Ohio Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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The Quest for Medical Records

In addition to the monthly post payment medical record request, Permedion recently completed two quality improvement studies that required an extra 3000 records for review and data collection. Because some of the records were requested from hospitals and some from physician offices, we received questions regarding two issues.

The first issue is always the HIPAA Privacy Rule and state laws that guard the rights of the patient's protected health information (PHI). As mentioned in last quarter's Quality Monitor (Volume 14, No 2), the patient's permission is not needed because Permedion is a "business associate" of ODJFS, the "covered entity". Permedion performs activities that involve the use of PHI on behalf of ODJFS and maintains a contract with ODJFS that describes the required uses of all requested PHI.

The second issue is the provider's costs associated with copying the requested medical records. Permedion always encourages the providers to provide the records electronically whenever possible to decrease the expenses.

Some providers are concerned with the fact that they are not reimbursed for copies of Medicaid medical records requested by Permedion. These providers will occasionally send bills to Permedion. On receipt of the bill, Permedion sends a letter to the provider indicating that there is **no reimbursement for the copy of the medical record.** This information is based on Ohio Administrative Code (OAC) 5101:3-1-27. The rule states "All records, documentation and/or information requested in accordance with paragraph (B) of this rule shall be submitted to the department or its' designee, in an appropriate manner as determined by the department. Records subject to audit and review must be produced at no cost to the department". The OAC rule also provides definitions that apply such as Audit, Hold and Review, and Review.

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The Expansion of the POA Indicator

Medical conditions that a patient acquires while hospitalized add enormous costs to medical care and result in significant number of deaths (CMS, 2006, 2008, 2011). In an effort to address the costs and quality issues, CMS introduced an initiative to curtail payments to hospitals for specific conditions that a patient acquires while hospitalized. CMS titled the provision "Hospital-Acquired Conditions (HACs) and Present on Admission (POA) Indicator Reporting.

As of October 2007, Inpatient Prospective Payment System (IPPS) hospitals are required to submit POA information on diagnoses for Medicare patient discharges (CMS, 2006). Although not mandatory, at that time, state Medicaid agencies were given the authority to similarly deny payment for certain HACs.

However, in June 2011, CMS issued the final rule on the Medicaid Payment Adjustment for HACs and POA Indicator Reporting. CMS indicated that by July 2012, under the Preventable Provider Acquired Conditions (PPC) Rule, all states must deny payments in any inpatient hospital setting in their Medicaid programs (Medicaid.gov).

The term "provider-preventable condition" is defined to encompass two categories:

1. Health Care Acquired Conditions (HCACs) apply to any inpatient hospital setting and are defined as the full list of Medicare HACs, with the exception of *Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement in pediatric and obstetric patients* (AHA Regulatory Advisory, 2011).

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****The Expansion (continued)*

The following is the list of current Medicaid HACs:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Stage III and IV pressure ulcers.
- Falls and trauma.

  Fractures, dislocations, intra-cranial injuries, crushing injuries, burns, electric shock.
- Manifestations of poor glycemic control.

  Diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity.
- Catheter-associated urinary tract infection (UTI).
- Vascular catheter-associated infection.
- Surgical site infection following: Coronary artery bypass graft (CABG)-Mediastinitis, Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery), orthopedic procedures (spine, neck, shoulder, elbow).
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE) (excluding pediatric and obstetric patients). Including total knee replacement, hip replacement.

2. Other Provider Preventable Conditions (OPPCs) apply broadly to Medicaid inpatient and outpatient settings, are defined to include, at a minimum, the three Medicare National Coverage Determinations (AHA Regulatory Advisory, 2011):

   - Surgery on the wrong patient
   - Wrong surgery on a patient
   - Wrong site surgery

The POA indicator is required for all Medicaid hospital admission claims. The POA is defined as present at the time the order for inpatient admission occurs. They include conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery. For each diagnosis on the claim form, there must be a POA value submitted.

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CODING CORNER

General Coding Guidelines for Reporting Neoplasms

This issue of the Coding Corner, includes a discussion of the guidelines for coding and reporting for the diagnoses of neoplasms.

To properly code a diagnosis of neoplasm it is necessary to determine from the medical record documentation whether the neoplasm is classified as benign, in-situ, malignant, or of uncertain histologic behavior. If the neoplasm is malignant, any secondary (metastatic sites) should also be determined if possible.

Coding Clinic Fourth Quarter 2008, pages 221 to 225, indicates the following guidelines in coding/reporting the diagnoses of neoplasm:

- If the treatment is directed at the malignancy, the coder needs to sequence the malignancy as the principal diagnosis. The only exception to this guideline is if the patient was admitted for chemotherapy/ immunotherapy/radiation therapy, the code (V58.X) is sequenced as the principal diagnosis with the diagnosis for which the service is being performed as a secondary diagnosis.
- When a patient is admitted because of a primary neoplasm with metastasis and the treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

EXAMPLES OF CODING AND SEQUENCING COMPLICATIONS OF NEOPLASMS:

- When a patient is admitted with anemia associated with malignancy and the treatment is for the anemia, assign the code (285.22), anemia in neoplastic disease as the principal diagnosis followed by the appropriate code for the malignancy as a secondary diagnosis.
- When a patient is admitted for anemia associated with chemotherapy and the treatment is only for the anemia, the anemia due to antineoplastic chemotherapy (285.3) is sequenced first followed by the code (E933.1) for the adverse effect of the chemotherapy drug with the appropriate code for the neoplasm as secondary diagnoses.
- When a patient is admitted for treatment of dehydration due to malignancy and the treatment is geared toward the dehydration (intravenous re-hydration), the code for dehydration (276.51) is sequenced as the principal diagnosis followed by the code for the malignancy as a secondary diagnosis.

If the admission is for control of pain related to, associated with, or due to the malignancy, assign code (338.3), neoplasm related pain as the principal diagnosis. The underlying neoplasm should be reported as an additional diagnosis. Since the neoplasm code will provide information regarding the specific site, an additional code for the site of the pain should not be assigned. As always, documentation by the provider is imperative to allow the coder to assign the appropriate diagnosis and procedure codes to the claim. If there is any question, the coder should always query the physician for clarification.

Medical Director *dialogue*

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

About a year and a half ago, I reported on the State Action on Avoidable Rehospitalizations (STAAR) initiative launched by the Institute for Healthcare Improvement (IHI). The aim of the STAAR initiative was to reduce rehospitalizations by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites and clinical interfaces.

The IHI partnered with five states, including Ohio, to provide strategic guidance, support and technical assistance to hospitals and cross-continuum teams to improve transitions in care and reduce avoidable rehospitalizations. As you may recall, the core concepts of the STAAR Initiative were focused on "the implementation of four key process-level improvements that require extensive collaboration between the hospitals and their community partners to effectively co-design better processes." The four processes were: **1) Perform an enhanced assessment of post-hospital needs; 2) Provide effective teaching and facilitate enhanced learning; 3) Provide real-time handover communications; 4) Ensure timely post-hospital care follow-up.**

The six keys to success were noted to be: 1) Focus on all re-admissions; 2) Form a cross-continuum team; 3) Start measuring all-cause 30-day readmission rate; 4) Determine baseline readmission rate and then track over time; 5) Focus first on improving current processes; 6) Stimulate the financial impact of reducing readmissions.

The Ohio Hospital Association (OHA) launched its STAAR participation in October 2010 with 18 individual hospitals participating (Unfortunately, some of those initial 18 have dropped out). As this effort has proceeded, significant results have been achieved.

The OHA has observed a reduction in both predicted readmissions and absolute readmissions at STAAR hospitals. For example, they note that for heart failure 30-day readmissions, STAAR hospitals had an 18.37% reduction in their readmission rate versus the rate at non-STAAR hospitals which reported a 5.61% reduction. This represents a significant step forward in the goal of reducing readmissions when one considers that Medicare data from July 2008 through the end of June 2011 showed that 24.7% of heart failure patients nationally were readmitted within 30 days of discharge. Several STAAR hospitals in Ohio were seeing on average a <7% readmission rate for heart failure patients – now that's real improvement.

Now that Medicare has begun financially penalizing hospitals with higher than expected rates of 30-day readmissions for select conditions, efforts such as STAAR take on a vital role in maintaining the bottom line of a healthcare organization. In order to better understand the impact of these penalties, the IHI has released an Issue Brief (Laderman M, Loehrer S, McCarthy D. STAAR Issue Brief: The Effect of Medicare Readmissions Penalties on Hospitals' Efforts to Reduce Readmissions: Perspectives from the Field. Cambridge, MA: Institute for Healthcare Improvement; February 2013) which synthesizes perspectives from

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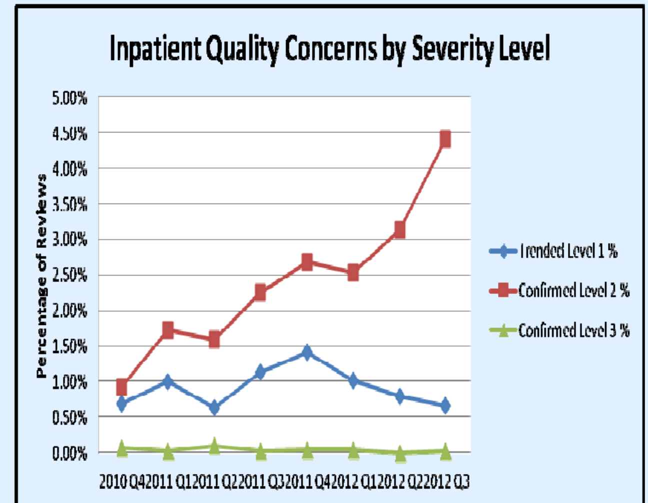
Quality of Care Report State Fiscal Year 2012 Quarter 3

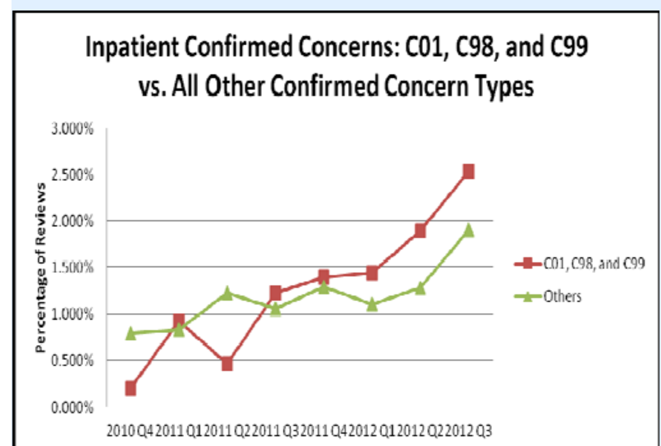
Inpatient confirmed concerns continue to increase steadily over the past two years, while trended concerns are decreasing to around two year lows.

Inpatient Quality Concerns by Severity Level



Through the 1st quarter of SFY 2012 the drivers of the increase in Level 2 concerns are C01 (Did not obtain pertinent history and/or findings from examination), C98 (Incomplete medical record), and C99 (Other quality concern not elsewhere classified). In the last two quarters, the increase in the C01-C98-C99 group versus that of the rest of the concern categories in aggregate has been proportional. The levels of these three concern types are now almost thirteen fold greater at the end of the analysis period than they were at the beginning, while all other confirmed concerns have no more than doubled.

Inpatient Confirmed Concerns: C01, C98 and C00 vs. All Other Confirmed Concern Types



Another way of looking at this increase is that in the fourth quarter of 2010 C01, C98, and C99 represented one in five of every confirmed concern. By the third quarter of 2012 they represent four of every seven.

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The Quest for Medical Records (cont.)

Because Permedion completes monthly post payment reviews, the majority of the medical record requests fall under the "Review" definition from OAC 5105:3-1-27.3. This is defined as "a post payment limited scope investigation, special project and/or special analysis, examination or monitoring of a Medicaid provider's records, claims and/or supporting documentation to determine quality of care, compliance with accepted standards of care, program compliance and/or validity of services rendered, billed, or paid for under the medical program".

Quality of Care (cont.)

The table of all inpatient quality concerns is shown below:

Inpatient Quality Concerns

Quarter	Reviews	Trended Level 1	Confirmed Level 2	Confirmed Level 3	Trended Level 1%	Confirmed Level 2%	Confirmed Level 3%
2010 Q4	3,015	21	28	2	0.70%	0.93%	0.066%
2011 Q1	3,015	30	52	1	1.00%	1.72%	0.033%
2011 Q2	3,015	19	48	3	0.63%	1.59%	0.100%
2011 Q3	3,015	34	68	1	1.13%	2.26%	0.033%
2011 Q4	2,978	42	80	1	1.41%	2.69%	0.034%
2012 Q1	2,958	30	75	1	1.01%	2.54%	0.034%
2012 Q2	3,000	24	94	0	0.80%	3.13%	0.000%
2012 Q3	3,000	20	132	1	0.67%	4.40%	0.033%
Total	**23,996**	**220**	**577**	**10**	**0.92%**	**2.40%**	**0.042%**

Medical Director (cont.)

leaders of state hospital associations, quality improvement organizations, and hospitals representing a range of performance and experiences in readmissions and their reduction. The brief notes that the penalties have positively influenced efforts in reducing readmissions and have improved care transitions between providers. Details about the penalties and their calculations are also reviewed.

Reducing readmissions is a goal that all aspects of healthcare need to be focused on. In order to do so, it requires a comprehensive approach with improvement in communications across providers and settings; engagement of patients and families and appropriate coordination between medical and social services – but it can be done. The STAAR Initiative is proving that very point, right here in the Buckeye state.

****The Expansion (continued)*

The following explanation of the POA codes is detailed as (DHHS, 2011):

INDICATOR	DESCRIPTION	MEDICARE PAYMENT
Y	Diagnosis was present at time of inpatient admission.	Payment made for condition by Medicare, when an HAC is not present
N	Diagnosis was not present at time of inpatient admission.	No payment made for condition by Medicare, when an HAC is present.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment made for condition by Medicare, when an HAC is present.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment made for condition by Medicare, when an HAC is present.
1	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1	Exempt from POA reporting

NOTE: The number "1" is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.

CMS is becoming increasingly more prescriptive through its payment policies regarding the quality of care delivered to its beneficiaries, hospital and all other healthcare providers (HCUP, 2011, Huron Healthcare, 2011). The benefits of the Medicaid PPC final rule are improved data for identifying patient safety events, increased quality of care, greater alignment of Medicare and Medicaid policies and more consistency in State non-payment policies and practices as they relate to designated PPCs/HCACs/ OPPCs.

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