Ohio | Department of Job and Family Services

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Appeals and Reconsiderations of Determinations Regarding Hospital Inpatient Services

The determinations made by Permedion are subject to the reconsideration process described in rule 5101:3-1-57 of the Administrative Code. A written request must be submitted to Permedion within 60 days of the date of the determination which may include a copy of the written determination, a copy of the patient's medical record, and copies of any and all additional information that may support the provider's position.

The Ohio Department of Job and Family Services (ODJFS) will conduct an administrative review of the reconsideration decision if the decision is upheld. A request must be submitted within 30 days and should include a letter requesting a review of the reconsideration, including a statement as to why the provider believes that the reconsideration was in error, and any further documentation supporting the provider's position. Providers do not need to send medical records to ODJFS unless there is new information as the medical records are available via the Permedion secure web site if needed.

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Unlisted Codes: Right, Wrong or Time for Change! (Part 2)

The Outpatient Unlisted Surgical Procedure Codes Study was developed into two sections. The first section involved cases with the unlisted dental procedure code of 41899. This group was called the Dental Group. The results of the Unlisted Dental Codes section were summarized in the Spring 2010 edition of the Quality Monitor. The second section included cases with non-dental unlisted surgical procedure codes. This group was called the Non-dental Group and the results are summarized in this newsletter edition.

Some services and procedures performed in the outpatient hospital setting cannot be defined by CPT and HCPCS codes. In those instances, the hospital is allowed to bill the services using unlisted or miscellaneous procedure codes. Coding rules dictate that providers should use these codes only as a last resort (CMS, 2009).

The Ohio Administrative Code (OAC) policies for outpatient hospital services as listed in 5101:3-2-21 (Lawriter, 2009) state that when a surgical services claim carries an unlisted surgical procedure code, line item charges on the claim, except for radiology, pregnancy, and laboratory CPT codes, will be paid at 69% of the line item charges. All claims in the study, except those from DRG-exempt hospitals, were paid in this manner.

The Outpatient Hospital Unlisted Non-Dental Procedures Study, Section Two provided information regarding the use of the unlisted non-dental procedure codes (15999-41599 and 42299-69979). Medical record review performed on the selected cases identified in the analysis determined whether the services were properly coded and properly billed. The objective of the study was to determine if the procedure identified as the unlisted CPT procedure code had a specific CPT code that was more appropriate.

The study population included Ohio Medicaid fee for service (FFS) outpatient cases with service dates from 1/1/2007 through 12/31/2007. Overall, there were 3,356 unlisted surgical procedure codes billed by outpatient hospitals in 2007. There were 964 unlisted non-dental procedure codes. A random sample of 412 unlisted non-dental procedures was selected for review.

Review of the overall population revealed that the average consumer age was 29 years. Use of the unlisted non-dental procedure codes by Ohio Medicaid aid program distribution showed that the Aged, Blind, and Disabled program accounted for 56% of the use of the unlisted non-dental procedure codes, while Covered Families and Children program accounted for 35%, and the Children's Health Insurance Program was only 4%. This is consistent with the current Medicaid FFS population.

Medicaid paid $1,287,413 to outpatient hospitals for unlisted non-dental surgical procedures. The average allowed charge was $1,335 ranging from $0 to $20,432. The median was $207. The procedure with the highest allowed charge was for 49659 (laparoscopic hernia repair) at $188,036. The highest average

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allowed charge was for 15999 (removal of pressure sore) at $13,743.

Approximately 74% of the unlisted non-dental procedures codes were incorrectly coded. Detailed descriptions of the unlisted procedures and resources used were available in 99% medical records. The surgical reports were used by the Permedion coding specialists to determine if the use of the unlisted code was correct.

Evaluation of the reasons for using the unlisted code was made for each case. In the overwhelming majority (96.6%) of the unlisted non-dental procedure codes that were identified as incorrectly coded, a more appropriate specific CPT code should have been used to describe the procedure performed. Use of the correct specific code negated the need for using the unlisted procedure code. The unlisted code most frequently coded incorrectly was 49329 (Laparoscopy, Abdomen/ Peritoneum/ Omentum).

A teaching hospital in Columbus received the highest total allowed charges for unlisted non-dental surgery procedure codes at $145,538. A hospital in Cincinnati had the highest volume of unlisted non-dental procedures (109) and claims with unlisted procedures (104), and the highest total claim reimbursements for unlisted non-dental procedure codes at $470,596. A Dayton hospital had the highest average cost per procedure of $5,750. Another hospital in Cincinnati had the highest average claim reimbursement of $14,479.

The findings of the Non-Dental Section of the Unlisted Surgical Procedure Codes Study support the following recommendations to further describe and identify opportunities to provide appropriate reimbursements for the unlisted procedure codes.

- Perform another study using a sample stratified by procedure and provider. The results of the study could be generalized to determine the most frequently incorrect unlisted procedure codes and identify the providers that incorrectly bill the unlisted procedure codes.
- Consider changing the Ohio Administrative Code policies to promote uniform use of the medical, surgcal, preventive, and diagnostic services included in unlisted procedure codes and provide standardized reimbursement for these services through the subsequent options:
  - Determine an established allowed charge for unlisted procedure codes regardless of the amount billed by the provider and provide a limited number of times the code can be listed on the claim for pay ment.

  – or –

  - Require prior authorization and/or retrospective review of all unlisted procedure codes in order to determine coverage and appro priate allowed charges. The review should include determinations of

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CODING CORNER

Coding of Complications Versus Aftercare

In this issue of the Coding Corner, we provide information on the importance of differentiating between an admission for a complication of surgery or medical care versus admission for aftercare.

Generally, a complication is defined as a condition that arises during the health care episode that modifies the course of the patient's illness or the medical care required. The definition of "other/secondary diagnosis" is all conditions that coexist at the time of the admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Additional conditions that could affect patient care are: clinical evaluation, therapeutic treatment, diagnostic procedures, and increased nursing care and/or monitoring. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. The coder must be careful not to assign complication codes for routine aftercare encounters, for example: admission for removal of pins from femur (V54.01).

As indicated, it is important to differentiate between an admission for a complication of surgery/medical care and an admission for aftercare. An admission for aftercare is usually planned in advance to take care of an expected residual or to carry out follow-up activity, such as removal of pins or plates placed during earlier orthopedic surgery. The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. For example, a closure of a colostomy (V55.3) during an encounter for treatment for another condition.

Also, certain aftercare V code categories need a secondary diagnosis code to describe the resolving condition or sequelae, for others, the condition is inherent in the code title. Additional V code aftercare category terms include, fitting and adjustment, and attention to artificial openings. For example, encounter for planned post-operative wound closure (V58.41).

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appropriate level of care, medical necessity of procedures, established standards of care, correct coding, and uniform allowed charges based on the actual procedures to be done.

Quality of Care Findings SFY 2008

As the utilization review entity for the Ohio Department of Job and Family Services (ODJFS), Permedion completes a semi-annual analysis of the quality concerns that are identified through our retrospective medical record review program. Every medical record is reviewed for quality according to generally accepted standard of medical practice and patient care. The most recent analysis incorporated State Fiscal Year (SFY) 2008 (July 2007 – June 2008).

The report includes quality concerns for each hospital, as well as hospital peer groups. The peer groups are designated by ODJFS for our reporting purposes. The reporting period takes into account the lag time involved in the examination and final determination of the identified quality issue. The goal of this program is to improve the medical care received by Medicaid consumers through identification of opportunities for quality improvement.

On an ongoing basis, Permedion analyzes patterns of quality of care for concerns which may be significant in a single episode or collectively. Cases identified by a Permedion nurse reviewer with a potential quality issue(s) are evaluated by credentialed Ohio physicians who are currently in active practice. The quality concerns are categorized into three severity levels:

- A **Severity Level 1 Concern** is defined as medical mismanagement without the potential for significant adverse effects on the patient. These concerns are trended or monitored and hospitals are tracked in terms of the number of Level 1 quality concerns that are identified; the hospital provider is not not fied and no further action is taken. An example of a Level 1 quality concern would be a medical record that is missing documentation such as laboratory tests or imaging study results.
- A **Severity Level 2 Concern** is defined as a confirmed quality problem with the potential for significant adverse effect(s) on the patient. These concerns are confirmed quality issues validated by a physician reviewer. An example of a Level 2 concern would be that an antibiotic was ordered; however, the drug was not administered.
- A **Severity Level 3 Concern** is a confirmed quality problem with significant adverse effect(s) on the patient. These concerns are also confirmed qual ity issues validated by a physician reviewer. An example of a Level 3 concern would be a patient had that experienced peritoneal bleeding after a nephrec tomy, which required a return to surgery.

The overall percentage of Level 1 concerns for SFY08 was unchanged from 2007. The overall percentage of confirmed quality concerns (Level 2 and 3) showed an increase; the peer group with the most increases was the teaching hospitals. No individual hospital showed significant changes.

There were 165 confirmed Level 2 concerns and 14 Level 3 concerns

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Medical Director *dialogue*

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

Guidelines and Medical Decision Making

Recently, I had a discussion with a physician who was upset about "these guidelines for care that insurers are always quoting." He continued by saying that so many of the things physicians do everyday haven't been studied or proven in the literature. "I don't need a guideline to tell me how to treat a patient with community-acquired pneumonia," he commented. Moreover, he offered the analogy that "there were no studies or guidelines to validate the use of parachutes in sky-diving; and yet, the use of a parachute is most definitely the accepted standard."

All of what he said was true, but he was missing the point. Guidelines are merely tools that help to guide decision making. They are very similar in purpose to the checklists now employed in the cockpits of airliners, which were cornerstones of the quality revolution that occurred in professional aviation around 20 years ago. Things like the nationally recognized and validated Pneumonia Severity Index help to provide insight into complex medical scenarios and provide the benefit of accumulated medical knowledge. Utilizing such information is likely to be advantageous for both the patient and the system. No one can debate the utility of checklists in the cockpit and the evidence shows that they have raised the level of quality and safety in aviation. Likewise, patients will benefit from more focused care as the system benefits from the more efficient utilization of resources.

By formulating and adhering to appropriate guidelines for the most common scenarios, we are able to provide a malleable blueprint to be used as a resource for providing effective and efficient care, not a cookbook which is to be followed rote. Our professional societies have begun to establish their recommended sets of guidelines for common conditions which out-line basic expectations for care that are consistent with the current best practices. This concept is

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Coders need to utilize the ICD-9-CM Official Coding Guidelines for Coding and Reporting for the selection of the appropriate principal diagnosis code, secondary diagnoses codes, and procedure codes to ensure appropriate billing and reimbursement of the claim.

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very similar to the way a checklist in employed. No one checklist can cover every scenario. But the concept is to provide a basic blueprint which is adaptable to many circumstances.

So the question really isn't whether or not a parachute is needed. We all know that it is. The question is: What type of fabric? What is the strongest stitching? How should it be folded? Certainly, if I have to jump out of a perfectly good airplane, I want to know that my parachute has been stitched, folded, and packed according the current best standards available. Likewise, when I am admitted for pneumonia, I would like to be the beneficiary of the body of accumulated medical knowledge as employed through a blueprint for effective care – not just followed rote out of a cookbook. As we all know, "When we work together, we are smarter than any one of us is when working alone."

Moving to Electronic Review

Permedion, the company selected by the Ohio Department of Job and Family Services (ODJFS) to review the necessity and appropriateness of health services, is moving towards an electronic records/document management system. What does this mean for you as a provider?

In the near future you will be requested to send your medical records that have been selected for review to a scanning center in Irving, Texas instead of the Westerville, Ohio address. The scanning center will be a centralized location for all records. Records will be scanned using a system called ImageNow. ImageNow ensures that all documents are secure and quickly & efficiently retrievable. Permedion will continue to follow standards for secure record storage and destruction. It is the policy of Permedion to retain records in accordance with all applicable laws, regulations and other requirements and to prevent unauthorized use or disclosure of Records that contain confidential information, including Protected Health Information (PHI) and privileged materials.

The scheduled date for this process is November of 2010. You will be receiving specific instructions as to how and where to send your records for the retrospective review process. Whether you currently send hard copies of medical records or electronic copies you will be able to continue the operations that are best for you. The most significant change in the process will be the discontinuation of onsite reviews. As always, Permedion will work with you to make this new process as smooth as possible.

Many Ohio facilities, who work with the Medicaid Managed Care Organizations, are already sending records to the scanning service center. The provider, client and clinical feedback have all been positive. Plans are to complete the migration of all of Permedion records to Image Now by the end of this year. Stay tuned for more information regarding this change of process.

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identified and included did not appropriately assess and/or act on laboratory tests or imaging study results; did not carry out an established plan in a competent and/or timely fashion; and did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans. Confirmed concerns increased in a significant manner, at a rate of over 46% over the previous year's results. Data analysis, at this time, does not support any conclusions regarding the increase in confirmed quality concerns.

Permedion provides individual hospital providers with a monthly Preliminary Summary of Quality of Care Findings report in addition to individual quality letters. Permedion also reports the complete information on the Level 2 and Level 3 confirmed quality concerns to ODJFS.

For additional information regarding Permedion's quality of care review program, please contact Sue Butterfield, IMR Service Line Manager at 1-800-473-0802 Ext 3428.

http://www.odjfs.state.oh.us/subscribe/.

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