Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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New Year! New Contract!

Permedion/HMS again has been awarded the Ohio Medicaid Fee for Service Quality and Utilization Review Contract through a bidding process that occurs at least every six years. Permedion has held this contract for the last 14 years.

As of July 1, 2011 (SFY 2012), a few changes in the scope of work will come with the renewal of this Ohio Medicaid contract. The changes are as follows:

- Permedion will perform utilization review on 1500 cases each month instead of the previous 1000 cases per month.
- Some of the 1500 cases will be outpatient or observation stays instead of the previous contract in which only inpatient stays were selected. Outpatient stays with unlisted dental and non dental surgery codes will be included in the retrospective reviews. When outpatient records are requested, the entire record should be submitted, including H&P, operative reports, radiology/lab reports, etc.
- Permedion will continue to move towards an electronic records/document management system. Starting in August 2011, providers will be requested to send selected medical records for review to a scanning center in Irving, Texas instead of the current Westerville, Ohio address. The scanning center will be a centralized location for all records. Each hospital will receive specific instructions as to how and where to send their records within the next month. See *Page 4* for the Image Now process.
- Submission of medical records in electronic formats (system generated and/or scanned) is encouraged. Most hospitals find it more efficient and secure, and it minimizes or eliminates shipping costs.

A Look at the Ohio Medicaid Developmental Disability Programs

Background

In January 2007, Ohio was one of 31 states and the fourth-largest grantee of the Money Follows the Person Demonstration enacted by Congress as part of the *Federal Deficit Reduction Act of 2005.* The Office of Ohio Health Plans (OHP) in conjunction with the "Front Door Stakeholder Group" is working towards a system of long-term care for the developmentally disabled consumers that maximizes choice and promotes community integration. The objective is to expand Ohio's capacity to serve these consumers with long-term service and support needs in the community.

Ohio Medicaid's current long-term care system is progressing toward greater flexibility in choosing long-term care options. Identification of care needs and preferences of consumers and family members for community care could provide important information to help prevent or delay institutional care.

The Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) and Waiver Functional Assessment Study provides information on profiles of levels of care criteria and long-term care placement in ICF/DD facilities and Developmental Centers (DCs), and the waiver programs of Individual Options, Level One, and Transitions DD. The study describes how characteristics of placement vary among consumers in each of the five programs.

Methodology

The study population included Ohio Medicaid consumers enrolled in the Individual Options, Level One or Transitions DD waiver programs, or residing in a ICF/DD (public, private) or DC.

Eligible recipients were placed into one of five comparisons groups based on their waiver enrollment or facility placement as of June 2008. A stratified random sample was selected from each of the five comparison groups. This sample size was chosen so that odds ratios as small as two could be detected with 80% power and 95% confidence.

Using logistic regression, separate models were constructed for consumers under 18 years old and 18 years old and over to reveal characteristics related to enrollment/admission to a waiver program or an institutional facility. Estimated odds of a consumer with a specific characteristic being enrolled in a waiver or institutional program were determined.

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Results and Discussion
Characteristic profiles provided a better understanding of the consumers in the developmentally disabled programs. From the results of this study, the following information regarding the differences and similarities in the groups was identified:

The Transitions DD Waiver benefit package includes home nursing services, personal care assistance services and/or skilled therapy services. Also included in the benefits are home modifications, adult day health care, respite care, transportation, adaptive/assistive devices and emergency response systems. The Transitions DD group had the youngest median age of 15 years. They had the highest percent of traumatic brain injuries (12%). Rehabilitation services and special equipment were required by 49% of these consumers.

For the Individual Options waiver program, Medicaid eligibility as the health insurance is required. With the waiver, Medicaid allows developmentally disabled people to stay in their homes and get support rather than require them to live in an ICF/DD facility. The Individual Options group had the lowest percent of functional disabilities in learning, communication, and mobility. They were most likely to exhibit inappropriate behaviors. They had the highest percent of consumers in 12 out of the 18 defined inappropriate behaviors.

The Level One Waiver is for people with developmental disabilities who require the care given in an ICF/DD facility but want to live at home. They must have a network of families, friends, neighbors, and professionals who can safely and effectively provide the needed care. The cost for this help is a set amount and cannot be more than the Level One Waiver allows. The Level One group had the lowest percent of mental disorders (42%). They also the lowest rate of drug utilization in nine out of the 12 categories and 11% did not take any medications.

The DCs are licensed and certified as ICF/DD facilities. The consumers must receive individually designed acute treatment services. The DC group was the oldest group with a median age of 50 years. They had the highest percent of mental disorders (75%) and also had the highest rate of utilization of anti-psychotic medications. They had the highest proportion of consumers with profound developmental delays (52%).

The ICF/DD facilities are licensed to be operated by a specific provider at a specific location. The facility is responsible for all aspects of care including financial matters, transportation, habilitation, and medical needs. The ICF/DD group had the highest rate of learning limitations (97%) but over 60% were employed in sheltered workshops. They also had the highest average percent of consumers with six defined developmental delay needs ranging from 80% to 100%. Three fourths of this group had been enrolled in their current program for over 73 months.

The program similarities revealed that all five programs had a higher proportion of males. The percent of males ranged from 57% to 66% of the population.

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CODING CORNER

Traumatic Brain Injury

In this issue of the Coding Corner, we would like to follow-up on the article presented in this issue of the Ohio Medicaid Quality Monitor on the ICF/DD and Waiver Functional Assessment Study. This study provides information on how consumers move between the waiver programs and institutional facilities and how the consumer's care needs change.

As indicated in the study, the results revealed that the Transitions DD group had the highest proportion of consumers with a claim for a traumatic brain injury (TBI) at 12%.

DEFINITION

Traumatic brain injury is defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force. These would include injuries such as:

- Traffic accidents
- Falls
- Physical assaults
- Accidents at home and at work
- Playing sports

SYMPTOMS

- Confusion, temporary memory loss, ringing in the ears, nausea, slurred speech, headache, loss of consciousness, drowsiness, and dilated pupils.

Coding Clinic Fourth Quarter 2010, pages 95-97, effective with discharges of 10/1/2010, indicates that new codes have been created to identify cognitive deficits related to a TBI and neurological conditions. These codes are used to describe cognitive impairments such as problems with memory, concentration, attention, communication, and executive function. They are intended to be used as supplementary codes when the cause of the deficit is known as well as before a more specific diagnosis is made. In addition, these codes may be used as supplementary codes when the cause of the deficit is known because the deficit is not inherent to the condition. These codes are located in Chapter 16, Signs, Symptoms and Ill-Defined Conditions, of ICD-9-CM with a new subcategory. This range of new codes are 799.51 through 799.59, which identifies the following deficits: attention, concentration, cognitive communication, visuospatial, psychomotor, frontal lobe and executive function.

CODING EXAMPLE

The patient presents as an outpatient with a diagnosis of psychomotor deficit following TBI. Assign code (799.54), psychomotor deficit as the first-listed diagnosis, followed by the code (907.0), for the late effect of the intracranial injury without mention of skull fracture, for the psychomotor deficit due to the TBI.

As always, when coding a diagnosis and it is questionable, always refer to the attending physician for clarification as final coding is dependent upon physician documentation in the medical record.

Medical Director *dialogue*

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

The STAAR Initiative from the IHI and its Early Lessons

It is no secret that readmissions are costly to our health care system. In fact, the Medicare Payment Advisory Committee (MedPAC), in their report, "Promoting Greater Efficiency in Medicare," to Congress in June of 2007, estimated that 20% of Medicare beneficiaries are readmitted within 30 days after discharge. This startling rate varies highly across states (13-24%) and even varies significantly within different regions of the same state. SF Jencks, et al, in their study, "Rehospitalizations among Patients in the Medicare Fee-for-service Program," NEJM, 2009, noted that this phenomenon costs an estimated $12 billion per year. Approximately 76% of these readmissions were deemed to be possibly avoidable.

It has long been known that comprehensive discharge planning works. Phillips et al. in their study, "Comprehensive Discharge Planning with Post-Discharge Support for Older Patients with CHF" JAMA 2004, demonstrated that with such planning significantly decreased readmit rates are achieved and, interestingly enough, all-cause 30-day mortality was also improved.

CMS has been paying attention to this research. The Patient Protection and Affordable Care Act (PPACA) legislation enacted in Congress in March 2010 contains a provision in Sec. 3025 which provides significant reimbursement penalties to hospitals whose readmit rates are higher than expected for selected diagnoses.

In order to study this issue, in May 2009, the Institute for Healthcare Improvement (IHI) launched the State Action on Avoidable Rehospitalizations (STAAR) initiative. I recently had the opportunity to hear Marian Birhle Johnson, MD from the IHI speak about the STAAR initiative. She noted that, "This initiative represents a groundbreaking, multi-state, multi-stakeholder approach focused on improving the delivery of effective care at a regional scale."

The IHI website details that: "STAAR initiative aims to reduce rehospitalizations by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites and clinical interfaces. IHI partners with STAAR states to provide strategic guidance, support and technical assistance to hospitals and cross-continuum teams to improve transitions in care and reduce avoidable rehospitalizations." The program is currently in four states: Washington, Massachusetts and Michigan started in 2009 and hospitals from Ohio were added in 2010. The core concepts of the STAAR Initiative focus on "the implementation of four key process-level improvements that require extensive collaboration between the hospitals and their community partners to effectively co-design better processes."

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The overwhelming majority of the consumers' marital status was single. The primary etiologies of the consumers' developmental disabilities for 5% or more of the population were Cerebral Palsy, Autism, Down's Syndrome, and Epilepsy. As expected due to larger populations, the program distribution of the county types revealed that metro counties had the highest percent of consumers in the programs.

Recommendations

The findings of this study support the following recommendations:

- For determination of a consumer's care needs, eligibility, planning, and monitoring across various agencies, and long-term developmental disability services, a uniform assessment instrument with common definitions and standard criteria may be needed.
- The establishment of a quality assurance program with emphasis on documentation and inter-rater reliability would improve consistency in the consumer information.
- A training program for personnel conducting consumer assessments would provide more accurate information across developmental disability care settings.
- A complete database that is used for consumers in all developmental disability care settings would provide better continuity of care and easier access to important consumer information.
- In order to more fully explain how consumers move between the waiver programs and institutional facilities, and how their care needs change over time, a second study would be needed to track a fixed group of consumers over a longer period of time with the use of all payer sources.

The entire report can be obtained at:

www.hmspermedion.com/Ohio Medicaid.

New ImageNow Process

The Ohio Medicaid Fee-for-Service Quality and Utilization Review Project will now use ImageNow. Permedion/HMS's enterprise-wide document imaging and workflow system saves time, improves quality, and increases efficiency. It is a significant improvement to the utilization review process. The ultimate goal is to create a paperless review process for both the provider and Permedion. Medicaid providers who already send records electronically, will not change their process. The medical record request sent to hospitals in July asks Medicaid providers to send their hard copy records to the scanning center by using one of the two following addresses:

For sending by FedEx or UPS
(you must have an address with the street name):

HMS
Attn: OH Medicaid Imaging
5615 High Point Drive
Irving TX 75016-5407

For sending by United States Postal Service
(you can send to a post office box without a street name):

HMS
Attn: OH Medicaid Imaging
P.O. Box 16778
Irving, TX 75038

The Permedion staff is excited about this new document imaging system knowing that it will make us more efficient in the Ohio Medicaid utilization review program.

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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The four processes are:

1. Perform an enhanced assessment of post-hospital needs
2. Provide effective teaching and facilitate enhanced learning
3. Provide real-time handover communications
4. Ensure timely post-hospital care follow-up

The six early lessons from the work to date are:

1. Focus on all readmissions
2. Form a cross-continuum team
3. Start measuring all-cause 30-day readmission rate
4. Determine baseline readmission rate and then track over time
5. Focus first on improving current processes
6. Stimulate the financial impact of reducing readmissions

As this seminal work proceeds, we are able to glean the lessons it offers. Readmissions are costly, too frequent, and are an area of potential improvement in the provision of healthcare. In order to do so, it requires a comprehensive approach with improvement in communications across providers and settings, engagement of patients and families and appropriate coordination between medical and social services.

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