Ohio medicaid QUALITY MONITOR

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Study steps: From data analysis to reporting

The last major steps in our quality and utilization study process are data analysis and reporting.

Once all the data are collected, data cleaning becomes the first priority. All data are edited for allowable values, reasonable values, and cross-field relationships prior to beginning analysis. This pre-analysis data cleaning decreases analysis re-work and improves the quality of results.

Once data are cleaned, the analysis plan goes into effect. The analysis plan is determined during the study design phase, before study initiation. Study analysis frequently includes sample disposition, analysis of sample description, quality indicator calculations, confidence interval calculations, and statistical testing. Most analysis is conducted using SAS software, while some support analysis may be completed in Microsoft Excel or Access.

A final report to ODJFS is the primary deliverable for utilization and quality improvement studies. Each study report serves to fully document the study and to make recommendations on how the study results can be used in improving Ohio Medicaid utilization and quality. The reports include: study background and rationale, definition of quality indicators, study methodology, sample disposition and descriptive statistics, results on quality indicators and any additional analysis, and discussion of study findings. The discussion of study findings summarizes the results and identifies opportunities for improvement found in the study. Suggested interventions generally involve the education and cooperation of the provider community.

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PERMEDION

Leading through planning

OHP begins building plan to direct future

The Office of Ohio Health Plans (OHP) administers Medicaid and Healthy Start/Healthy Families—which include Ohio's State Children's Health Insurance Program (SCHIP), the Disability Assistance Medical Health Plan, and the Medicare Premium Assistance Health Plan—as well as the Hospital Care Assurance Program. In this role, OHP oversees health coverage for approximately 12% of Ohioans, works with over 36,000 health care providers, coordinates services and payments through at least seven other state agencies, and plays a significant role in the lives of Ohioans.

OHP Mission

To support the quality of life of Ohioans through coverage of high quality, cost effective, accessible health care and related services.

OHP Vision

To be a leading public sector health plan by demonstrating excellence through the organization and leadership in health system reform.

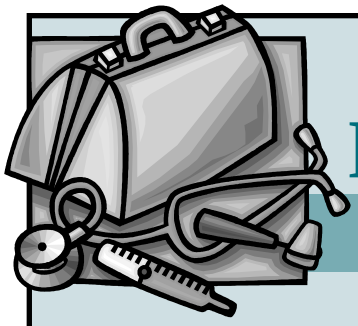
OHP Values

As an organization and individuals, we value:

- Treating our diverse consumers, colleagues, and stakeholders with dignity, integrity, and respect
- Leading through innovation, flexibility, and teamwork
- Pursuing fiscal integrity, accountability, and outcome-based decision making
- Communicating promptly and effectively
- Exemplifying pride in public service

OHP constantly strives to be an efficient value purchaser that is responsive to its diverse constituents, including consumers, advocates, providers, and the citizens of Ohio. In doing so, OHP must respond to sometimes conflicting challenges from the health care industry, consumer needs and demands, budgetary constraints, and federal government regulations. To enhance its effectiveness as a public entity and health insurer, OHP has created a strategic plan using the "Balanced Scorecard" approach. This approach focuses on five organizational perspectives essential to success—Consumer/Stakeholder, Financial, Internal Processes, Learning and Growth, and Employees/Staff. The comprehensive evaluation of efforts across all of these perspectives, rather than from just a subset, is the origin of the term Balanced Scorecard.

Strategic plan *continued on p. 3*



Medical Director *dialogue*

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

As the medical director for the Office of Ohio Health Plans (OHP), I provide clinical leadership in the development and operation of OHP's agendas for quality improvement and program integrity. In this role, I draw from my experiences as an administrator, a practicing internist, and a professor of internal medicine. One of my responsibilities as the medical director is to communicate with providers and their staffs regarding OHP's program requirements.

I recently worked with OHP staff in the Hospital Benefits and Financial Management Section to clarify OHP's policy that requires documentation of a physician's order to admit in the medical record. This issue has come up because some hospitals in Ohio have had their claims for inpatient admissions denied due to not having a physician's order to admit documented in the medical record. Furthermore, some hospitals see the order to admit merely as a technicality, especially when a patient's condition obviously has required admission. This confusion warrants a reminder and an explanation of this important policy.

OHP requires documentation of a physician's order to admit to ensure that there is a provider who is accountable for the patient's care from the time they are admitted to the hospital. The order to admit is a formal declaration that contains two important pieces of information: 1) who ordered the patient to be admitted and, 2) the willingness of the attending physician to be a provider of care. It clarifies who is responsible for the patient's admission and who will provide for them once there. The admission order also addresses medical necessity, documenting that the patient meets criteria for a hospital admission and needs care that can only be provided in the inpatient setting.

Inside the claims review and appeal processes

The Ohio Department of Job and Family Services (ODJFS) and Permedion conduct a retrospective review program that maximizes appropriate utilization of inpatient and outpatient hospital services to Ohio Medicaid recipients. The ultimate goal of this program is to attain measurable improvement in the appropriate utilization and quality of Medicaid services, while recovering reimbursement for inappropriate services. Every month, Permedion reviews 955 Medicaid medical records to assess for appropriate utilization, billing, DRG assignments, readmissions, and quality.

In this article we'll explain the review and appeal processes associated with the identification of utilization, billing, DRG assignments, and readmission concerns. Although similar, quality review and appeal processes will be covered separately in the next issue.

The review process

Permedion's claim review process begins with a registered nurse reviewing medical records against the Physician Developed Criteria (PDC). The PDC include medical practice guidelines developed and maintained by National Health Services. Permedion sends the PDC, which is evaluated and/or modified annually, to the designated utilization contact person at each hospital. Because more than half of denials related to hospital admissions are due to lack of medical necessity, our explanation of the review process will use such a scenario.

If the registered nurse reviewer finds that the illness and treatment do not meet the PDC guidelines, the medical record is reviewed by a physician licensed in Ohio and actively practicing in the field relevant to the patient's condition and treatment. If the physician finds that the care provided was not medically necessary, Permedion issues a letter to the hospital denying the medical necessity of the admission and requesting that the Medicaid payment be recouped. This letter also includes instructions, policies, and timelines related to appealing denials.

In addition to assessing medical necessity, the nurse reviewer also focuses on administrative or technical components of the record, such as adherence to Medicaid billing instructions, inclusion of required documentation, and appropriate coding. As an example, if the reviewer finds improper billing transfers, a denial is issued.

The appeal process

The hospital may appeal the decision to deny a claim within 60 days of the denial date. The appeal process for denied claims is comprehensive. Its purpose is to review the documentation and decisions rendered and incorporate any additional medical information provided to either overturn or uphold the previous determination. The original medical record

Processes *continued on back*

Strategic plan *continued from front*

OHP's strategic plan was developed in three phases. In the first phase, all OHP employees collaborated to refine the organization's mission, vision, and values in order to better reflect what OHP is and what it strives to accomplish. In the second phase, OHP developed organizational strategies and supporting objectives through an environmental scan—to assess political, economic, technological, and health care marketplace trends and realities—and a SWOT (strengths, weaknesses, opportunities, and threats) analysis. Key stakeholders also contributed to this process. The results of the first and second phases are displayed in the graphics within this article.

OHP is currently working on the third phase of the Strategic Plan—developing key performance measures that will provide people at all levels of OHP with the ability to monitor success in pursuing its strategies and achieving its vision. These measures will enable OHP to compare actual performance to baseline and target performance. Improving the quality of care for consumers and pursuing outcomes-based care will be emphasized in the measures.

OHP Strategies

Use value purchasing approaches to provide our consumers with a health plan that emphasizes accessibility, network management, quality, and improved outcomes.

Continually increase integrated community service options for persons with disabilities through improved effectiveness of publicly funded health care systems.

Continually improve our program administration to be more effective and responsive.

Continually improve our ability to manage costs.

Continually enhance our workforce excellence through proactive management, staff development, support, and recognition.

Progress also is being made on other fronts of the Strategic Plan. Currently, the different bureaus in OHP are determining how their work fits into the Strategic Plan. Employees are finding that some activities that they are already doing support the success of the plan. On the other hand, some efforts and projects may need to be refocused. This exercise will add understanding of how each employee's work fits into the bigger picture and how it affects the success of his or her colleagues' work. In the end, OHP's goal is for staff to have an increased sense of purpose and to be able to work more efficiently by focusing their efforts on projects that the whole organization has decided are priorities.

We look forward to continue reporting to you on OHP's Strategic Plan—to offer a window into its sense of purpose and priorities as well as the foundation and framework upon which decisions are made.

CODING CORNER

When septicemia has been ruled out

In a recent review of claims performed by Permedion, nurse reviewers identified several cases in which septicemia was the primary diagnosis, even though the physician had documented that septicemia was ruled out. In this issue, *Coding Corner* explains the correct coding and identification of septicemia versus a viral infection diagnosis.

ICD-9-CM Diagnosis Coding Advisor 2001 defines septicemia as an infection with fever or hypothermia, tachypnea, tachycardia, and impaired organ system perfusion, such as altered mental status, oliguria, and relative hypotension. Metabolic acidosis also may be present secondary to impaired lactate level, increased anion gap, or reduced blood pH. Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia in patients with clinical evidence of the condition. However, when the attending physician has documented in the medical record that "sepsis is ruled out," a septicemia diagnosis should not be coded.

Coding Clinic for ICD-9-CM (2nd Quarter, 1991) indicates that most self-limited fevers in a host that is not immunocompromised are probably viral in origin. In the majority of these cases, there will be no confirmatory cultures, and diagnoses will be made purely on clinical grounds.

An example:

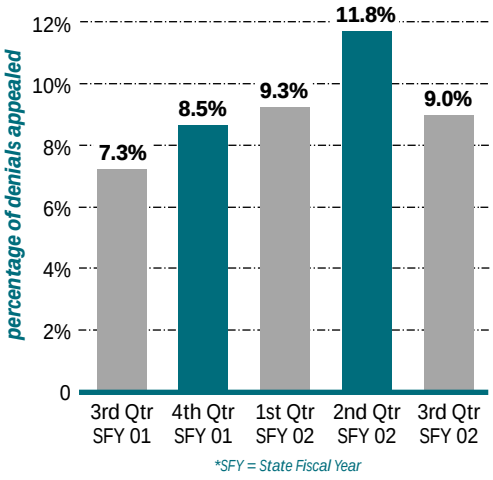
A 6-month-old female presented to the Emergency Room with a one-day history of vomiting and reported cyanosis. Upon examination, her tympanic membranes were clear, her abdomen was soft, there was no cyanosis, and she was alert. Her temperature was 99.4, WBC was 23.0, and blood cultures were negative. The patient was treated with Rocephin and one dose of Tylenol. By the next morning, her WBC had decreased to 9.6, she remained afebrile, and she was discharged to home. In this case, the diagnosis of septicemia (038.9) was ruled out, and the attending physician concluded that the patient had a viral infection (079.99), which is the appropriate principal diagnosis.

Remember, if the attending physician documents in the medical record that a diagnosis has been ruled out, it is inappropriate to code that diagnosis on an inpatient record. If a diagnosis is questionable, always refer to the attending physician for clarification.

Processes *continued from p. 2*

and any additional information are submitted to another Ohio licensed peer-matched physician reviewer for a second independent assessment. Permedion again sends a letter to the hospital with the appeal results based on the second reviewing physician's decision.

Appeal Rates: *Retrospective review*



If the appeal is denied, the hospital may send a second appeal to ODJFS within 30 days of the "denial upheld" letter date. At this stage, a Medicaid health system specialist performs a thorough administrative review. During this administrative review, the specialist examines the record to assure that Permedion considered and noticed all the details in the medical record and correctly interpreted and applied Medicaid policy. The denial will be overturned if information is revealed that contradicts the basis for Permedion's decision.

Permedion sends review activity correspondence, PDC guidelines, record requests, monthly and quarterly utilization reports, and program updates to each hospital's designated Medicaid utilization contact person. If you have any questions related to the claims review and appeal process, or to make a change in your hospital's contact person, please contact Permedion's Phyllis Alder at (614)895-9900 or palder@permedion.com.

Medicaid requires an order to admit

A physician's order to admit a patient is always necessary for an acute hospital admission. The admission order must follow any ED, outpatient, or observation stay when the patient's condition warrants an inpatient hospital setting. Sometimes, however, the order is missing from the medical record. Permedion reviewers have found that cases involving observation are those most often missing an order to admit.

Occasionally, a physician may need to prescribe a period of observation for a Medicaid patient. Observation beds are used in instances when a decision regarding the medical necessity of admission cannot be made when the patient first presents to the hospital. The maximum reimbursement allowed for observation is 22 hours.

After an observation period and if the patient's condition requires admission as an inpatient, the physician must change the order from "observation" to "admission." The admission order documents that the patient meets criteria and the standards of care for the hospital admission and needs care that can only be provided in the inpatient setting. After the admission order is written, definitions and payment policies of inpatient stays apply.

During the course of the Medicaid retrospective review program, nearly 10% of medical records with an observation stay followed by an inpatient stay do not have an order to admit the patient to the hospital as an inpatient. The order to admit is a formal declaration of the attending physician that he/she is responsible for the care of the patient and that the admission is medically necessary. The order must be included in the physician orders or on the emergency department orders. If a retrospective review finds there is no documentation of a physician-signed order to admit in the claim's medical record, Medicaid issues a denial and recoups payment for that claim.

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