Ohio medicaid QUALITY MONITOR

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It's that time of year again: Pattern analysis monitor report

Hospitals will soon see in their mailboxes their annual *Pattern Analysis Monitor Report*. Permedion sends this report to each hospital that submitted a Medicaid claim to the Ohio Department of Job and Family Services (ODJFS) during the year. Each report covers the hospital's data for three state fiscal years (SFYs) and provides a three-year comparison. The current report covers SFY 2001, 2002, and 2003.

Comparative statistics for each hospital's peer group are included in the report. Outliers (indicators with three standard deviations over or under the peer average) are noted in the report. The measured indicators include the following:

- 0-1 day readmissions
- 2-7 days readmissions
- Admissions due to complications
- Transfer out
- Transfer billing
- Outliers
- Significantly short lengths-of-stay

The *Pattern Analysis Monitor Report* details outliers on both the low and high end. Outlier detection allows hospitals to understand their Medicaid population better. Comparison statistics enable the hospitals to recognize good performance and potential problems. The information from this report can assist hospitals in developing benchmarks to improve performance monitoring and service to Medicaid consumers.

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PERMEDION

Study Looks at Medication Use in Nursing Facilities

Nursing facilities have traditionally provided long-term custodial services to the elderly. Today, however, they also provide a critical part of the continuum of care for much higher acuity patients. This has resulted in an escalating use of medications along with an increased risk of adverse drug events (ADEs), drug-drug interactions, and iatrogenic disease in nursing facilities.

ODJFS and Permedion conducted the *Medication Use in Nursing Facilities Study* to determine the incidence of ADEs, the medication errors leading to ADEs, and the severity of ADEs among Ohio Medicaid nursing facility residents. The goal of this study was to learn more about medication administration and ADEs so that strategies to improve the appropriate use of medication in the nursing facility population can be developed.

Registered nurses from Permedion reviewed 689 nursing facility resident records, using a random sample of 960 Medicaid residents who received a Minimum Data Set assessment during the SFY 2001. One month was then randomly selected for medical record review for each resident.

Study indicators included demographic characteristics, number of medications per resident, number of major diagnostic categories per resident, facility characteristics, number of medications per therapeutic class, frequency of ADEs, and severity of ADEs. Nine ADE indicators were also examined.

Reviewers Examined Nine ADE Indicators
Failure to Receive a Routine Medication
Failure to Receive Routine Medication at the Scheduled Time
Drug-allergy Interaction
Medications Administered to Treat Adverse Drug Reaction to Another Drug
Potential Duplicate Therapy
Drug-drug Interaction
Routine Medication Administered Without Documentation of Indication
Unauthorized Drug Use
Unanticipated ADE

Females made up 73% of the study population. The average age of residents in this study was 78.8 years.

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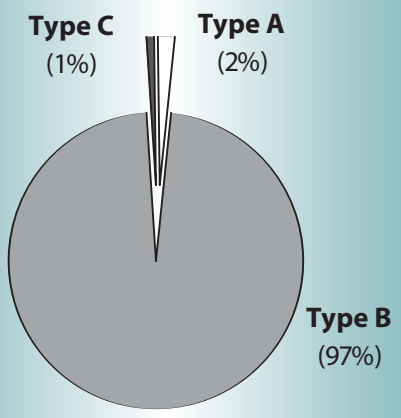
Nursing facilities *continued from p. 1*

Major diagnostic categories can be understood as disease involvement in major organ systems. The average number of major diagnostic categories per resident was 4.4 with a range from 0 to 9. The majority of residents had cardiovascular (78%), neurological (71%), and/or psychiatric (58%) conditions.

Polypharmacy was found to be quite common among Ohio Medicaid nursing facility residents. Residents were prescribed an average of 13.4 medications, with a range of 1 to 48. Almost 30% of residents were prescribed between 6 and 10 medications during the review month, while 32% of residents were prescribed between 11 and 15 medications.

The results of the quality indicator *medications ordered but not administered* revealed that, during the one-month study period, 62% of the residents did not receive at least one dose of medication. Of the 1,457 regularly scheduled medications ordered, 16% had at least one dose not documented as administered. However, fewer than 1% of medications ordered but not administered resulted in an actual ADE causing harm that could be attributed to not receiving a regularly scheduled medication. The majority of the 429 medical records revealed at least one "missing" dose with no documentation of why the dose was not given. This may indicate a lack of documentation rather than a medication error.

Figure 1. ADE Severity Levels



Type A - Potential Error
Type B - Error with No Adverse Effect
Type C - Error Causing Temporary Patient Harm

The ADEs were categorized as either potential or actual ADEs. **Type A** (*potential error*) and **Type B** (*error with no adverse effect*) were considered potential ADEs that could have caused the resident harm, but did not because of chance or because the effects were not detected. **Type C** (*temporary patient harm*), **Type D** (*permanent patient harm*), and **Type E** (*death*) were defined as actual ADEs with measurable resident harm.

Figure 1 displays the breakdown by severity level the potential and actual ADEs

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CODING CORNER

Leukemia and chemotherapy treatments

In this issue of the Coding Corner, we provide information from the *Coding Clinic for ICD-9-CM* on the basic types of chemotherapy treatments for acute leukemia.

Patients with acute lymphocytic leukemia or acute myelogenous leukemia will receive chemotherapy at various times during the course of the disease process. Individual protocols for chemotherapy fall into the following basic types.

- Remission induction chemotherapy, given to reduce the leukemia cell mass and induce remission.
- Consolidation (early intensification) chemotherapy, given immediately following achievement of the remission status. The dosage of chemotherapy drug is the same as or higher than the dosage given during the remission induction phase. Only one course may be needed, but two to four courses could be required.
- Maintenance chemotherapy, given as a lower dose after consolidation therapy is completed and usually continued over several years.
- Late intensification chemotherapy, administered as an intensive chemotherapy phase and given as reinforcement to a patient who is still in remission.

If a patient with acute leukemia relapses during any of the above treatment phases, re-induction may be attempted to re-induce remission.

Example:

A patient was recently diagnosed with acute myelogenous leukemia and is now being admitted for the first cycle of induction chemotherapy.

Assign admission/encounter for chemotherapy (V58.1) for all patients admitted for chemotherapy, regardless of the protocol or staging. Assign the appropriate code for acute myelogenous leukemia (204.00) as the secondary diagnosis.

Remember, consult the *Coding Clinic for ICD-9-CM* and the *Official Guidelines for Coding* to ensure correct code assignments and sequencing for all diagnoses and procedures.

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in this study. The majority of ADEs (97%) were categorized as **Type B**. *Figure 2* presents the severity of potential and actual ADEs by quality indicator. The majority of **Type A** drug events were caused by a *drug-drug interaction* (83%); the majority of **Type B** (85%) and **Type C** (57%) drug events were from a *failure to receive ordered medication*.

Figure 2. Medication Errors Per Quality Indicator by ADE Severity Level

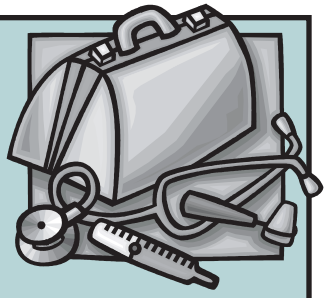
Quality Indicator	A	B	C
Failure to receive ordered medications	6%	85%	57%
Failure to receive medication at scheduled administration time	0%	1%	0%
Drug-allergy interaction	3%	1%	0%
Drug-drug interaction	83%	3%	14%
Routine medication ordered with no diagnosis	8%	8%	0%
Medication administered without an order	0%	2%	7%
Unanticipated drug event	0%	0%	21%

The findings from this study suggest that polypharmacy and multiple chronic health conditions were prevalent among this population. Failure to receive ordered medications was the most frequent cause of potential and actual ADEs. Further analysis revealed 2.3 actual ADEs per 100 resident months.

Recommendations from this study included the following:

- Further investigate residents taking numerous medications concurrently to determine appropriateness and medical necessity of their drug regimens.
- Collect data on the number of diagnoses per resident to determine specific correlations between number of diagnoses, number of medications, and number of ADEs.
- Perform a study with direct observation of live medication passes to determine the frequency of errors due to administration of medications and the percentage of these errors that are potentially harmful.
- Provide additional education on the importance of documentation to nursing facility staff.
- Further review residents' prescribed medications by applying updated Beers' criteria for determining inappropriate medication use in the institutionalized elderly population.
- Build a predictive model of clearly identifiable and easily trackable factors leading to the development of an ADE.

Medical Director *dialogue*



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

Quality is important in nursing facilities. In January 2004, the Centers for Medicare and Medicaid Services (CMS) started to publicly report a set of nursing facility quality measures endorsed by the National Quality Forum, a voluntary standard setting, consensus building organization that represents providers, consumers, and researchers. These measures reflected care delivered to post-acute and chronic nursing facility residents. Subsequent enhanced updates continue to occur quarterly.

The current enhanced risk-adjusted quality measures are dynamic and will continue to be refined as part of CMS's ongoing commitment to quality.

The enhanced chronic care measures are as follows:

- Percent of residents whose need for help with daily activities has increased
- Percent of residents who have moderate to severe pain
- Percent of residents who were physically restrained
- Percent of residents who spent most of their time in bed or in a chair
- Percent of residents whose ability to move about in and around their room got worse
- Percent of residents with a urinary tract infection
- Percent of residents who have become more depressed or anxious
- Percent of high risk residents who have pressure sores
- Percent of low risk residents who have pressure sores
- Percent of low risk residents who lose control of their bowels or bladder
- Percent of residents who have/had a catheter inserted and left in their bladder

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Ohio Commission to Reform Medicaid

The Ohio Commission to Reform Medicaid was established by Ohio budget bill H.B. 95 in November 2003. The purpose of the nine-member commission is "to conduct a complete review of Ohio's Medicaid program and make recommendations for comprehensive reform and cost containment."

ODJFS is assisting this committee by providing important information and statistics on Medicaid programs and initiatives. A few of the topics discussed were long-term care and community services; support and waivers; the needs of the aged, blind, and disabled population; and pharmacy programs.

After participating in many meetings, briefings, and testimonies, the commission will submit its final report to the Governor, Senate President, and House Speaker by January 1, 2005.

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The enhanced post acute care measures posted are:

- Percent of short stay residents who had moderate to severe pain
- Percent of short stay residents with delirium
- Percent of short stay residents with pressure sores

The results of the quality measures provide consumers with additional information about the quality of nursing facility care. Many nursing facilities have already made significant improvements in the care provided to residents.

More information on the enhanced measures, including a table that compares the initial quality measures and the enhanced set of quality measures, can be accessed at the CMS web site, **www.cms.hhs.gov**. Comparative nursing facility information can be found at **www.Medicare.gov** (click on **Nursing Home Compare** link), or by calling 1-800-MEDICARE (1-800-633-4227).

Precertification 101

The Ohio Medicaid Precertification Center, managed by Permedion, handles over 1,800 calls monthly. Requests for precertification are reviewed for the medical necessity of elective inpatient and some outpatient surgical procedures. Permedion works jointly with ODJFS to evaluate the effectiveness of the Precertification Program and to monitor trends in utilization.

The hospital is ultimately responsible for obtaining a precertification number. However, hospitals and physicians' offices should work together to provide the necessary clinical information required for precertification. Each hospital's utilization contact person has received a copy of the nationally recognized Physician Developed Criteria (PDC), which is used by Permedion's nurse reviewers to evaluate clinical information.

At the first level of precertification case review, nurse reviewers do not "deny" requests. They compare provided clinical information to the PDC criteria. If the medical information provided does not meet the standards of these criteria, the information can be sent to an Ohio-based, specialty-related physician reviewer. If the physician reviewer denies the request, the hospital or physician's office can submit a request for reconsideration in writing to Permedion within 60 days of the original determination date. A different specialty-related physician will review the reconsideration request. If the procedure is still denied after reconsideration, a request can be made to ODJFS for an administrative review. The Medicaid recipient also has the right to request a hearing at any time during this process.

For questions regarding the precertification of elective surgical procedures, please call the Ohio Medicaid Precertification Center at 1-800-772-2179. For all other questions related to Medicaid claims, eligibility, prior authorization of procedures not normally covered by Medicaid, or procedure plan coverage, please call ODJFS at 1-800-686-1516.

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