Ohio Department of Job and Family Services

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Continued Transition to MITS

ODJFS implemented the new Medicaid Information Technology System (MITS) on Tuesday August 2, 2011. That is the date when all precertification and prior authorization (PA) requests must be submitted via the MITS web portal; paper requests are no longer accepted.

The new MITS system will fulfill the need for an information technology system capable of rapidly implementing state and federal Medicaid program changes and meeting today's business needs for Ohio Medicaid.

As with all changes in our ever evolving world, this transition has not been without some difficulties and has generated multiple questions from providers. In using this new system, training is of the utmost importance, so that everyone understands how to use it effectively and efficiently. Training opportunities have been offered and post-implementation training is available through November to help providers through the transition.

For the most current updates about provider training information, MITS functionality, frequently asked questions, past issues of MITS news, tools and enhancements, and other MITS related information, bookmark the MITS web site: **http://jfs.ohio.gov/mits/index.stm**.

For immediate assistance and troubleshooting questions please contact the Provider Help Line at 1-800-686-1516; this may include how to enter cases on the MITS system, how to register, or how to find the tutorials. Permedion staff members are not equipped to provide this service. When a provider does contact Permedion with these questions they will be redirected back to the Provider Help Line.

There have been some issues when trying to update pre-certifications and prior authorizations which were completed prior to July 22, 2011 and converted into the MITS system. The recommendation would be that the provider submits a new PA request in MITS. However, if there have been no updates to the request all six (6) digit prior authorization numbers issued after January 1, 2011 are valid in MITS.

Working together we can ensure that we are ready to handle the growing business operations needed to support the Ohio Medicaid program.

Hospital Peer Group Patterns Analysis

Hospitals have recently received their annual **2011 Pattern Analysis Monitor Report**. Permedion, an HMS company, produces this report for each hospital that submitted a Medicaid claim to the Ohio Department of Job and Family Services (ODJFS) during the past year. The report examines eight predetermined indicators calculated from the Medicaid claims data as well as comparative statistics for each hospital according to the hospital's peer group and the state averages. Each report covers the hospital's data for three state fiscal years (SFYs) and provides a three-year comparison. The current report covers SFYs 2008, 2009, and 2010.

Peer groups are defined in the Ohio Administrative Code Rule 5101:3-2-072 and include 14 categories such as Children's Hospitals, Rural Hospitals, Major Teaching Hospitals and others that are grouped according to MSA information. A total of 177 hospitals were included in this report. Active facilities that did not have any eligible inpatient claims during the reporting period were not included.

The results of the report identify providers that have indicators that are either (1) significantly above or below the overall results or (2) significantly above or below (three standard deviations) other providers in their peer group. Mental health, alcohol and drug addiction, transplant, and delivery and newborn claims are excluded from the analysis except for the Transfer Billing indicator. The number of admissions serves as the denominator for all percentages.

Over the three year period, overall admissions had an 11.5% increase in 2008, a 13.1% decrease in 2009 and a 3.1% decrease in 2010. The trend of rise and fall took place among nine of the 14 peer groups. In 2010, the largest gain was made by *MSA Toledo* (23.0%) and the largest loss was observed in *MSA Youngstown-Warren* (-54.8%).

The results of the eight key indicators that were analyzed from the claims data include:

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1) 0-1 Day Readmissions – readmissions to the same provider for any DRG within 0-1 day:

Statewide, the average percentage of 0-1 day readmissions remained stable (2008-0.2%; 2009-0.2%; 2010-0.2%). In 2010, the *Non-MSA <100 Beds* peer group had the highest percent (0.7%) and *Hamilton-Middletown & Lorain -Elyria* had the lowest (0.0%).

2) 2-7 Day Readmissions - readmissions to the same provider for any DRG within 2-7 days:

Statewide, there was a slight increase in the average percentage of 2-7 day readmissions (2008 – 4.9%; 2009-4.8%; 2010-5.2%). In 2010, *Teaching Hospitals* continued to have rates at least three standard deviations above the overall percentage (6.7%) and *MSA Cleveland* continued to have rates at least three standard deviations below the overall percentage (4.1%).

3) Admissions Due to Complications - admissions with a primary diagnosis of ICD-9 codes 996.xx, 997.xx or 999.xx):

The statewide rates remained somewhat stable for the three year period (2008-4.9%; 2009-4.8%; 2010-5.1%). In 2010, *Teaching Hospital* continued to have rates at least three standard deviations above the overall percentage (6.1%). *Non MSA <100 Beds* continued to have rates at least three standard deviations below the overall percentage (2.1%).

4) Transfers Out - discharges coded as transfers to other hospitals:

Statewide, transfer-out cases have slightly declined over the last three year period (2008-4.1%; 2009-4.0%; 2010-3.4%). *MSA Cleveland* had the highest rates for all three years (2010-12.4%). *Children's Hospital* peer group had the lowest percentage for all three years (2010-0.8%)

5) Transfer Billing - cases that may have either the admit source or the discharge status coded incorrectly:

Statewide, potential transfer billing errors have remained relatively constant over the last three years (2008-0.42%; 2009-0.45%, 2010-

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CODING CORNER

Appropriate Coding and Sequencing of Pregnancy Complications

In this issue of the Coding Corner, we would like to review the coding guidelines for the appropriate coding and sequencing of complications of pregnancy. **Faye Brown Coding Handbook for ICD-9-CM 2012,** indicates when conditions that affect the management of pregnancy, childbirth, and the puerperium are classified to categories 630 through 676 and 678 through 679 (found in Chapter 11 of ICD-9-CM). Conditions from other chapters of ICD-9-CM are usually reclassified in Chapter 11 when they complicate the obstetrical experience or are themselves aggravated by the pregnancy.

Codes from the following categories apply throughout the entire obstetrical experience, which begins at conception and ends six weeks after delivery:

- **Complications related mainly to pregnancy – 640-649**
- **Normal delivery and other indications for care in pregnancy, labor and delivery -650-659**
- **Complications occurring mainly during the course of labor and delivery – 660-669**
- **Complications of the puerperium – 678-679**
- **Other maternal and fetal complications – 678-679**

Coding Clinic Second Quarter 1990 pages 11-12 indicates "when a patient is admitted because of a condition that is either a complication of pregnancy or that is complicating the pregnancy, the code for the obstetric complication is the principal diagnosis. An additional code may be assigned as needed to provide specificity."

Example: A patient who was seven months pregnant with a diagnosis of Type I diabetes mellitus was admitted for regulation of insulin because of persistent elevated blood sugars. Code 648.03 is assigned as principal diagnosis. Also assign 250.91 for the diabetes out of control.

Any condition that occurs during pregnancy, childbirth, or the puerperium is considered to be a complication unless the attending physician specifically documents that it neither affects the pregnancy nor is affected by the pregnancy. As always, when coding a diagnosis and it is questionable, always refer to the attending for clarification as final coding is dependent upon physician documentation in the medical record.

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
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Where is the Quality in Health Care Reform?

The Patient-Centered Outcomes Research Institute (PCORI) is a non-profit, non-governmental agency which was created in 2010 by the Patient Protection and Affordable Care Act (PPACA) (501(c)1, pg 690) legislation. It will serve as an independent organization with its focus to be helping patients, clinicians, purchasers and policy makers in making better-informed health decisions. One of the main missions of PCORI will be to commission research that is "responsive to the values and interests of patients and will also focus on providing patients and their caregivers with a clearinghouse of reliable, evidence based information for the health care decisions and choices they must face when engaging the health care system." Of significant interest is that fact that PCORI will be required, by law, to receive public input and comment at each step in the process - an unprecedented step in the conduct of scientific research. Also of importance, PCORI is *not* a governmental agency; it is funded in part not only by tax dollars, but also by private health insurance dollars as well.

As an independent nonprofit organization, PCORI can operate at arm's length from government agencies and government policies. Indeed, none of its board members are affiliated with the government. Its 21 member board of governors includes multiple interests (patients, providers, manufacturers, payers and others) and includes several with expertise in the health and health care of minority groups and small patient populations; PCORI is positioned to become a trusted independent authority on comparative effectiveness research.

PCORI has adopted the following mission statement: "The Patient-Centered Outcomes Research Institute (PCORI) helps people make informed health care decisions – and improves health care delivery and outcomes – by producing and promoting high integrity, evidence-based information – that comes from research guided by patients, caregivers and the broader health care community."

The New England Healthcare Institute (NEHI) notes that a "thoughtful and aggressive" policy should be employed by PCORI to turn research findings into improved medical treatment. It goes to say that it "will be critical if the nation is going to get better value for its health care dollar." In overseeing comparative effectiveness research, PCORI should become a "highly visible champion" for disseminating

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0.42%). In 2010, *MSA Parkersburg-Marietta & Steubenville-Weirton* had the highest percentage (0.8%) and *Non-MSA >100 Beds* had the lowest (0.3%). However, none of the peer groups were outside of three standard deviations.

6) Cost Outliers - cases that have costs that are considerably more than the average costs of the assigned DRGs:

Statewide, cost outliers have been increasing over the three year period (2008-14.8%; 2009-15.9%; 2010-17.2%). In 2010, *MSA Toledo* had the highest percentage (27.9%) and *Non-MSA <100 Beds* had the lowest (1.7%).

7) Day Outliers – cases that have a length of stay (LOS) that is considerably longer than the assigned DRG's average LOS:

Statewide, day outliers have decreased over the three year period (2008-0.8%; 2009-0.8%; 2010-0.6%). In 2010, *MSA Canton and Mansfield* had the highest percentage (2.8%) and *Akron, Cincinnati, Dayton Springfield* peer group had the lowest (0.2%).

8) Significantly Short Lengths of Stay - cases that have a short length of stay with respect to the DRG lower trim point and/ or primary diagnosis:

Statewide, the significantly short lengths of stay have increased over the three year period (2008-1.8%; 2009-3.1%; 2010-3.7%). In 2010, *Non-MSA <100 Beds* had the highest percentage of cases with short LOSs (4.4%) and *MSA Youngstown-Warren* had the lowest percentage (2.1%).

These comparison statistics enable hospitals to recognize good performance and potential problems. Hospitals can use this information to develop benchmarks to improve performance monitoring and services to Medicaid consumers.

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that research, says the paper from NEHI. Also emphasized is the concept that an "expansive view" must be taken of dissemination. "New research findings rarely leap from a journal article straight into clinical practice," the paper says. "Intermediary groups," such as medical societies, "typically play an enormous role in translating medical evidence and taking a position on how it should be utilized in the form of medical guidelines," it adds. PCORI should build "diverse partnerships" to spread findings, including with national medical societies and patient groups.

To that end, 25 physician specialty groups have recently begun a dialogue with PCORI, urging it to "strategically target support for patient-centered outcomes research where it will significantly improve health care value by enhancing physician clinical judgment, foster the delivery of patient-centered care, and produce substantial benefit to the health care system as a whole." Research, focused in that manner, has the potential to make a profoundly positive impact upon the quality of the information available to physicians and patients alike and, when employed appropriately, may even help to address the ongoing problem of escalating health care costs.

Required Documentation for Outpatient Claims

Outpatient claims are now included in the Medicaid Fee-for-Service Utilization Review process. There have been some issues with the required documentation missing from outpatient records. Outpatient claims with missing documentation will be issued a Technical Denial. This denial is based on the lack of essential medical records that provide adequate documentation to complete the UR & Quality reviews. There is no appeal process for a Technical Denial.

To avoid a Technical Denial for outpatient claims, be sure to include **all** documentation that supports the **Billed Outpatient claim** including but not limited to:

- Medical Record
- Clinic Notes
- Dialysis records
- Laboratory /Diagnostic Reports
- History & Physical Examination
- Operating Room records
- Flow Sheets

If providers have difficulty determining what service documentation to include with the medical records submission, it is recommended they contact their billing department for information on the specific line items billed.

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