Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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HOSPITAL SELF REVIEWS

Many hospitals initiate a self review through their own internal quality assurance process. The goal of the self review should be to identify any overpayment issues that may have occurred in the past and to prevent future noncompliance.

After identifying an error that resulted in an overpayment, a letter should be sent to the Surveillance and Utilization Review Section (SURS) explaining how the hospital identified the potential overpayment, the time period of the review, what procedure codes are in question and why this resulted in an overpayment. The letter should also include how the analysis was completed, how the error rate was calculated (if applicable), the dollar amount of the universe of Medicaid claims that were affected, how you ensured the completeness of the population and the total amount of the overpayment. Additionally, include what action the hospital has taken to prevent these errors from reoccurring.

The Surveillance and Utilization Review Section requires the following information be included when submitting a self review:

Provider Information:

Name and Medicaid Number
Tax identification number(s)
Contact person and phone number

An Electronic copy of a spreadsheet listing the following claim information:

Recipient Name and Medicaid ID
TCN/Internal Control Number (ICN)
Date of Service
Amount Billed
Amount Paid
Type of Service (e.g. procedure codes)
Units Billed
Date the Claim was Paid
Overpayment Amount

All of the information should be sent to the following address;

Rachel Jones, Section Chief
Ohio Department of Job and Family Services
OFMS/BACS/SURS
30 E. Broad St. 38th Floor,
Columbus, OH 43215-3414

Self reviews are processed within the Surveillance and Utilization Review Section (SURS), the Ohio Department of Job and Family Services.

New International Classification of Diseases (ICD-10): What? Why? When? How?

The International Classification of Diseases (ICD) is a system developed between the World Health Organization (WHO) and 10 international centers for grouping together statistical comparability on medical terms reported by physicians, medical examiners, and coroners on death certificates. "Since 1900, the ICD has been modified about once every 10 years, except for the 20-year interval between the last two revisions, ICD-9 and ICD-10. Effective with deaths occurring in 1999, the United States replaced ICD-9, with ICD-10 for death certificates. Publications showing mortality data coded under ICD-10 will differ substantially from those under ICD-9 because of changes in coding rules, changes in category names, and ICD numbers." (WHO, 1992)

According to the National Center for Health Statistics (2000), the five main reasons to use ICD-10 code sets are:

- ICD-9 dates back to 1979 and its function has become exhausted.
- ICD-9 does not reflect the changing medical advancements;
- Some of the ICD9-CM are full and required putting codes in unrelated chapters;
- ICD-9 has insufficient detail.

ICD-9-CM is no longer supported by the World Health Organization. WHO states that: "In an age of electronic health records, it does not make sense to use a coding system that lacks specificity and does not lend itself well to updates… Emerging health care technologies, new and advanced terminologies, and the need for interoperability amid the increase in electronic health records (EHRs) and personal health records (PHRs) require a standard code set that is expandable and sufficiently detailed to accurately capture current and future health care information".

The Federal Register 49799-49800 indicates that as we become a global community, it is vital that our health care data represents current medical conditions and technologies, and that they are compatible with the international version of ICD-10. In addition to the need for precise diagnosis and procedure codes for payment purposes, precision in coding is critical to the national and international health care community for mortality reporting, bio-surveillance, treatment of patients, hospital management, and research (HIPPA, 2011)

The Final Rule released in the January 16, 2009 Federal Register announced an October 1, 2013 deadline for compliance with ICD-10-CM.

How Does This Affect The Medical Coders?

According to AHIMA, "for a successful transition to ICD-10, the challenges for the Coding Specialists is to:

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- Ensure they have sufficient foundational knowledge of the biomedical sciences.
- Learn how to correctly assign both ICD-10-CM and ICD-10-PCS codes.
- Understand how to apply maps and crosswalks between ICD-9-CM and the ICD-10 systems.

Healthcare organizations should begin to prioritize and implement the training of coding staff before the ICD-10 go-live date. Physicians and all clinical staff will also be undertaking an extensive overhaul in how they will need to document in the medical record. The coder will not be able to correctly assign a ICD-10 code to a claim if they do not have the proper information and distinct documentation from the physicians/clinical staff. This could slow the coding process down, which will impact the timeframe of processing/billing the claims. Also, it could lead to some very frustrated physicians who might not be as willing to answer multiple queries from the coders. There is no set standard written to date to alleviate this potential issue between physicians and coders.

Hospitals Should Have Already Taken These Steps To Prepare For ICD-10.

Form a team to prepare your hospital for ICD-10 from a variety of perspectives

- Assess your current resources
- Talk to software vendors about their plans for ICD-10 implementation
- Budget for major changes (i.e. IT and Billing Department)
- Talk to commercial payors on their progress towards ICD-10
- Begin training the coding staff on anatomy and physiology, changes in coding rules, and applying maps and crosswalks between ICD-9 and ICD-10 coding systems
- Inform physicians and clinical staff on changes to documentation processes
- Plan for coding processes to be significantly slower following implementation
- Plan to use raw data from ICD-10 codes to improve your hospital's processes

American Health Information Management Association reported that the transition to ICD-10-CM and ICD-10-PCS (ICD-10) represents much more that just an increase in codes and field sizes. The scope and complexity of the transition are significant and should not be underestimated. The ICD-10 transition will have a pervasive impact throughout the healthcare industry and will be a significant undertaking for providers, payers, system vendors, and other stakeholders, requiring organization-wide planning and preparation. Proper planning and preparation is critical so that organizations can leverage their ICD-10 investments and move beyond mere compliance to achieve strategic advantage. Organizations that start early can spread their resources across multiple years, rather than incurring a large budgetary investment at one time. As several of the preparation activities provide benefits to the organization before the October 1, 2013 implementation date, such as clinical documentation improvement strategies and advancing the knowledge and skills of the coding staff.

CODING CORNER

CLINICAL SIGNIFICANCE OF OBESITY

In this issue of the Coding Corner, we would like to discuss the clinical significance of obesity and the effects that this condition has on everyone's overall health.

The clinical definition of obesity is a body mass index (BMI) of 30 or higher. The BMI is the body's weight in kilograms divided by the square of the body's height in meters. Obesity results when a person ingests more calories than can be burned off. When this happens, the body will store the extra calories as fat.

Research indicates that obesity is a very serious health problem and that it can shorten life expectancy by at least nine years. Obesity can lead to many health complications, such as infertility, depression, stroke, and heart disease. Problems can occur when weight reaches the level of obesity such as, irregular breathing, sweating with the simplest tasks, irregular sleeping patterns, and persistent feeling of fatigue.

Obesity is usually caused by poor diet and lack of exercise, but there are some medical causes for this condition:

- Underactive thyroid or Cushing's disease.
- Certain medications, such as steroids, antidepressants, and contraceptive pill.
- Cessation of smoking.

It is possible to prevent obesity by following some rules regarding your health and lifestyle; for instance, it is recommended that staying physically active and eating a healthy diet are the most effective. Weight loss and getting in shape requires patience and hard work, but taking these preventive steps is the best way to avoid illnesses such as cardiovascular disease, diabetes, and certain cancers.

Coding and Reporting Obesity and Morbid Obesity

Faye Brown ICD-9-CM Coding Handbook indicates that the diagnosis codes for Obesity (278.00) and Morbid Obesity (278.01), are assigned only on the basis of the physician's diagnostic statement. The BMI code assignment should be based on medical record documentation, which may be found in the notes of other clinicians involved in the care of the patient (ex. dietitian or nurse). This is an exception to the guideline that requires that code assignment be based on the documentation by the physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Therefore, while BMI may be reported on the basis of another clinician's documentation, the codes for overweight and obesity should be based only on the provider's documentation.

Medical Director *dialogue*

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

Of the many topics in the current healthcare debate, there has been significant discussion surrounding the use of public report cards for the evaluation of individual physicians. Their use is purported to help foster a value-based system in which patients, providers, and other stakeholders may use comparable information to make better informed decisions and, thereby, serve as a catalyst for improvements.

Proponents of public reporting assert that it is associated with significant improvements in care. Data from the 2006 National Healthcare Quality Report, produced by the Agency for Healthcare Research and Quality, found that hospital measures of quality improved at a median annual rate of 7.8% when public reporting was utilized. Privately reported data does not result in similar gains. Clearly, transparency can be a powerful tool in data reporting of quality measures.

However, reporting on physician performance is more elusive as it is difficult to establish measures which are risk-adjusted, of adequate sample size, and truly reflective of physician performance versus overall team performance. Experience in public reporting to date has demonstrated 3 ways in which to improve scores: #1- Deliver better patient care, #2- Report more severe patient co-morbidities to skew risk-adjusted outcomes and #3- Transfer severely ill, high risk or non-compliant patients to another practice/facility. Obviously, the third method is the most concerning and, distressingly, has already been observed in several pilot projects.

What makes reporting such a powerful stimulus, for better or for worse, is its ability to threaten the reputation and livelihood of the entities being evaluated. While many benefits of reporting are touted, often physicians decry that outcomes measures aimed at individual providers are, at best, inaccurate and misleading. With this in mind, *Carolyn M. Clancy, an internist and the director of the* Agency for Healthcare Research and Quality, *proffers that in order to* get reporting right, physician leadership in the process is crucial. Toward this end she relates that, "Already, the nation's physician organizations have begun to lead the efforts in developing effective, fair physician performance measures and report cards. Moreover, they are collaborating with consumers, policymakers, insurers and others to ensure that report cards are used to improve care rather than to deny coverage."

Such reporting has now been in the public forum for the last decade and shows no signs of falling out of favor. In fact, recent surveys have found that a greater percentage of the public (currently 15-20%) is now using such reporting as a factor in their healthcare decision making. Additionally, pay-for-performance programs, tied to physician-level reporting, have been employed across the country; such programs have not only been utilized by CMS but also by private insurers as well. The ultimate goal is to add value by making it easier to provide the best care and focusing on what physicians believe to be in the best interest of their patients.

Current Quality Improvement Activity

As part of Medicaid's *Ohio Institutional Quality and Utilization Management Program*, Permedion performs studies, projects and focused reviews to evaluate the quality of care received by Medicaid recipients. These quality improvement activities include evaluations that encompass the quality of services received, access to care, regulatory impact on care, and recommended changes to delivery systems. The following activity is currently in progress:

Long Term Care Level of Care Assessment Study

Background | In January 2007, Ohio was one of 31 states and the fourth-largest grantee of the Money Follows the Person (MFP) Demonstration Project enacted by Congress as part of the Federal Deficit Reduction Act of 2005. The Office of Ohio Health Plans (OHP) within the Ohio Department of Job and Family Services (ODJFS) leads an inter-agency effort to meet the four objectives of the Demonstration Project as outlined below.

- Transition elderly people and persons with disabilities from institutional settings (e.g., nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MR) and hospitals) to home and community-based settings.
- Eliminate barriers, whether in State law, the State Medicaid Plan, the State budget, or otherwise, which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in settings of their choice.
- Ensure continued provision of home and community -based services to eligible individuals who choose to transition from an institution to the community.
- Ensure that procedures are in place to provide quality assurance and continuous quality improvement.

Additionally, Am. Sub. H.B. 119 created a Unified Long -Term Care System (ULTCS) Workgroup chaired by the Director of the Department of Aging (Parker, 1999). The workgroup, consisting of consumer advocates, providers, and state policymakers, was to recommend a new budgeting process that:

- Provides consumers with a choice of services that meet the consumers needs and improve the consumer's quality of life;
- Provides an array of services that meet the consumer's needs throughout life;
- Consolidates policymaking authority and the associated budgets for long-term services and supports in a single entity (promotes simplicity and

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flexibility); and

- Assures a system that is cost effective and links disparate services across agencies and jurisdictions.

The MFP Demonstration Project and the ULTCS Workgroup are complementary initiatives aimed at moving toward a system of long-term services and supports that maximizes choice and promotes community integration.

In May 2008, the "Front Door Stakeholder Group" was formed. This stakeholder group was formed as a component of Ohio's strategic goal to balance the long-term services and supports system (ODJFS, 2011). The group is modifying the entry into long-term services and supports by focusing attention on the functional criteria and operational processes that lead to consumer entrance.

OHP in conjunction with stakeholders is working toward a system of long-term care that maximizes choice and promotes community integration (ODJFS, 2011). For the past two years, OHP has been revising and reforming the current Medicaid level of care (LOC) determination system. A Medicaid LOC is required in order for Medicaid to pay for an individual's home and community-based waiver services (HCBS) or institutional stay. The current work has been in making short-term LOC process changes and clarifying the policy and procedures. The next phase of LOC is long-term system reform of the current, fragmented, paper LOC determination process.

Purpose | In order to complete the next step in the long-term system reform, OHP is looking at major changes that other states have made to their LOC determination system. Permedion will provide an environmental scan and research of ten states' LOC determination systems. The purpose of *The Long Term Care Level of Care State Assessment Study* is to provide information on various management strategies, techniques, and program features that the selected States have put in place to rebalance their Medicaid long-term care systems and determine levels of care. The states chosen are Indiana, Kentucky, Michigan, Minnesota, North Carolina, Oregon, Rhode Island, Washington, West Virginia, and Wisconsin.

Objectives | Although each state has different Medicaid rules and regulations, a number of provisions in the Affordable Care Act require states to have core standard assessment tools in place (Kaiser Family Foundation, 2011). Each state must determine the kinds of supports that are most suited to its needs and will be compatible with consumer needs and budgetary restraints. The outcome of this study will be to provide ideas and suggestions on the best way for Ohio to proceed with LOC system reform.

Where Do You Go for Help with MITS?

If you are a Medicaid provider who needs assistance with the MITS Web Portal or has complaints about MITS PA entry/submission issues and errors, or needs assistance with troubleshooting, please contact the Provider Call Center at 1-800-686-1516, option #3. Follow the additional prompts carefully and you will arrive at the MITS help desk with staff members who are trained to assist providers with any problems that you may experience. The PA staff members at Permedion are not able to assist with these questions and will redirect any providers experiencing MITS PA issues to this number.

You may also receive additional information at www.jfs.ohio.gov/mits - MITS Provider Training. Here you can view MITS Portal User Manuals designed to assist providers in navigating the web portal. These manuals include such features as descriptions of edit and audit related messages, table of values for data fields, and illustrations of the web portal panels for prior auth.

Contact Information

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