the hospital. Once the scan is over, most people can resume their normal activities immediately. To appropriately assign the CPT procedure code for the specific area of the body, please refer to the following code (s) ranges (70336, 70540, 70551-70553, 71550, 72141,-72158, 72196, 73220, 73221, 73720, 73723, 74181, 75557-75564, 77058-77059, 77084) for magnetic resonance imaging (MRI).

## Medical Director dialogue



By Anthony J. Beisler, MD, MBA, FACS  
Assistant Medical Director, Permedion

### Continuity of Care

Of all the quality issues that can occur during the course of medical care, one of the most common is a failure to maintain the continuity of care. It doesn't seem that relaying patient diagnostic information and treatment plans should be so difficult, but in reality, continuity of care issues are quite complex.

Patients in our system now receive care from multiple sources and may see several doctors at any given time. The goal is for all involved in a patient's care to communicate and collaborate in order to achieve high quality care. Many have forgotten that the HIPAA legislation protected communication between providers. In fact, during the comment period before the final rule, changes were made to the privacy provisions to permit the communication of protected health information between providers – particularly when a consultant had not yet seen the patient and was not officially one of the patient's providers. The third party organization provisions were also put in place to enhance quality, and improve communication and utilization.

Indeed, the most important link in the continuity of care chain is the documentation. It is the vessel which carries information between providers. Record continuity should be the cornerstone of any continuity effort. Having the right information in the right hands at the right time is the very essence of continuity of care.

So what can we do to enhance communication and improve quality of care? The current thinking is that electronic health records may be the answer. I believe utilizing electronic health record technologies is only part of the solution. Physicians need to engage the patient as an active participant in the transitioning of care to

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MRDD Home and Community-based Services (HCBS) waivers. The study will evaluate levels of care criteria and long-term care placement needs. It will review patient characteristics and levels of care and access current long-term care services. The study describes how characteristics of placement and service needs vary among consumers in each of the five programs.

Provider participation in supplying the requested patient information is essential to the success of the study. When completed, the summaries of the results will be published in the newsletter and the full reports will be available on our Website [www.hmspermedion.com](http://www.hmspermedion.com).

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the extent that it is possible and the physician assuming care needs to be proactive in assuring that relevant documentation is received in a time appropriate fashion. When appropriate, disease specific interdisciplinary teams, whether formal or informal, need to be utilized to form a consensus plan of care to ensure that all issues are addressed and that treatments or diagnostics are not needlessly duplicated. And finally, case managers might be utilized as a sort-of "central hub" which could manage the flow of information. They would be in a unique position to receive information and then distribute it to the next entity in the course of care.

Medical care is only going to get more specialized as the body of medical knowledge grows. The healthcare system needs to be cognizant of quality issues surrounding continuity of care and take steps to improve it. Any reform in the healthcare system would be wise to address this basic issue. Lastly, we, as clinicians, need to do our part to actively engage the patients, so that they might act as their own continuity of care quality assurance tool. After all, aren't doctors and patients supposed to work together?

**Obtain Precertification at HMSPermedion.com**

Permedion is the designated utilization review entity for Ohio Medicaid's precertification program. The current list of procedures requiring precertification includes elective inpatient and outpatient surgical procedures and can be found on Permedion's web site ([www.hmspermedion.com](http://www.hmspermedion.com)).

Permedion has offered providers the option of initiating precertification requests via confidential secure Web site access since January 30, 2006. Recent reports show that only 5% of Medicaid providers are using this option. **We encourage everyone to give it a try!** Providers can expect the same excellent customer service that they receive through the traditional request methods **while improving their internal efficiency and accuracy.**

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| Log onto <a href="http://www.hmspermedion.com">www.hmspermedion.com</a> and click on the link for <b>Ohio Medicaid</b> which can be found on the left side of the page. This brings the user to the Ohio Medicaid page. |
| Locate and select the " <b>Precert Registration</b> " link (upper right corner, yellow box) which takes you to the <b>Precertification Registration Form</b> .  |
| Complete the <b>Precertification Registration Form</b> with required information.   |
| Once registration is complete, Permedion will send the user name and password via e-mail within one business day.   |

Once you receive the user name and password, the user can easily go to the secure site to provide the needed information for precertification by completing the electronic form. The Permedion Precertification staff will review the request and call if additional information is needed and/or fax an approval letter.

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