Ohio medicaid QUALITY MONITOR

VOL. 8, NO. 2 SPRING 2007

Billing Instructions for Special Cases

Precertification and retrospective review cases completed by Permedion, the utilization review entity for ODJFS, may require a special billing practice on the part of a hospital provider of Medicaid services. Specific information regarding these special cases can be found within the ODJFS Hospital Provider Manual in "Hospital Billing Instructions."

The Ohio Administrative Code (OAC) Rule 5101:3-2-40 addresses precertification by Permedion. For all claim types, if the claim includes a procedure on the precertification list, but is exempt from precertification due to the provisions of OAC Rule 5101:3-2-40, the provider needs to submit a claim with the condition code "AN" in Form Locator 32-35. Permedion precertifies elective procedures only. Address precertification of inpatient psychiatric stays to Health Care Excel at 1-800-580-1937.

The Ohio Administrative Rule 5101:3-2-40 states that upon retrospective review, a medical review agency may determine the location of service was not medically necessary, but the services rendered were medically necessary. In this instance, the hospital may bill on an outpatient basis for those medically necessary services rendered on the date of admission. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed for the outpatient claim.

The outpatient bill must be submitted with copies of the original denial decision, the reconsideration letter affirming the original decision, and the remittance advice recouping payment. The Condition Code C3 must be recorded on the outpatient claim in one of the Form Locators 24-30.

The outpatient bill with attachments must be submitted within 60 days from the date of the remittance advice recouping payment for the admission to:

Billing *continued on p. 4*

published in cooperation with:

PERMEDION

Understanding Post-Acute Recovery Care Facilities

Ohio Medicaid patients receive institutional, non-hospice care after a hospitalization in three post-acute settings: nursing facilities (NFs), inpatient rehabilitation facilities (IRFs), and long-term acute care hospitals (LTACHs). Each facility has a different type of payment, eligibility, coverage, and certification, yet there may be overlapping processes in the facilities for healing patients to self-sustaining levels. In fact, the facilities seem to share similarities in service delivery type and intensity and in the types of patients they serve. A rapid growth in LTACHs and Medicaid spending highlight the need for more information about post-acute care facilities and the care recipients receive in them.

The *Understanding Post-Acute Recovery Care Facilities Study* provides a description of non-Medicare eligible Ohio Medicaid patient characteristics, appropriateness of admission, and indications for level of care for post-acute care in the three types of recovery facilities. The study provides descriptions of facility profiles and referral patterns, acute hospital and facility costs and lengths of stay, readmission rates, and mortality rates. It also looks at appropriate recovery facility placement according to Milliman Care Recovery Facility Guidelines.

The study population included non-Medicare eligible, Ohio Medicaid patients who were transferred from an inpatient hospital in State Fiscal Year (SFY) 2003 to an Ohio LTACH, IRF, or NF. Records selected for review included 80 LTACH stays (out of 80 eligible stays), 250 IRF stays (out of 342 eligible stays), and 236 NF stays (out of 331 eligible stays). The patients had a diagnosis/procedure associated with LTACH use, including: respiratory diagnosis with ventilator support, amputation, osteomyelitis, endocarditis, skin graft and wound debridement, and paralysis.

RESULTS

Of the 566 records that were requested, 535 were produced for study analysis. The table on Page 2 summarizes the patient and facility profile reports, along with the quality indicators.

Patient Profiles. The average age of the patients ranged from 48 at IRFs to 58 at LTACHs. A slightly lower percentage of females were discharged to an IRF (44%) than to an NF (51%) or to an LTACH (57%). The race distribution for the facilities was significantly different, with white patients making up 80% of LTACHs, 51% of IRFs, and 61% of NFs. The predominant major diagnostic category was respiratory system for LTACH patients (38%) and nervous system

Facilities Study *continued on p. 2*

Facilities Study *continued from p. 1*

	LTACH	IRF	NF
Patient Profile			
Average age	58	48	51
Females	57%	44%	51%
Whites	80%	51%	61%
Most common major diagnostic category	Respiratory	Nervous	Musculoskeletal
5 or more co-morbidities	91%	85%	92%
Facility Profile			
Discharging hospitals affiliated with hospital housing recovery facility	38%	16%	4%
Average distance patient lived from recovery facility	28 miles	13 miles	10 miles
Quality Indicators			
Hospital readmissions within 30 days	22%	14%	7%
Inpatient hospital average length of stay	24 days	12 days	10 days
Recovery facility average length of stay	34 days	18 days	21 days
Inpatient average reimbursement	$21,990	$19,390	$13,440
Recovery facility average reimbursement	$33,760	$14,490	$2,200
Mortality rate	9%	0.4%	6%
Appropriateness of admission	100%	31%	99%
Indications for level of care (highlights)			
• Needed physician visits 7 days a week	37%	30%	1%
• Needed continuous cardiac monitoring	25%	7%	1%
• Needed traction or special braces	15%	18%	21%
• Could have tolerated high-intensity rehabilitation but did not receive it	12%	47%	32%

for IRF patients (62%). NF patients varied in their diagnoses, with musculoskeletal system (17%) and circulatory system (16%) being the most prevalent. More than 90% of LTACH and NF patients and 85% of IRF patients had 5 or more co-morbidities.

Facility Profiles. LTACH patients lived an average of 28 miles away from the facility, a distance significantly higher than the average distance patients traveled to IRFs (13 miles) and NFs (10 miles). Sampled LTACHs were located in major metropolitan areas only, while IRFs were more numerous and dispersed, but still tended to be located in heavily populated areas. NFs were the most numerous and widely dispersed throughout the state.

Facilities Study *continued on p. 3*

CODING CORNER

Decubitus Ulcers

In this article of the Coding Corner, we provide information on the identification, staging, and coding for decubitus ulcers.

A decubitus ulcer is a pressure sore commonly called a "bed sore." It can range from a very mild pink coloration of the skin, which disappears in a few hours after pressure is relieved on the area, to a very deep wound extending to and sometimes through a bone into internal organs. These ulcers, as well as other wound types, are classified in stages according to the severity of the wound.

Stage I - Characterized by a surface reddening of the skin. Skin is unbroken and the wound is superficial.

Stage II - Characterized by a blister either broken or unbroken. A partial layer of skin is now injured. Involvement is no longer superficial.

Stage III - The wound extends through all layers of skin. It is the primary site for a serious infection to occur.

Stage IV - The wound extends through the skin and involves underlying muscle, tendons and bone. The diameter of the wound is not as important as the depth. This is very serious and can produce a life-threatening infection.

Stage V - The wound is extremely deep, having gone through the muscle layers and now involves organs and bones. This type of wound is difficult to heal and may require surgical removal of the decayed tissue. In some cases, amputation may be necessary.

CODING OF DECUBITIS ULCERS

The subcategory decubitus ulcers (707.0) has a fifth digit to identify the specific site of the ulcer, such as elbow (707.01), upper back (707.02), lower back (707.03), hip (707.04), buttock (707.05), ankle (707.06), heel (707.07), and other site (707.09).

An example of correct coding for a chronic ulcer of the skin is: **decubitus ulcer, sacral area (707.03)**.

If unsure of the diagnosis, always query the attending physician to ensure that you are assigning the appropriate diagnosis codes for billing.

Facilities Study *continued from p. 2*

Only 38% of the discharging hospitals were affiliated with the hospital that housed the LTACHs. Likewise, just 16% and 4% of the discharging hospitals were affiliated with the hospital that housed the IRFs and NFs, respectively.

Hospital Readmission Rate Within 30 Days. LTACHs had the highest readmission rate at 22% compared to IRFs (14%) and NFs (7%). This finding contradicted a MedPac study showing that LTACHs had fewer readmissions than similar patients treated in other settings. The IRF rate, on the other hand, was comparable to published averages.

Inpatient Hospital Length of Stay. The average length of stay prior to an LTACH admission was 24 days, followed by 12 days before an IRF admission, and 10 days before an NF admission. This finding was different from a study that showed Medicare patients discharged to an LTACH had shorter short-term acute hospital stays than similar patients who were not discharged to such a facility. Therefore, the assumption that LTACH stays may substitute for continued acute hospital stays was not supported.

Recovery Facility Length of Stay. The average length of stay in an LTACH was 34 days, followed by 18 days at an IRF and 21 days at an NF - all of which are in line with national results. No significant relationships were found between short-term acute and recovery facility lengths of stay.

Inpatient and Recovery Facility Reimbursement. This study found expected differences in payments among the three types of recovery facilities, both during the inpatient stay and recovery facility stay. LTACH patients averaged the most expensive inpatient stays at nearly $22,000, while the average inpatient costs for patients discharged to IRFs was slightly lower at $19,390. Patients discharged to NFs had the lowest average inpatient costs at $13,440. Recovery facility costs followed the same pattern, with LTACH stays being the most expensive, averaging $33,760. IRF stays were less than half that cost at $14,490 on average, while NF stays averaged just $2,200.

Appropriateness of Admission. All the LTACH patients in this study met the guidelines for the LTACH level of care. Likewise, 31% of the IRF patients and 99% of the NF patients met the guidelines for care in the recovery facility to which they were admitted. Using Milliman's criteria, 49% of the IRF patient admissions were deemed inappropriate because they could have been cared for in a NF.

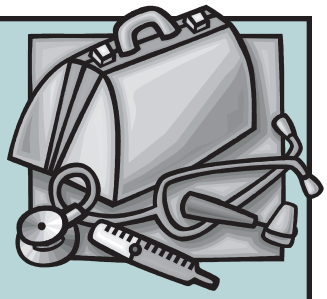
RECOMMENDATIONS

The findings of this initial study of understanding post-acute recovery care facility services for the Ohio Medicaid population support the following specific recommendations:

- Perform further investigation to determine the difference in the types of physician services and visits in LTACHs and IRFs. This study showed that only 37% of LTACH patients and 30% of IRF patients were reported to need at least daily physician visits. The majority of the patients, instead, needed physician visits 5 to 6 days a week.
- Conduct further studies to justify the significant disparity of post-recovery facility costs, with a focus on the differences in post-acute levels of

Facilities Study *continued on p. 4*

Medical Director *dialogue*



by David J. Sand, MD, MBA, FACS, CHCQM, FAIHQ
Corporate Medical Director, Permedion

What We Know About LTACHs

The health care system has long recognized the need for the distinct services provided by LTACHs. LTACH availability aids the exhaustive searches by the social service departments for assuring post-recovery care for respiratory failure, non-healing wounds, and other diseases that are medically complex. They also help eliminate the day and cost outlier stays in acute hospitals.

Since approximately 1999, there has been a rapid increase in the number of LTACHs nationwide. Ohio's number of LTACHs has increased from 6 in 2002 to 15 in 2007. This rapid growth has increased The Centers for Medicare and Medicaid Services' (CMS) concerns that some LTACHs are being used as inappropriate substitutes for skilled nursing facilities and inpatient rehabilitation facilities.

A recent LTACH demonstration project in Connecticut was reported in March 2007. Both free-standing and "hospital within a hospital" LTACHs were studied. The findings concluded that the adult residents within the LTACHs' areas were the dominant users of the services. There was a significant savings associated with transferring eligible patients to an LTACH. There were also improved clinical outcomes in terms of mechanical ventilation weaning, functional status, and one-year survival after discharge.

The continued increase in the number of Ohio LTACH facilities, changes in CMS payment rules, Ohio Medicaid budget constraints, and more defined LTACH clinical criteria all support continued assessment of Medicaid LTACH patients.

Recommendations from our baseline study *Understanding Post Acute Recovery Facilities* include continued review of cost-efficiency, medical necessity, and patient outcomes of all Ohio Medicaid post-acute care.

Facilities Study *continued from p. 3*

care. Include comparisons of diagnoses, severity of illness, risk of mortality, intensity of monitoring, type and availability of services, and number of staff and their knowledge and specialization to determine if there is a significant overlap of services and patient substitution among NFs, IRFs, and LTACHs.

- Study the use of continuous cardiac monitoring in all three levels of care. In this study continuous cardiac monitoring was seen in all three types of recovery facilities.
- Perform a review to determine why the patients who, through medical record review, were perceived to be able to tolerate high-intensity rehabilitation did not receive it. This study showed that, of the patients who received rehabilitation, 12% of LTACH, 47% of IRF, and 32% of NF patients could have benefited from high-intensity rehabilitation.

Billing *continued from p. 1*

Ohio Department of Job and Family Services
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461
1-800-686-1516

A medical necessity denial of an inpatient stay is the only scenario in which an outpatient claim can be submitted. A retrospective review denial for compliance (lack of precertification) cannot be rebilled as an observation case.

Retrospective review denials from billing errors (incorrect discharge status code, wrong Medicaid number, etc.) can be rebilled with a corrected claim that is mailed to the above address.

For additional information on hospital billing instructions, refer to the ODJFS Web site: *http://emanuals.odjfs.state.oh.us/emanuals/*. Select **Ohio Health Plans-Provider**, **Hospital Handbook**, and **Billing Instructions.**

Who to Contact When Your Facility Changes Name or Location

It is important to keep Medicaid informed of changes to your facility's name and location. All Medicaid provider name and/or location changes must be directed to the Provider Enrollment Unit at ODJFS. Once changes are verified, they will be updated in the Ohio ID system. Please follow these guidelines for updating facility name and location:

1) Put the request for hospital name and/or location changes in writing.
2) Notify ODJFS within 30 days of name and/or location changes (if you have past changes notify immediately).
3) Verification must be given if name and/or location changes are due to change in ownership.
4) Provide your Medicaid contact information in case ODJFS needs to contact you.

Send facility update information to:

Ohio Department of Job and Family Services
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43216-1461

Just as Medicaid contacts at the hospitals are important to keep current, so are the names and locations of the facilities. This process will better serve Medicaid in providing correct notifications to the Ohio Medicaid providers.

CONTACT INFORMATION

Permedion • Sue Hackett, Project Manager
• 350 Worthington Rd., Suite H • Westerville, OH 43082 • 614/895-9900 • fax 614/895-6784
• www.permedion.com • shackett@permedion.com

Ohio Department of Job and Family Services – Surveillance and Utilization Review Section
• Linda McCabe, Contract Manager • 4020 E. Fifth Ave. • Columbus, OH 43219
• 614/466-7936 • fax 614/728-3334 • www.jfs.ohio.gov

350 Worthington Rd., Ste. H
Westerville, OH 43082