Ohio medicaid QUALITY MONITOR

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New Quality Studies

The Ohio Department of Job and Family Services (ODJFS) and Permedion are developing four new focused quality studies. Selected Ohio providers will be asked to collaborate by providing records for these studies.

The **Hospital Admissions/Readmissions Study** will describe and compare characteristics and risk factors of Ohio Medicaid patients with hospital admissions and readmissions. Additionally, the study will identify and compare patterns of health care service use occurring between admission and readmission. This study will also compare changes in severity of illness between admissions and readmissions.

The **Long-term Acute Care Hospital, Acute Rehabilitation, and Skilled Nursing Facility Services Study** will provide information on the role these facilities play in providing care to the Ohio Medicaid population. Quality indicators include characteristics of patients, geographic profiles, and the impact of discharge destinations on hospital length of stays and readmissions.

The **Appropriate Nursing Facility Placement Study** will evaluate appropriateness of nursing facility placement. Referral patterns; relationships between hospital length of stays with discharges to nursing facilities, home with home health services, and home without home health services; and costs will be evaluated.

The **End-of-Life Care Study** will assist in understanding the services received by Medicaid ABD recipients within the last 12 months of life. Objectives include the identification of services and evaluation of costs.

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PERMEDION

Observations on Observation Units

Submitted by Michael Dick, MD, MSc

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Until recently, only two options for ongoing care were available after a patient was assessed and stabilized in an emergency department (ED): admission to the hospital or discharge and treatment in the outpatient setting. However, increased numbers of ED visits and hospital admissions, as well as concerns over costs, led to the development of a third option, the observation stay.

Typically, observation care is used to provide a diagnostic evaluation, provide acute treatment and evaluation, or monitor an event or recovery from an event. Patient admission is short-term, ranging from 6 hours to a maximum of 23 hours. Two broad categories of observation beds exist: any bed designated as such upon admission or a bed in a special observation area associated with the ED.

A patient who is admitted to any bed in the hospital, with the admission designated as an observation stay or observation status, is cared for as an inpatient admission, by a team that generally attends inpatients. Patients in observation status beds are billed as outpatient observation as long as their stay is less than 24 hours. Patients requiring acute care for more than 24 hours must meet standard inpatient admission criteria.

In contrast, an observation area may be a specific unit that is directed by the ED. It is often, but not necessarily, within or adjacent to the ED. The goals of observation care may be either treatment or diagnosis. Observation services are an extension of ED evaluation and stabilization that go beyond the traditional three- or four-hour limit. A benefit of this continued patient management is better definition of the patient's problem with reduction in both costs and inappropriate dispositions. The ultimate goal is to improve the quality of medical care to patients through extended evaluation and treatment while reducing inappropriate admissions and health care costs.

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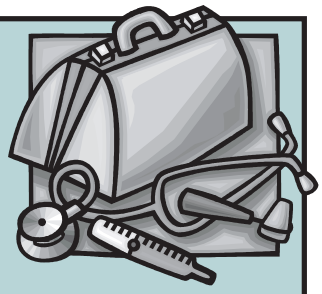
Medical Director *dialogue*



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

In these times of budget cuts, the medical community is always looking for ways to cut costs without jeopardizing the quality of care. Chest pain observation units have been proven to cut costs while improving care.

According to the Agency for Healthcare Research and Quality (AHRQ), the death rate from coronary artery disease - the major cause of myocardial infarctions (MIs) - declined 29% from 1985 to 1995. However, they caution that still nearly 14 million Americans are affected with this disease and one dies about every minute from a coronary event.

With these staggering numbers, it is extremely important to foster appropriate treatment for MIs. About 1.5 million Americans are admitted to hospitals yearly for serious chest pain, which is often a warning sign of an MI. Statistics from various studies show that only about 30% receive a diagnosis of threatened or confirmed MI. This means that 70% must have an expensive evaluation before they know that they have not had an MI. This translates into more than $3 billion of unnecessary expenses for patients with chest pain per year!

Using chest pain observation units not only reduces the unnecessary expenditures but improves care. AHRQ-funded research revealed that:

- Fewer MIs go undiagnosed in hospitals with these units than in comparison hospitals because fewer patients are mistakenly sent home without being observed.
- Hospital admission rates are reduced by 55% and the average length of stay goes down by more than 25% when an exercise EKG is

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New Criteria for Medicaid Reviews

On April 1, 2005, ODJFS will begin using Milliman *Care Guidelines* for quality and appropriateness of care reviews for Ohio Medicaid claims. Previously, Physician Developed Criteria (PDC) were used for these types of review. *Care Guidelines* are nationally accepted guidelines founded on the use of evidence-based research methodology to support the development and understanding of medical care processes.

Research shows that clinical practice guidelines can be a key factor in better decision-making, including care management planning, point-of-care decisions, and quality-improvement initiatives. Both providers and health plans need tools to ensure that their decisions are based on the best possible information. The complex and fast-changing medical environment challenges health care professionals to deliver high-quality patient care while managing resources efficiently. The need for consistent, best-practice decisions has emerged as critical to patient safety and satisfaction.

Care Guidelines are a focused summary of the current best medical evidence and are designed to be used in conjunction with a health care professional's clinical judgment. They enable more informed and consistent decisions and promote the best possible care management. The clinical criteria were developed and are updated on a regular basis with input from health care providers in active clinical practice. Sources of information for all *Care Guidelines* include medical literature and textbooks, nationally-recognized guidelines published in all fields of medicine, practice observation, and database analyses.

ODJFS has contracted with Permedion to provide a utilization management program that involves retrospective chart review and precertification of elective surgical procedures. Permedion will use *Care Guidelines* to assist in making determinations regarding medical necessity and quality of patient care. Providers can expect to see some changes in how reviews are performed as it will reflect the use of these new guidelines. The guidelines will provide clinical indications for specific procedures and for the need for acute care hospital admission. They also identify key care steps and milestones for optimal treatment and recovery, which are presented in a "care pathway" table. This approach can assist with day-to-day changes in status and with tracking patient progress more accurately and quickly. *Care Guidelines* also provide goal length-of-stay information and both admission and discharge criteria for observation care for both adult and pediatric conditions.

Many providers throughout the state are already using the Milliman *Care Guidelines* within their facilities and have access to these criteria. Widespread distribution of the *Care Guidelines* to all providers, however, will not be possible because of a copyright restriction by Milliman USA, Inc. Sample guidelines are available on their website at *www.careguidelines.com* (follow the links for Products and Samples). For further information or questions regarding the change to these *Care Guidelines*, please call Maureen Riley, Permedion Utilization Review Service Line Manager, at (614) 895-9900, Ext. 3430.

Observations *continued from p. 1*

The criteria for admission to an observation unit vary. Some patients may have signs and symptoms requiring further treatment and observation such as adverse reactions to treatments or medications or cardiovascular, respiratory, neurologic, or electrolyte abnormalities. There may be considerable overlap of admission criteria for observation, inpatient, and outpatient units.

Some patients may require evaluation of specific chief complaints that may be indicative of conditions with high morbidity or mortality. For example, a chest pain patient may have a low probability of a myocardial infarction but meet inpatient admission criteria. Although admitting this patient may not be necessary, a discharge after the initial examination would place the patient at risk.

Other patients may need short-term therapy for emergency conditions. Many patients with conditions such as asthma or dehydration have not improved enough after the first few hours of intensive treatment to allow discharge, but are very likely to improve enough for discharge after 12 to 23 hours of therapy.

Although observation units and observation stay admissions can improve patient outcomes by providing an alternative site of care that offers both quality of care and cost savings, these units do not correct or compensate for inefficiencies that may exist within a health care system, nor should they be used as a holding place for admitted patients. For an observation unit to function efficiently there should be well-defined operating policies and procedures. Milliman's 2005 *Care Guidelines* provide admission and discharge criteria for observation care. This document includes a general observation criteria guideline and 42 observation guidelines for specific conditions.

CODING CORNER

Angina Pectoris Vs. Intermediate Coronary Syndrome

In this issue of the Coding Corner, we provide information from the *Coder's Desk Reference* for ICD-9-CM on the identification and coding of angina pectoris and intermediate coronary syndrome.

Angina pectoris (413.9) is a clinical symptom of myocardial ischemia, which may be caused by atherosclerotic heart disease, but may also be due to coronary artery spasm, severe aortic stenosis or insufficiency, syphilitic aortitis, vasculitis, marked anemia, paroxysmal tachycardia with rapid ventricular rates, or any disease or disorder that markedly increases metabolic demands. Angina decubitus is a form of angina occurring at night or when the patient is resting quietly. Prinzmetal angina is a variant characterized by chest pain at rest by sinus tachycardia segment elevation, rather than depression, during the attack.

For example: A 59-year-old male presents to the ED with chest pain and a possible myocardial infarction. After study, the patient is diagnosed with an acute anginal attack. The physician indicates in his discharge summary that myocardial infarction was ruled out.

Code assignment: other and unspecified angina pectoris (413.9).

Intermediate coronary syndrome (411.1) is a condition that is also known as unstable angina, preinfarction angina, or crescendo angina. This condition represents an intermediate stage between angina of effort and an acute myocardial infarction. The patient's pain is more acute, longer lasting and more frequent than angina pectoris, and more resistant to anti-anginal treatment. This type of angina often results in an acute myocardial infarction. Initial onset of angina is also classified to code 411.1. Code 413.9 excludes preinfarctional angina.

Note: If the patient is admitted with unstable angina but the documentation states that the condition has progressed to an acute myocardial infarction, code only the infarction.

For example: A 63-year-old female is admitted with unstable angina. After successful treatment the patient is discharged to home.

Coding Corner *continued on p. 4*

Studies *continued from p. 1*

These studies are slated to begin in Spring 2005. The results will be published in future issues of the Ohio Medicaid Quality Monitor.

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added to the evaluation procedure used in the observation unit.

- Patients who receive treatment in chest pain units report being more satisfied with their care, compared to those admitted to inpatient cardiac units for observation.

Almost all large teaching and urban hospitals in Ohio have chest pain observation units. These units can also be supported in hospitals far from big cities. A rural hospital with a chest pain observation unit is much less likely to transfer a cardiac patient to a larger facility that is miles away. Basic cardiac tests available immediately in the unit are a significant health care improvement to rural families.

Because our health care has become based more on an outpatient system, a hospital chest pain observation unit is quickly becoming a necessity. It not only saves health care dollars, but also saves patient lives.

Coding Corner *continued from p. 3*

Code assignment: intermediate coronary syndrome (411.1).

Clarification should be obtained from the physician as to the specific type of angina, because a patient who is admitted to the hospital would usually be treated for preinfarctional or unstable angina (411.1, intermediate coronary syndrome). If further specification cannot be obtained, the diagnosis of "angina" should be assigned (413.9, other and unspecified angina pectoris).

Avoid Technical Denials by Providing Both Stays

Each month, Permedion sends a **Medical Record Request** to hospitals requesting charts for on-site and off-site reviews. Some of the requests include hospital stays with two different admissions. In certain instances, two or more dates of stay are combined for billing purposes. For example, when a patient is discharged and readmitted to the same hospital within 24 hours, both stays are billed as one admission. Likewise, when a patient is discharged to a non-exempt rehabilitation unit at the same hospital, both stays are billed together.

When pulling these charts for an on-site review or when copying for an off-site review, it is important to verify the admit and discharge dates to ensure that both stays are included. Permedion is not able to complete the review until both stays are produced. If only the discharge date is verified, the first admission may be overlooked. The chart is not considered "produced" until both stays are available for review.

Providers are expected to have the records postmarked within 30 days of the date on the **Medical Record Request** letter. If a chart is not produced in a timely manner, it may result in a technical denial, resulting in ODJFS taking back payment.

The nurse reviewer performing the on-site review will notify the hospital at the time of the visit if both admissions are not available for review. For missing parts of off-site reviews, Permedion will notify the hospital contact person by telephone concerning the missing admission and the date that the chart is due to Permedion.

For more information about the Ohio Medicaid Utilization Review Program, contact Maureen Riley, Permedion Utilization Review Service Line Manager, at (614) 895-9900, Ext. 3430.

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