Ohio medicaid QUALITY MONITOR

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Focus on health care needs of the poor

In the United States, there is growing concern over the health care of the poor. In Ohio, the average percentages of people without health insurance were 10.7% for 1999-2000 and 11.2% for 2000-2001. One source of information about Ohio's uninsured population is data collected on hospital care through the Hospital Care Assurance Program (HCAP).

HCAP is Ohio's mechanism for meeting the federal requirement to make additional payments to all nonpsychiatric hospitals that provide a disproportionate share of care to indigent patients. As the administrative body for HCAP, ODJFS has an interest in acquiring more insight into the health care needs of this population and the quality of the health care provided.

ODJFS, through the Ohio Medicaid Institutional Quality and Hospital Utilization Management Program with Permedion, is currently conducting the **HCAP Quality Review Study** for Federal Fiscal Year 2002. The study will provide descriptive information about the health care services reported for HCAP and about the recipients of these services. The objectives of the study are:

- to generate demographic profiles of recipients of the services reported for HCAP.
- to describe the types of hospital services reported for HCAP by patient eligibility category and selected demographic characteristics.
- to describe diagnoses, procedures, quality and appropriateness of the services provided.

The study is slated for completion by May 2003. The results will be published in a future issue of the *Ohio Medicaid Quality Monitor*.

published in cooperation with:

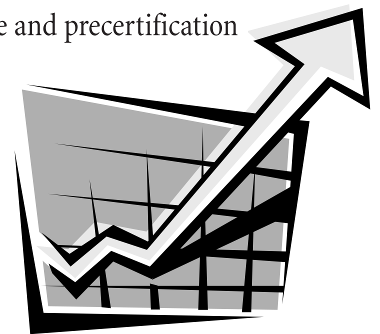
Analysis and selection of precertification targets

Precertification is one of the key functions in the Ohio Medicaid Utilization Management Program and is described in Rules 5101:3-2-40 and 5101:3-2-42 of the Ohio Administrative Code (OAC). Precertification is used to prospectively monitor the medical necessity of covered procedures that have the potential to be performed unnecessarily. Precertification applies only to procedures performed under elective conditions. Procedures performed on an emergency basis do not require precertification. When precertification is required, there will be no financial reimbursement to the hospital if precertification is not obtained. (Prior authorization is also a prospective utilization management tool that monitors medical necessity. However, prior authorization differs from precertification in that it applies to transplants and procedures not normally covered under the Medicaid program, e.g., plastic surgery and treatment of obesity. See Rule 5101:3-2-03 of the OAC.)

SELECTION

The selection of specific procedures requiring precertification is a multifaceted process. Procedures currently precertified and procedures that previously required precertification but are no longer on the list are subject to the same analyses.

The monthly volumes for retrospective and precertification reviews, as well as monthly volumes for all procedures submitted for reimbursement, form the basis of the ongoing analysis. This analysis typically involves examining the volumes of primary procedures per 1,000 eligible Ohio Medicaid recipients. In other words, the analysis focuses on increases in rates per 1,000 recipients, thus excluding those increases in volumes that are simply a result of having more eligible recipients.



When analyzing trends and patterns, Permedion uses Statistical Process Control (SPC), which is a useful method for identifying when processes go *"out-of-control."* All processes involve change—so the number of any specific procedure will vary from month to month. SPC allows Permedion to identify when the volume of the procedure increases more than expected given the

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normal variation in processes. In this way, Permedion identifies procedures that require a closer look as potential precertification targets for overutilization.

Procedures that display a pattern of increasing volume are not necessarily ideal precertification targets. Other factors are considered, such as whether the procedure in question is one that may be open to abuse in terms of unnecessary utilization or overutilization.

Another issue that is considered is whether the procedure has become more commonly used as a result of a change in the standard of care. For example, analyses have revealed that the number of colonoscopies increased steadily over the past 24 months. Permedion believes this trend reflects a change in the standard of care. Colonoscopies are recommended as an effective screening test for colon cancer, the second leading cause of cancer death in the United States.

Requests for precertification for Ohio Medicaid consumers can be phoned or faxed to:

National Health Services, Inc.
9200 Shelbyville Road, Suite 700
Louisville, KY 40222
Telephone: 800/772-2179
Fax: 800/591-1819

PRECERTIFICATION

When requesting precertification, be sure to have the following information ready:

- Medicaid consumer demographic information
- Physician demographic information
- Facility demographic information
- Clinical information

Section III of the ***Ohio Medicaid Utilization Review Program Manual*** provides a detailed description of the information needed for precertification. Section III also lists procedures that currently require precertification, the corresponding ICD-9-CM and CPT-4 codes, and suggested Physician Developed Criteria. Reconsideration and appeal requests are managed in accordance with Rule 5101:3-2-07.12 of the OAC.

National Health Services, Inc. (NHS), a comprehensive medical management and review organization, serves as Permedion's subcontractor for the nurse review portion of the Ohio Medicaid Precertification Program. NHS is accredited by the American Accreditation HealthCare Commission (URAC), whose standards support the structures and processes necessary to promote high quality care and preserve patients' rights. NHS provides utilization management services for several managed care organizations evaluated and accredited by the National Committee for Quality Assurance (NCQA). Thus, NHS' utilization review

Precertification *continued on last page*

CODING CORNER

Identifying and coding debridement of skin

Recently, Permedion nurse reviewers identified several cases in which excisional debridement of the skin was incorrectly coded. In this issue, we explain the correct coding and identification of excisional versus nonexcisional debridement of the skin.

Coding Clinic for ICD-9-CM (3rd Quarter, 1991) indicates that unless the attending physician documents in the medical record that an excisional debridement was performed (e.g., definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of skin should be coded to 86.28, nonexcisional debridement of skin. Any debridement of the skin that does not meet the criterion noted above, or is described in the medical record as debridement and no other information is available, should be coded 86.28, nonexcisional debridement.

An example:

A 56-year-old diabetic female with a history of diabetic foot ulcers presented to the Emergency Room with left toe redness, swelling and blackness. The patient was admitted to the hospital with dry gangrene of the left foot and was placed on IV antibiotics. Blood sugars were monitored and the patient was treated with insulin. A bone scan revealed osteomyelitis, and the blood cultures revealed no growth. The nursing staff provided wound care by performing wet-to-dry dressings, nonexcisional debridement and whirlpool baths. In this case, the excisional debridement of the foot was incorrectly coded as excisional debridement of skin (86.22). This code is not substantiated because the document notes that wound care included nonexcisional debridement, and there is no additional information in the medical record to indicate that excisional debridement was performed. Based on documentation in the medical record, the procedure should have been coded as nonexcisional debridement of the skin (86.28).

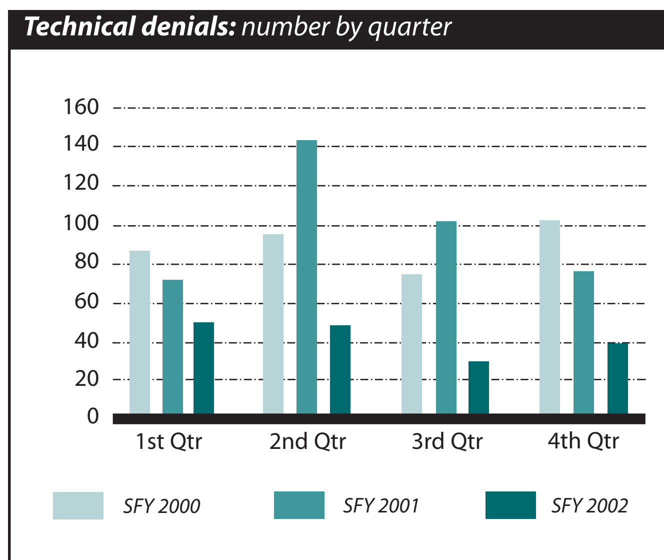
If a diagnosis or procedure is questionable, always refer to the attending physician for clarification. Final coding is dependent upon physician documentation in the medical record.

Preventing technical denials

Every month, Permedion requests approximately 955 medical records for review as part of the Ohio Medicaid Retrospective Utilization Review Program. As described in Rule 5101:3-2-07.13 of the Ohio Administrative Code, medical records requested by Permedion for review must be supplied within 30 days of the request. Failure to produce records within 30 days will result in a technical denial, which means the withholding or recoupment of Medicaid payments.

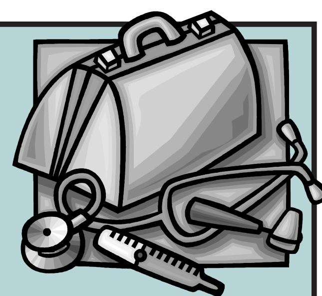
Early in the Retrospective Utilization Review Program, medical records selected for off-site review were sent to NHS, the Permedion subcontractor in Louisville, Kentucky. During SFY 2002, Permedion began to review off-site medical records at their office in Westerville, Ohio. For hospitals that have 10 or more records selected for review, a nurse reviewer goes on-site to hospitals to review medical records. When fewer than 10 medical records are requested, the hospital is required to mail copies of the targeted records directly to Permedion. All selected records are reviewed for billing, utilization, readmission, DRG validation and quality.

A tracking system was developed to log medical records that are requested from hospitals. The tracking system is used to identify the hospitals that have not submitted the requested records within the 30-day time frame. As a courtesy to these hospitals, Permedion calls the designated Medicaid contact person for every hospital whose records have not been received by the 21st day. The purpose of these courtesy calls is to reduce the number of technical denials that hospitals receive for nonproduction of medical records within the mandated 30-day time frame.



The table ***above*** suggests that the courtesy calls may have resulted in a substantial reduction in denials based on nonproduction of the medical records.

Medical Director *dialogue*



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

In the Autumn 2002 issue of the *Quality Monitor*, Barb Edwards, the Deputy Director of ODJFS, Office of Ohio Health Plans (OHP), wrote about the economic challenges facing Ohio's Medicaid program. Let me offer some other thoughts as a practicing clinician, and, I hope, valuable perspective.

“Where there is crisis, there is opportunity” is an old saw, but a valuable reminder. Because 80% of Ohio Medicaid expenditures are for enrollees in the Aged, Blind and Disabled (ABD) population, which represents only 20% of all Medicaid enrollees, meaningful cost savings will not occur without addressing the ABD population. We in OHP have been discussing for some time, a new approach for Ohio Medicaid—care management for the ABD population. One option being considered is the Physician Network Management (PNM) model.

A PNM is a network of physicians and other professionals that focuses on preventive, primary and ambulatory services. OHP would contract with PNMs that agree to manage the care of high-cost ABD enrollees who reside in the community (i.e., not in a nursing facility). If properly designed and implemented, this approach would reduce the use of costly, preventable hospital and emergency department services, improve health outcomes and lead to better use of prescription and over-the-counter drugs.

OHP could offer enhanced reimbursement to those PNMs that provide greater value through quality, cost-effective care. This would be consistent with the first strategy in OHP's Strategic Plan (see “Leading Through Planning” in the Summer 2002 issue of the *Quality Monitor*): To “use value purchasing approaches to provide our consumers with a health plan that emphasizes accessibility, network management, quality and improved outcomes.”

Medical Director *continued on back*

Precertification *continued from p. 2*

activities, policies and procedures are consistent with NCQA requirements and guidelines.

Permedion project managers Phyllis Alder and Sue Hackett are available to answer questions at 614/895-9900. NHS project manager Carolyn Baete can be reached at 800/772-2179.

Medical Director *continued from p. 3*

We will know that this new strategy is successful when we (OHP, physicians, hospitals, pharmacists, case managers and other providers) relate with our patients and each other in a more coordinated and more value-based way.

Transmittal letters go electronic

ODJFS has converted to an electronic publication of policies that previously were provided on paper. Starting in October 2002, ODJFS ceased sending paper copies of attachments (e.g., copies of new rules) to Ohio Health Plan provider program updates. However, Medical Assistance Letters and update cover letters (e.g., MHTLs, HHTLs) that announce policy implementation, updates and changes will continue to be distributed in paper format through March 31, 2003. Then, beginning April 1, 2003 both the attachments and the cover letters will be in electronic form only.

Program updates are available in electronic format at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.

Providers can also access program updates through the Legal/Policy Central calendar, which is available on the Internet at http://www.state.oh.us/odjfs/lpc/calendar. This site requires more detailed instructions; tips for how to maneuver through this site will be provided in the Spring 2003 issue of the *Quality Monitor*.

Improved data-collection process

Current literature indicates the use of computer application programs to collect data has been a success. This information led Permedion to investigate whether computer-based data collection could be used for the paper-based Medicaid retrospective record review process.

As a result of that investigation, Permedion developed a computer program for retrospective reviews that enables the RN reviewer to key data from medical records into a laptop computer, where the data are stored. Once the review is complete, the RN reviewer returns the abstracted information to Permedion's main office, where the stored data are combined into one database for processing and analysis.

Microsoft's Visual Basic was chosen as the programming language to develop the new application program (ORION). Numerous meetings were held between Permedion's programming and project staff to create an application design that would meet the needs of both the RN reviewers and the administrative personnel. The same group of people also was involved in thoroughly testing the application. The culmination of the team's efforts resulted in ORION being placed into production for the December 2002 review process.

If Permedion schedules your hospital for an on-site review of medical records, please make sure that the RN reviewer is provided with a space that includes an electrical outlet. This will facilitate the new laptop data-collection process. If you have questions or comments related to the retrospective review process or the improvements in the data-collection process, please contact Phyllis Alder at 614/895-9900 or palder@permedion.com.

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