Ohio medicaid QUALITY MONITOR

VOL. 5, NO. 1 WINTER 2004

Hospital Care Assurance Program Study

Background

The Ohio Department of jobs and Family Services (ODJFS) requested Permedion to perform a study to analyze characteristics of the patients served under the HCAP program and the hospital services provided to this uninsured/ under insured population of patients. A representative randomized sample of all patient encounters reported for the HCAP program in the fiscal year 2001 were selected.

A total of 1370 medical records from 40 hospitals were included in the study. Three strata of patient categories were included. 1. Disability Assistance (DA), 2. Above Poverty Level without Insurance (APL), 3. At or Below Poverty Level (BPL). The results of the analysis included types of services: Inpatient (IP), outpatient (OP), and emergency department/urgent care (ED/UC).

Results:

The demographic characteristics of the HCAP population in this study were similar to nationally published statistics. The greatest number of patients were among the young at age 1-18 at 23.4% and 18-30 years at 26.6% of the total HCAP population. Approximately 55% of the Ohio HCAP population was younger than 30 years old, compared to 53% nationally. Gender distribution was identical to national statistics with 53% of population male and 47% female. Nearly two-thirds of the HCAP population was employed when employment status could be determined, but employment status could not be determined for 26% of the population The current national literature states 80% of the uninsured population has at least one member of the family employed.

More than three-quarters of patients were seen in urban and teaching hospitals (55% and 21% respectively).

HCAP *continued on p.2*

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Quick tips on Saving Time

In the current SFY 2004, Permedion has received a staggering 15,000 telephone calls. Of these calls approximately 2500 precertifications were performed. A substantial number of these additional phone calls are from providers who are searching for information that is not related to Permedion's precertification program. The Ohio Department of Job and Family Services or ODJFS and Permedion have a variety of resources available for providers to use. These resources can be found online and by telephone service to aid in answering providers' questions.

The Permedion web site www.permedion.com offers useful information for providers to access. There is a copy of the procedures requiring precertification and a copy of the Ohio Precertification Manual. There is also a copy of the form used for faxing precertification requests to Permedion. The Ohio Precertification Manual offers CPT and ICD-9 surgical codes requiring precertification, exemptions to precertification and a "click to find" feature on the contents page that will automatically take you to the section of your choice.

The online web site http://jfs.ohio.gov/ohp takes you to the ODJFS web site that contains provider and consumer information. The ODJFS provider web site is an excellent resource for recent hospital transmittal information. It offers online information regarding drugs that do not require prior authorization, and how to prior authorize a drug when it is required. For those using the recently introduce Interactive Voice Response (IVR) system, helpful directions are provided on the ODJFS web site location: http://jfs.ohio.gov/ohp/bpo/pnms/ivrs/IVROverview_Guide.pdf. The following is a list of phone numbers that may provide further resource information:

- Medicaid Consumer Hotline —1 800 324 8680
  For consumer complaints and hearing information
- Interactive Voice Response System —1 800 686 1516
  A provider relations information resource that requires a PIN number
- Prior Authorization —1 800 686 1516
  See Ohio Administrative Rules 5101:3203, 5101:3207.1, and 5101:3221 for more information regarding what services and procedures require special authorization.
- Pharmacy POS Program — 1 877 518 1545
- Pharmacy POS Program Prior Authorization Help —1 877 518 1546
- First Health precertification of Ohio psychiatric admissions —1 800 770 3084
- Provider Network Management —1 800 686 1516
- Provider Enrollment —1 800 686 1516
- Bureau of Health Plan Policy —1 614 466 6420
- Bureau of Managed Health Care —1 614 466 4693
- Ombudsman/Technical Assistance Unit —1 614 752 9551
- Surveillance and Utilization Review Section —1 614 466 7936

The resources provided should help to answer your provider inquiries in a successful manner.

***HCAP** continued from front*

Similar to the initial HCAP study, visits to the ED/UC setting (51%) were the most frequent services provided to the HCAP patients, followed by OP visits with 32% and radiology with 8% of the encounters. Other services analyzed were labs, physical and occupational therapy, IP, and observation.

The most frequent ED/UC diagnosis was A\injury and poisoning at 27.3% of visits. Slightly more than two-thirds (68%) of the visits were determined to be emergent or urgent as compared to national average of 47% urgent/emergent. The ED/UC was the source of admission for 50% of the patients as compared to one third of admissions for all patient categories nationally.

Mental disorder was the most common primary and secondary diagnostic category, while mental disorder was the third most primary and secondary diagnostic category in the OP setting, and was the eight most common primary diagnosis and fifth most common secondary diagnosis in the ED/UC setting.

Physician developed criteria (PDC) were utilized to determine the appropriateness of treatment, location, quality and level of care in each setting. According to these criteria, a third of the IP stays could have been treated in the OP or observation status. A small number of potential quality concerns were identified and included inappropriate discharges, lack of appropriate follow-up plans, inappropriate diagnostic codes and assessments.

Discussion:

Issues that may contribute to improper utilization and setting of care for the uninsured/underinsured population include the lack of stability of physician-patient relationship and inability to acquire medications due to the cost. Patients without a primary care physician may use the ED/UC setting as a substitute. Moreover, the lack of continuity in the provision of care because of the absence of regular OP care and the reduced access to medication may have a negative impact on the insured patient's ability to follow a prescribed form of therapy, with a concomitant increase in the severity of his or her illness and a resulting ED/UC visit. Continuity of OP care and the ability to adhere to the prescribed course of therapy would likely result in fewer ED/UC visits and a decrease in total hospitalizations. Current literature indicates the uninsured are more likely to be hospitalized for conditions such as diabetes, congestive heart failure, pneumonia, chronic obstructive pulmonary disease, and asthma, which could have been prevented with access to optimal routine OP care.

CODING CORNER

Asthma with Associated Conditions

In this issue's "The Coding Corner" we provide information from the ICD-9-CM Coding Advisor on asthma with associated conditions, along with coding assistance for identifying these diagnoses.

Asthma **(493.0X - 493.9X)** is a bronchial hypersensitivity that is characterized by mucosal edema, constriction of bronchial musculature, and excessive viscid edema. Manifestations of asthma are wheezing, dyspnea out of proportion to exertion, and cough.

Chronic obstructive asthma **(493.2X)**, or chronic obstructive pulmonary disease with asthma, is characterized by a continuous obstruction to airflow on expiration, unlike nonobstructive asthma, which is characterized by wheezing during an asthma attack but a return to normal breathing when the attack subsides.

Chronic obstructive pulmonary disease with asthmatic bronchitis is a condition that is often referred to as chronic obstructive pulmonary emphysema (492.8) with chronic pulmonary heart disease (416.8). Consult the attending physician to verify if this classification assignment describes the diagnosis.

Status asthmaticus **(493 category with a fifth digit of 1)** refers to a prolonged, severe asthmatic attack or airway obstruction (mucus plug) not relieved by bronchodilators. Symptoms of status asthmaticus are prolonged, severe, intractable severe respiratory distress, asthma with respiratory failure, asthma attack with absence of breath sounds, lethargy, confusion, and failure to respond to the usual therapy. The following two types are noted:

- **Early status asthmaticus**, which is refractory to the usual therapy.
- **Advanced status asthmaticus**, in which a patient shows full development of an asthmatic attack that may develop into respiratory failure symptoms and signs of hypercapnia.

Documentation in the medical record must always be clear and concise when identifying asthma and any associated conditions affecting the patient. If the diagnosis is questionable, always refer to the attending physician for clarification.

Medical Director *dialogue*

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

The Quality of Care

There has been a great deal of literature recently describing some of the issues that surround clinical quality. There is significant room for quality improvement even in the best, most respected organizations. One leader in effecting profound change in improving the quality of health care is the Institute for Healthcare Improvement or IHI.

IHI is a non-profit organization that works to bring together people and organizations in the fragmented health care industry to share ideas and experiences, cultivate great improvement ideas, and rapidly spread successful quality improvement initiatives throughout the health care industry.

One of the projects IHI is involved with is developing disease collaboratives. IHI and community health center partners have developed disease collaboratives which provide for the management of asthma, diabetes, depression and cancer screening. These health centers with established collaboratives have made significant improvements in the quality of care around these diagnosis and as a result are making their patients healthier.

It is surprising then that this IHI approach for the management of chronic conditions has not been more widely adopted by commercial payers, or large hospital systems. Implementing innovative quality improvement initiatives that result in meaningful and sustainable results often necessitates changes in the culture of the organization. While cost may also be of concern, deciding to provide high quality of care is more about developing will. For example, community health centers, who serve primarily low income and or indigent patients, generally have a very impressive record around the quality of care. With a little luck, the enthusiasm for high clinical quality will grow and gain momentum among providers, patients and payers alike.

Enhanced Care Management

Ohio Medicaid providers may soon be hearing, or may have already heard, about a new program designed to serve Ohio Medicaid consumers with certain chronic illnesses. The Office of Ohio Health Plans in the Ohio Department of Job and Family Services (ODJFS) has issued a Request for Applications for the delivery of Enhanced Care Management (ECM) to certain Aged, Blind, or Disabled Medicaid consumers in selected counties. Eligible applicants are organizations, or collaboratives of organizations, that have the ability to offer the required comprehensive care management services and that agree to meet program specifications for accountability and quality. Applicants that demonstrate this capacity in response to the Request for Applications and during a subsequent readiness review phase will be eligible to enter a provider agreement with ODJFS as an ECM provider.

The program places a strong emphasis on the role of the physician as well as the involvement of other local providers and agencies currently serving the target population. The ECM services will include individualized care management (including the development and implementation of a care treatment plan), member education, and a 24/7 health advice line. A monthly per member rate will be paid to each ECM organization for providing or arranging for the delivery of ECM services. Individual providers will continue to be paid fee-for-service for Medicaid-covered services, with reimbursement for any ECM services (such as a per member monthly payment to those physicians agreeing to act as the primary care provider for care management) coming directly from the ECM organization.

The ECM program reflects ODJFS' continuing commitment to offering the benefits of care coordination to more Medicaid consumers, as proposed in Strategy One of the Ohio Health Plans Strategic Plan. This strategy entails using value-purchasing strategies to afford consumers health plans that provide accessibility, network management, quality, and improved outcomes. By using a range of care management strategies, the ODJFS intends not only to enhance the delivery of quality, cost-effective services, but also to slow the rate of growth in Medicaid expenditures over time. The ECM program will focus on certain Aged, Blind, or Disabled consumers residing in the community but not enrolled in waiver programs. Included in the initial ECM-eligible population will be adults with a diagnosis of diabetes, congestive heart failure (along with coronary artery disease and severe hypertension), chronic obstructive pulmonary disease, or asthma, as well as children with a diagnosis of asthma. The initial program implementation will be phased in beginning in the Autumn of 2004 and will include the following service areas:

♦Cuyahoga County	♦Montgomery County	(Muskingum, Noble,
♦Franklin County	♦Stark County	Guernsey, Morgan
♦Hamilton County	♦Summit County	Coshocton, and
♦Lucas County	♦Zanesville Cluster:	Perry Counties)

Further information about the ECM program is available at the following Web site: *www.jfs.ohio.gov/ohp/bmhc/applibrary.stm* .

The Importance of a Complete Medical Record

Once a month, Permedion requests medical records from acute care facilities. These records are either reviewed on-site at the hospital or copied for off-site review at our office. If a medical record is referred for further review after an on-site visit, we request that a copy of that chart be sent to our office.

Complete medical records are essential for a medical record audit. However, progress notes, physician orders, and nursing notes are sometimes omitted from the copy of the charts. If pages of the medical record are missing, the nurse reviewer and/or physician reviewer cannot make a fair decision. The failure to complete a medical record could also be an issue of quality. To prevent these problems, we ask that you verify that all pages of the medical record are included before sending the requested records to Permedion.

Records with medical necessity concerns are forwarded to physician reviewers to make a final determination.

Lead Testing Rates Improving:
Improvements Still Needed

Childhood lead poisoning continues to be a persistent health problem in Ohio. In 2002, more than 7,500 children younger than the age of seven in Ohio had confirmed elevated blood lead levels of 15 ug/dL or greater submitted to the Ohio Department of Public Health's (ODH) STELLAR database.

Preliminary data indicate that Medicaid providers have increased their lead testing rates for one- and two-year-old children enrolled in Medicaid. In particular, blood lead testing increased significantly, from 22% to 32%, for two-year-old Medicaid consumers during calendar year (CY) 2001 to 2002. Lead testing for one-year-old Medicaid consumers saw a slight increase from 38% to 39% during the same period. However, screening rates need to continue to improve in order to meet the screening goal of 60% set by the Office of Ohio Health Plans for CY 2003.

Blood lead screening tests are a required part of Medicaid's Healthchek program (Ohio's name for the Early and Periodic Screening, Diagnosis, and Treatment exams). All 12- and 24-month-old children with Medicaid health care coverage must have a blood lead screening test. In addition, children between 36 and 72 months of age must have a blood lead screening test if there is no documentation that the child previously had a blood lead test.

ODJFS and ODH have begun a collaborative effort to reduce blood lead poisoning by coordinating education, awareness, screening, and reporting efforts with Healthchek, Help Me Grow, and PLANET (Pediatric Lead Assessment Network Educational Training). For more information about this collaborative effort, contact Donna Bush at *bushd@odjfs.state.oh.us*. Information and outcomes will be provided in future issues of the Ohio Health Plan Provider Update Newsletter.

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