Ohio medicaid QUALITY MONITOR

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How Does the Privacy Rule Affect Communications Between Hospitals and ODJFS?

The Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) was enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule provides the first comprehensive Federal protection for the privacy of health information nationwide. The Rule is balanced to provide strong privacy without compromising patient access to, or the quality of, health care (U. S. Department of Health and Human Services, Office of Civil Rights, HIPAA Privacy, December 3, 2002). HIPAA privacy requirements must be implemented no later than April 14, 2003. The Privacy Rule permits hospitals and ODJFS to exchange protected health information (PHI) through the billing and payment of Medicaid claims and also through the utilization management activities and quality studies administered by Permedion.

In general, 45 CFR 164.506 permits a covered entity (e.g., ODJFS or a hospital) to release PHI, without an individual's authorization, for the purpose of treatment, payment, and health care operations. For example, a hospital exchanges PHI with ODJFS to get payment. This is allowed under the general rule — 45 CFR 164.506(a), — and no special exception is needed.

ODJFS contracts with Permedion to administer its institutional quality and hospital utilization management program. Duties assigned to Permedion, and its subcontractor National Health Services, include precertification, retrospective reviews, and quality studies. Under 45 CFR 164.506(c)(4) of the Privacy Rule, a provider may furnish an individual's PHI to another covered entity to enable that covered entity to conduct quality assessment or improvement activities and population-based activities related to improved health or reduced health care costs, as long as the receiving entity has a relationship with

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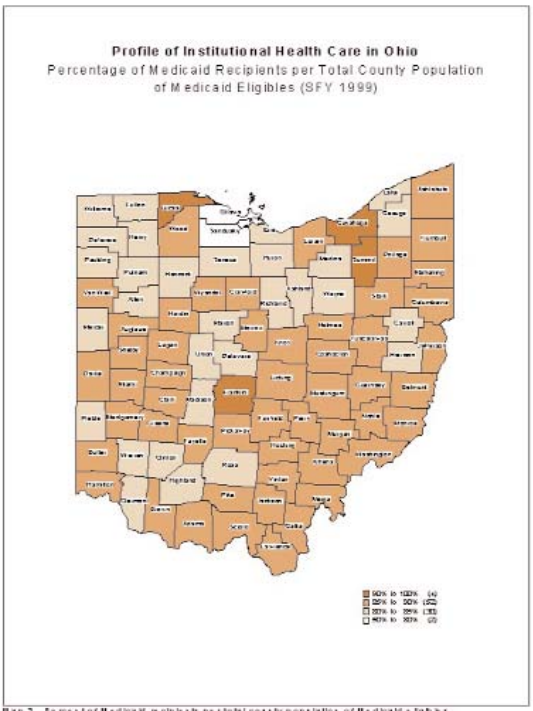
Mapping in Health Research Analysis

Mapping allows the reader to visualize and quickly comprehend large amounts of complex data. The many health research organizations that now include location, when appropriate, as a key component of interpreting research results often use mapping software to identify geographic areas with similar demographic, disease, or health services characteristics.

In April 2002, Permedion conducted the Ambulatory Care Project Phase Six Study as part of the Ohio Department of Job and Family Services Institutional Quality and Hospital Utilization Management Program. The Phase Six Study, also referred to as *Profile of Institutional Care in Ohio,* is a descriptive summary of Ohio's general and Medicaid population, cross-referenced with Ohio hospital and Medicaid managed care plan information. MapInfo software was used to plot the locations of Ohio hospitals on state, Metropolitan Statistical Areas, and county maps. In addition to showing location, the maps display icons that represent the number of beds, admissions, inpatient days, and outpatient visits per hospital. Map 3 (right) is one of the maps created for the study. This map, which shows the percentage of Medicaid recipients per total county population of Medicaid eligibles in FY 1999, allows the viewer to immediately identify the four counties with the highest percentages: Cuyahoga, Franklin, Lucas, and Summit. Permedion continues to look for opportunities to incorporate mapping into its analysis of health data. For example, the SFY 2003 Hospital Care Assurance Program (HCAP) quality study will examine patient care-seeking behavior by analyzing the number of patients who received care in their county of residence, an adjacent county, or a nonadjacent county.



Map 3. Percent of Medicaid recipients per total county population of Medicaid eligibles.

Surgical Procedures Requiring Precertification to Change

Effective June 1, 2003, ODJFS' policies governing elective surgical procedures requiring precertification will change. The policy change is based on analysis of claims data and precertification data for procedures performed during the past 12 months.

Hysterectomy procedures **performed electively,** will require precertification in both the **inpatient and outpatient settings:**

❒Hysterectomy
ICD9 codes 68.3, 68.4, 68.51, 68.59
CPT codes 51925, 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550, and58951

The following procedures will require precertification ONLY if performed in the **inpatient setting**:

❒Arthroplasty, arthrotomy, or arthroscopy, temporomandibular joint
ICD9 codes 76.5, 80.29, and 80.19
CPT codes 21010, 21050, 21060, 21070, 21240-21243, 29800, and 29804

❒Arthroscopy - knee
ICD9 code 80.26
CPT codes 29870, 29871, 29874-29877, and 29879 – 29889

❒ Cervical laminectomy
ICD9 code 81.02-81.03
CPT codes 22554, 22556, 22558, 22585, 22808, 22810, 22812, 22590, 22600, 22610, 22612,
22614, 22800, 22802, 22804, 22840, 22851, 63075, and 63076

❒Laparoscopic cholecystectomy
ICD9 codes 51.23, 51.24
CPT codes 47562 – 47564

❒ Laparoscopy – diagnostic
ICD9 code 54.21
CPT codes 49320 – 49323, 49329

❒Lumbar laminectomy - posterior
ICD9 codes 80.51 and 81.08
CPT codes 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22842, 22843,
22844 and 22851

❒ Percutaneous angioplasty - noncoronary vessel
ICD9 code 39.50
CPT codes 35470 - 35476

❒Peripheral vascular shunt or bypass
ICD9 code 39.29
CPT codes 33619, 34520, 35516, 35518, 35521, 35533, 35551, 35556, 35558, 35566, 35571,
35583, 35585, 35587, 35616, 35621, 35623, 35650, 35654, 35656, 35661, 35666, and 35671

❒ PTCA - coronary angioplasty
ICD9 code 36.01
CPT codes 92982, 92984, 92995 and 92996

❒ Shoulder arthroscopy
ICD9 code 80.21
CPT codes 29826, 29805 and 29819

❒ Total hip replacement
ICD9 code 81.51
CPT codes 27130 and 27132

❒Total knee replacement
ICD9 code 81.54
CPT codes 27437, 27438, 27445, 27446, and 27447

❒ Transurethral resection of the prostate
ICD9 code 60.21 and 60.29
CPT codes 52601, 52612, 52614, 52620, 52630, 52647 and 52648

As discussed in the Winter 2003 ***Ohio Medicaid Quality Monitor,*** procedures performed on an emergency basis do not require precertification. When precertification is required but not obtained, there will be no financial reimbursement to the hospital. A revised CD Rom edition of the ***Ohio Medicaid Utilization Review Program Manual*** will be mailed to hospital UR contacts in the next few weeks. The CD Rom will provide you with a description of the information required for precertification. The electronic manual will also include PDC criteria for determining the medical necessity for the procedures, applicable Ohio Administrative Code, a list of exemptions to precertification and information on how to access the manual via the Permedion website. Paper copies of the manual are available upon request to palder@permedion.com. **Call or fax precertifications to 800-772-2179.** National Health Services, Inc. (NHS), a comprehensive medical management and review organization, serves as Permedion's subcontractor for the nurse review portion of the Ohio Medicaid Precertification Program. NHS is accredited by the American Accreditation HealthCare Commission (URAC), whose standards support the structures and processes necessary to promote high quality care and preserve patients' rights. Permedion project manager Phyllis Alder is available to answer questions at 614/895-9900. NHS project manager Paula Lowery can be reached at 800/772-2179.

CODING CORNER

Audits Indicate Upcoding Of DRG 415

In recent audits of hospital medical records, DRG 415 (Operating Room Procedures for Infectious and Parasitic Diseases) was found to be frequently upcoded or miscoded.

The 1/16/03 *Report On Medicare Compliance* states that DRG 415 is vulnerable to upcoding through a clinical misunderstanding by the coder. This DRG has now caught the attention of the Justice Department for filing of false claims due to upcoding.

Example:

A patient presents to the Emergency Room with severe abdominal pain, fever, and chills. After work-up and a surgical consultation, the patient is diagnosed with a ruptured diverticulum and is taken to surgery for resection of the large bowel. During surgery, intestinal bacteria leaks into the abdomen, and the patient developed sepsis. The physician documents sepsis along with ruptured diverticulitis as the final diagnosis on the discharge summary.

In this case scenario, two ICD-9-CM coding guidelines must be reviewed when selecting the appropriate principal diagnosis: (1) principal diagnosis, which is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care," and (2)"the presence of two or more diagnoses that equally meet the definition of principal diagnosis."

In the above example, the surgery was performed to correct the ruptured diverticulitis, not the sepsis. Therefore, the hospital should bill for DRG 148 (Major Small and Large Bowel Procedures with Complications/Comorbidity). It is crucial that coders understand billing compliance issues to prevent coding errors and filing of false claims. Coders should refer to the attending physician for clarification of any questions before submitting final coding for billing.

Remember, use the *Official Guidelines for Coding (AHA, 2003)* to ensure that the correct code is assigned based on sequencing of the appropriate principal diagnosis and principal procedure.

Medical Director *dialogue*

by T.J. Redington, MD
Ohio Department of Job and Family Services

As part of being good stewards of public funds and maintaining the integrity of the Medicaid program, ODJFS monitors both the quality of health care services reimbursed by Medicaid and their appropriate use. Most articles in the Quality Monitor focus on ODJFS' work with hospital providers in this regard. However, ODJFS also works with consumers to improve their appropriate use of health care services. One example of this is the Primary Alternative Care and Treatment (PACT) program.

In 1983, ODJFS established the PACT program to match Medicaid consumers who overuse or abuse medical services with a single primary care physician (PCP) and a single pharmacy. ODJFS' staff identifies prospective PACT members through reviews of claims, including prescription drugs.

Before enrollment in the program, the consumer is contacted and allowed to select a PCP and a pharmacy. If the consumer does not select a PCP and pharmacy, PACT staff will make the selection. PACT staff contacts the PCP and pharmacy and obtains an agreement to provide services to the consumer. The PACT PCP and pharmacy provide to the PACT member all nonemergency services within their scope of practice.

PACT members are enrolled for a minimum of 18 months. Consumers are released from the PACT program when: 1) a review of their claims finds that all of their service use was medically necessary, 2) they enroll in a Medicaid managed care plan, or 3) they are admitted to a long term care facility. A PCP may request that a PACT member be removed from his or her practice by contacting the ODJFS PACT staff.

Any physician who is a Medicaid provider in General Practice, Family Medicine, or Internal Medicine can be a PACT provider, as can any

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the individual. That provision of the Privacy Rule permits the exchange of PHI for the activities performed by Permedion on behalf of ODJFS. Because Permedion is a business associate of ODJFS, hospitals may treat Permedion as ODJFS for the purpose of disclosing data as long as the disclosure is for the duties assigned to Permedion by ODJFS.

Thus, under the Privacy Rule provisions of HIPAA, hospitals, ODJFS, and Permedion are permitted to exchange protected health information for the purposes of paying claims, managing utilization, and conducting studies on quality of care. As with any legal issue, it is advisable to consult with independent legal counsel. In addition, providers may contact the ODJFS Privacy Official, Robert Bergin, by phone at 614-728-8976 or by email at HIPAA_COMPLIANCE_OFFICIAL@odjfs.state.oh.us .

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pharmacy. PCPs receive a case management fee of $8.00 per month for each PACT member under their care. PACT members are encouraged to contact their PCP before going to a hospital emergency room (ER) for care. However, access to emergency rooms cannot be prevented or denied.

Certain administrative procedures are associated with PACT, such as PCP referrals for specialty care, billing for the case management fee, and procedures for removing a patient from the PCP's practice. Inquiries about the PACT program can be directed to Ruth Svarda, RN, CPHQ, Supervisor, Surveillance & Utilization Review Section, PACT Program at 614-466-9689 or by email at svarda@odjfs.state.oh.us .

Transmittal letters go electronic

Past communications for ODJFS, including the Winter 2003 Quality Monitor, stated that ODJFS would stop sending paper copies of cover letters and attachments of policy updates (e.g., MALs, MHTLs, HHTLs). However, that policy has been modified in response to customer needs, because ODJFS learned that providers have different preferences (namely, paper or through the internet) regarding how to access policy updates. Within the next month, providers will receive a Medical Assistance Letter (MAL) with a form to indicate their preferred format (paper or from the Internet) for receiving updates to Medicaid handbook information. Providers should follow instructions in the MAL to complete and return the form to ODJFS. More detailed information about this change will be provided in that forthcoming MAL. Meanwhile, providers can continue to access program updates electronically from the Internet at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid. In addition, providers may obtain a copy of the ODJFS handbook on CD. For further information, contact Lisa Bynum, Chief of Document Development Section, at 614-728-7305 or at bynuml@odjfs.state.oh.us

Technical Denials

Since our Winter 2003 article, *Preventing Technical Denials*, technical denials have substantially declined. As you may recall, Ohio Administrative Code requires that during a record audit, the hospital must produce the applicable medical record within 30 days. If the record is not produced or is received in an untimely manner, a technical denial of the claim will occur. During the review month January 2003, only one hospital technical denial was issued. In SFY 2002, the number of technical denials ranged from 3 to 38 per month. This substantial decline in denials is proof of a job well done by Ohio hospitals. Congratulations!

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