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Facts, Vision, and Priorities

Recently, the Governor's Office of Health Transformation released an Ohio Medicaid report, *Better Health, Better Care, and Cost Savings Through Improvement.* The report includes many Ohio Medicaid facts about coverage, costs, acute care, emergency room use, and hospitalizations.

FACTS

Medicaid is Ohio's largest health payer:

- Provision of health coverage for low-income children, parents, seniors, and people with disabilities
- Coverage of 2.2 million Ohioans (1 in 5) including 2 in 5 births
- Spending of $18+ billion annually (all agencies, all funds – SFY 2011)
- Accounting for 4% of Ohio's total economy and is growing
- A few high-cost cases account for most Medicaid spending
  - 1% of the Medicaid population consumes 23% of total spending
  - 4% of the Medicaid population consumes 51% of total spending

VISION

The vision for better care coordination includes:

- Creation of a person-centered care management approach
- Services are integrated for all health care needs
- Services are provided in the setting of choice
- Easy navigation for consumers and providers
- Seamless transition among settings
- Payment linked to person-centered performance outcomes

PRIORITIES

The Ohio Health Transformation priorities are:

- Improve care coordination
- Integrate behavioral and physical health
- Modernize reimbursement

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CMS' HACs and POA: What are they?

The Winter 2010 Quality Monitor newsletter provided a summary of the Ohio Medicaid CMS Selected Hospital Acquired Conditions Study. The study is part of Ohio Medicaid's efforts to pay for better care, with regard to quality, outcomes, and overall costs of care. It was based on the Center for Medicare and Medicaid Services (CMS) list of hospital acquired conditions (HACs) for which additional Medicare payments are withheld if the condition was not present at admission. State Medicaid agencies have been given the authority to similarly deny payment for these "never events." CMS has encouraged the States to adopt a State Plan Amendment to avoid both the Medicaid primary and secondary payer payments for CMS-denied events.

The term "never event" was first introduced in 2001 by the National Quality Forum (NQF), in reference to particularly shocking medical errors (such as wrong-site surgery) that should never occur. Over time, NQF, a nonprofit national coalition of physicians, hospitals, businesses and policy-makers, identified 28 events as occurrences that should never happen in a hospital (NQF 2008). The events can be prevented, thus labeled "never events" and are of concern to both the public and healthcare providers for the purpose of public accountability. They include surgical events such as performing the wrong surgical procedure, product or device events such as contaminated drugs or devices, and criminal events such as abduction of a patient.

In 2007, CMS introduced an initiative to curtail payments to hospitals for specific conditions that a patient acquires while hospitalized and that could be "reasonable prevented" by following established evidence-based guidelines. CMS also reduced reimbursement for those "never events" identified by the NFQ. Because the CMS selection criteria for HACs and the NQF selection criteria are similar, the conditions selected for each overlap. CMS' HACs overlap with eight of the events on the NQF list.

To identify which diagnoses were present on admission and which were hospital acquired, hospitals must report a present-on-admission (POA) indicator for all diagnoses on the claim. There are specific POA reporting procedures to comply with the CMS policy. Actual payment impact of this policy began in FY 2009.

The HACs subject to the POA reporting and payment reduction initiative as of October 1, 2008 are as follows:

Healthcare-Associated Infections

- Catheter-associated urinary tract infections. The ICD-9 code does not distinguish between catheter-associated infection and inflammation.
- Vascular catheter-associated blood stream infection (BSI). CMS now has a specific code for central-line vascular catheters (CVC). CVC-BSIs are not limited to the ICU.

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HACs/POA *continued from p. 1*

- Surgical site infection (SSI):
  - Mediastinitis after CABG surgery. This infection has a specific complication code.
  - Selected orthopedic surgeries – spinal fusion and other surgeries of the shoulder and elbow.
  - Bariatric surgery for morbid obesity– laparoscopic gastric bypass and gastroenterostomy.

Other Hospital-Acquired Conditions

All selections are from the National Quality Forum's list of 28 "Serious Reportable Events" frequently referred to as "never events."

- Object left in surgery (refinement - reaction to foreign substance accidentally left during a procedure)
- Air embolism
- Blood incompatibility
- Pressure ulcers (Category III and IV only)
- Falls- Codes are not actually for "falls" but for potential adverse events or injuries occurring as the result of falls; injuries that should not occur during a patient's hospitalization. The generic categories of coded injuries include: fractures, dislocations, intracranial injury, crushing injury, burns, and other unspecified effects of external causes.
- Venous thromboembolism (VTE) after hip and knee replacement. Although VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE), CMS has only selected PE codes to which this payment policy applies at this time.
- Poor glycemic control - Ketoacidosis and Coma (hypoglycemic and hypoosmolar).

Many private payers are adopting a similar payment reduction policy if a diagnosis was not present on admission and some will not pay at all for "never events." Currently, Ohio Medicaid policy does not include withholding payment for HACs that are listed by CMS. However, Medicaid providers are encouraged to conduct reviews of their HAC occurrence rates. The results should be used to determine where it may be advantageous to implement stricter clinical care guidelines that promote optimal patient care, as well as maximize legitimate reimbursement.

Visit www.hmspermedion.com to read the CMS Selected Hospital Acquired Conditions Study and Ohio Medicaid Quality Monitor Winter 2010 article *"Hospital Payments are Linked to Patient Safety."*

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- Rebalance long-term care

More information on the Ohio Health Transformation initiative can be found at *www.healthtransfromation.ohio.gov*.

CODING CORNER

Healthcare-Associated Infections

In this issue of the *Coding Corner*, we provide information on Hospital-Acquired Infections/Healthcare-Associated Infections.

Healthcare-associated infections (HAI) are defined as infections not present and without evidence of incubation at the time of admission. As a better reflection of the diverse healthcare settings currently available to patients, the term healthcare-associated infections replaced old ones such as nosocomial, hospital-acquired or hospital-onset infections.

Healthcare-associated infections occur in both adult and pediatric patients. Bloodstream infections, followed by pneumonia and urinary tract infections are the most common healthcare-associated in children; urinary tract infections are the most common healthcare-associated infections in adults. With the pediatric patients, children under one year, babies with extremely low birth weight (<1,000g), and children in either the PICU of NICU have much higher rate of healthcare-associated infections. Other risk factors for getting a hospital-acquired infection are a long hospital stay, the use of indwelling catheters, failure of healthcare workers to wash their hands, and overuse of antibiotics.

An infection is suspected any time a hospitalized patient develops a fever that cannot be explained by a known illness. Some patients, especially the elderly, may not develop a fever. In these patients, the first signs of infection may be rapid breathing or mental confusion. Once the source of the infection has been indentified, the patient is treated with antibiotics or other medication that kills the responsible microorganism.

Hospital-acquired infections are serious illnesses that cause death in about 1% of the cases. Rapid diagnosis and identification of the responsible microorganism are necessary so that treatment can be started as soon as possible.

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. If at the time of code assignment, the documentation is unclear as to whether a condition was present on admission or if the condition was a healthcare-associated infection, it is appropriate to query the provider for clarification.

Medical Director *dialogue*

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

Observation Level of Care

Recently, a significant number of questions have come in regarding the application of the rules surrounding the observation level of care. Ohio Administrative Code rule 5101:3-2-21(L) states: *"Payments for observation services will be made for up to two consecutive days only. To receive payment for a third consecutive date of service, the patient must have been discharged, and, for medically necessary reasons, readmitted as an outpatient."* The observation level of care is not a 48-hour period. It is two consecutive calendar days.

When assigning a level of care to a patient encounter, it is inappropriate to base a decision on the amount of time the person actually spent in the hospital. Rather, did they meet the clinical criteria for inpatient admission or should they be at the observation level of care?

I'll use an example from my own specialty.

> *On August 15, 2011, a 17 year-old male presents at 9 p.m. with progressive abdominal pain localizing to the right lower quadrant. CT scan confirms acute appendicitis. WBC=12.2, T=98.4, HR=98, BP=120/78, RR=16. At 3 a.m. on August 16, 2010, the patient undergoes an uneventful laparoscopic appendectomy, no perforation, no abscess. He receives IV antibiotics and PO pain medications on August 16, 2011 and is discharged to home on August 17, 2011 at 6 a.m. The patient's total stay is less than 48 hours, but encompasses three consecutive calendar days.*

It is important to note that time in-house is not the driving factor. The issue is that the inpatient level of care criteria as practiced in the community were not satisfied. I had every reasonable expectation this patient would have no complications, follow a typical clinical course, and would safely be able to go home in an expeditious manner. The observation level of care is the most appropriate level of care for this patient encounter.

Using a similar scenario, let's say:

> *The patient came in at 9 p.m. on August 15, 2011 and was found to have appendicitis with an abscess and spiked a fever. If the patient underwent the appendectomy with abscess drainage, then defervesced, was started on adequate oral antibiotics and was able to be discharged at 10 p.m. on August 16, 2011.*

He would still have met the inpatient admission criteria and the inpatient level of care is appropriate.

Let's say it's the same situation as above with a different time frame: he came in at 4:00 a.m. on August 16, 2011, has the operation and went home later that same day at 8:00 p.m. Even though he might have satisfied inpatient admission criteria, he does not qualify for such as he did not actually spend a night in the hospital. Technically, a patient must stay past midnight for the claim to be billed as an inpatient stay. Therefore, this should be billed as outpatient/

Medical Director *continued on p. 4*

MITS = Paperless Prior Authorization and Precertification

Background

Ohio's plan for a new Medicaid Information Technology System (MITS) was approved by the Centers for Medicare and Medicaid Services (CMS) in June 2001. In 2005, ODJFS identified over 3,000 business requirements that were needed to support the needs of the Ohio Medicaid program. Hewlett Packard (HP) was selected through competitive bidding in 2007, to design and implement MITS.

MITS is replacing the 20 year old legacy Medicaid Management Information System (MMIS). Ohio's MMIS is a mainframe-based system which has processed millions of health care claims each year. However, there are many processes that must be completed manually. It cannot provide the needed support for the increasing demands placed on Ohio's Medicaid program.

MITS will be able to provide an information technology system capable of rapidly implementing state and federal Medicaid program changes and meeting business needs for Ohio Medicaid. It will have the web-based technology that can easily adapt to program fluctuations and needs. The new "go live" date for MITS is August 2, 2011.

Training

MITS provider training has been extensive. There have been Ohio Medicaid and HP consultant hosted provider training sessions and presentations, online tutorials, special training webinars, provider frequently asked questions (FAQs) and MITS handouts. If anyone was unable to attend training sessions previously offered or wants to view the MITS training presentations again, they are available at http://www.ohiohcp.org/mitsmain.html.

Prior Authorization Functions

One of the new MITS functions is that paperless prior authorization and precertification for the fee-for-service providers will be available in the new MITS web portal. Providers will be able to enter requests directly into the system 24 hours a day, seven days a week. This will allow providers to submit requests outside of normal business hours. They will be able to track the status of each request from the time of submission, through review, to the approval or denial.

Every request successfully submitted through the portal will receive a unique ten-digit number. Using this prior authorization/precertification number, providers will be able to verify a variety of information such as:

- Status
- Requested and authorized effective

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MITS *continued from p. 3*

and end date
- Requested and authorized units or dollars
- Balance of units or dollars
- Reviewer notes and comments
- Additional supporting documentation

In addition, prior authorizations and pre-certifications will be integrated with claims processing to allow for real-time adjudication of claims with approved requests.

Providers must establish an account. Through the account, the provider agent will submit prior authorization and precertification requests through easy data entry. The portal will not allow a request to be saved if it is incomplete or contains formatting errors. All requests will be subject to "edits" and "audits." Permedion, the current vendor, will continue to review special services and to perform precertifications. Providers will not contact Permedion directly. Requests must be entered through the portal for Permedion to review.

Providers must use the portal to check the status of requests. In order to make this process paperless, approval letters will not be sent to providers or consumers. MITS will generate denial letters.

This information is also available on Provider Information Release #9.11, Paperless Prior Authorization, 04/18/2011.

Change in SURS Telephone Number

ODJFS' Surveillance and Utilization Review Section (SURS) has changed their telephone number from (614) 466-7936 to 1-800-627-8133, Option 7.

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observation. The Medicaid definition of an inpatient is "one that has been admitted and whose stay continues beyond midnight on the day of admission." (OAC rule 5101:3-2-02 {B} {1}) Whereas in observation status, it is available immediately up until two consecutive calendar days.

Alright, let's review one final scenario. This time it is the same patient but he has a history of severe asthma and history of congenital cardiac disease with arrhythmias, all of which are stable and well-controlled. He presents with appendicitis and undergoes an uneventful laparoscopic appendectomy. While recognizing the potential for complications in a high risk patient such as this one, the attending notes the patient's comorbidities are stable and he does not anticipate the need to acutely manage them. He makes the decision to keep the patient in observation instead of sending him home immediately. If the risks and complications don't materialize by the end of observation time period and the surgeon feels it is safe for the patient, the patient should be discharged. If the surgeon still feels that it is not safe for the patient to be discharged, then the patient can be admitted to inpatient status with the appropriate clinical event documentation and rationale as to why they need an extended period of monitoring for risks/complications.

Be aware that, in some isolated occurrences, an inpatient status may be appropriate even if the patient was not there overnight. According to OAC rule 5101:3-2-02 (B)(3), it states in part, "Outpatient includes a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission, except in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital, or to a state psychiatric facility."

As we move forward with cost consciousness in the health care reform environment, assigning the most appropriate level of care to a given patient encounter episode will take on an ever increasingly important role.

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