Ohio medicaid QUALITY MONITOR

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New Co-payment for Non-Emergent Emergency Department Services

In response to H. B. 66, the Ohio Department of Job and Family services will institute co-payments for Dental, Vision, Pharmacy and Non-Emergency Emergency Department Services.

Effective for dates of service on or after January 1, 2006, Medicaid consumers shall pay a co-payment of three dollars for non-emergency emergency department services as defined in OAC rule 5101:3-2-21.1, except as excluded in OAC rule 5101:3-1-09, listed below.

The consumer is:

- Under age 21, or
- in a nursing home or an intermediate care facility for the mentally retarded, or
- a female who is pregnant, or
- a person seeking family planning service, or
- receiving hospice care.

Hospital providers shall report, through claim submission, the applicable co-payment to the Ohio Department of Job and Family Services in accordance with hospital billing instructions. Hospital billing departments will be asked to add COPAY NEMR in the first 10 digits of the remarks field (Box 84) to indicate that a co-pay was taken because services were of a non-emergent nature. The department shall reimburse the emergency department claim

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PERMEDION

Study Reveals That More Education is Needed for Diabetics

Diabetes is a chronic illness that requires continuing medical care and patient self-management to prevent acute complications and reduce the risk of long-term complications. In the United States, approximately 20 million people have diabetes. Diabetes care is complex and requires that many issues be addressed. A large body of evidence supports a range of interventions to improve diabetes outcome. Findings from the Diabetes Control and Complications Trial Research Group (1993) revealed that intensive treatment reduced the risk of complications 50% to 76%.

In collaboration with the Ohio Department of Job and Family Services (ODJFS), Permedion developed and coordinated the *Diabetes Study* to determine if Ohio Medicaid Aged, Blind, and Disabled (ABD) recipients with diabetes are receiving treatment according to the standards of the American Diabetes Association. The recipients were stratified according to the geographic location in which they lived. Recipients residing in one of the 13 counties where the Enhanced Care Management (ECM) program was available were designated the ECM eligible group and all remaining were designated the non-ECM eligible group.

These comparison statistics enable healthcare providers to recognize good performance and potential problems. Providers can use this information to develop benchmarks to improve performance monitoring and services to Medicaid ABD consumers.

The eligible population included non-institutionalized Ohio Medicaid ABD patients, 21 years or older, who had a physician claim for a visit between July 1, 2002 and June 30, 2003 with a primary diagnosis of diabetes. A random sample of 928 visits was selected from this population. Of the 928 records requested, 743 were produced for study.

The average age for recipients in ECM counties was 53 years old; non-ECM 50 years old. Females represented 68% of the ECM sample and 70% of the non-ECM sample. The ECM sample contained 53% Caucasian and 42% African American recipients. The non-ECM sample contained 86% Caucasian and 12% African American recipients.

Twenty-six quality indicators provided the focus of this study. See the table on *Page 2* for a summary of the results.

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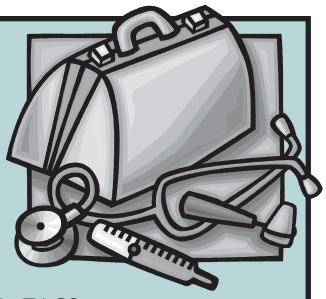
Medical Director *dialogue*



by David Sand, MD, MBA, FACS
Corporate Medical Director, Permedion

The Diabetes Control and Complications Trial demonstrated conclusively that tighter glycemic control resulted in lower complication rates of renal disease (down 50%), peripheral neuropathy (down 60%), and retinopathy (down 76%). In this study of 1441 patients, intensive therapy resulted in an average HbA1C of 7.1% compared to 8.9% in the standard therapy group.

Understandably, many patients who are not already insulin-dependent are not anxious to begin injection therapy with insulin. Those who already take insulin shots may also be resistant to increasing the number of daily injections and glucose checks. The greatly anticipated advent of inhaled insulin therapy may remove these barriers to care on the part of those who are unwilling (or unable) to initiate or escalate injection therapy.

A recent series of articles in the journal Diabetes, Obesity and Metabolism (2005 Nov;7 Suppl 1) documented the clinical safety and efficacy of inhaled insulin. In studies comprising more than 3500 patients over 7 years, promising results have been seen in both Type I and Type II diabetics. Inhaled insulin has shown comparable results to subcutaneous insulin in several phase 3 trials, and has demonstrated superiority in those individuals on oral therapy who failed to achieve target HbA1C levels. The lungs are exposed to 2 to 3 times the concentration of insulin normally seen at the injection site in subcutaneous therapy. Pulmonary function testing revealed generally insignificant changes that are reversible when therapy is discontinued. The most common side-effect was cough.

Rosenstock, et al (Ann Intern Med. 2005 Oct 18;143(8):609-10) looked at the addition or substitution of inhaled insulin in patients on dual-agent oral therapy who failed to achieve target HbA1C levels. In this open-label, randomized, controlled trial, inhaled insulin, alone or in

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Diabetes study *continued from pg. 1*

Approximately 4% of the Ohio Medicaid ABD adult population had an episode of care for diabetes in SFY 2003, compared to about 9% nationwide. Interestingly, ECM counties had about 19% more diabetic patients, even though they had only a 7% larger ABD population. The higher proportion of African Americans in ECM counties could explain this difference, given that diabetes is more prevalent in African Americans.

Summary	Patients in ECM Counties	Patients in Non-ECM Counties
Diagnosis of diabetes	7,936	6,675
Retinal eye exam	89%	91%
Hospitalizations	440[1]	461[1]
Emergency department visits	44%	48%
Readmissions within 30 days	22%	16%
Foot exam	46%	46%
Hospitalizations for lower extremity complications	22[1]	21[1]
HbA1c screening	72%	74%
HbA1c controlled	43%	44%
HbA1c poorly controlled	26%	21%
LDL-C screening	57%	57%
LDL-C controlled	80%	76%
LDL-C well controlled	48%	43%
Triglyceride screening	57%	57%
HDL cholesterol screening	58%	56%
Blood pressure controlled	28%	30%
Monitoring of nephropathy	40%	39%
ACEI or ARB use for patients with microalbuminuria	48%	54%
Daily aspirin	36%	27%
Pneumococcal vaccine	19%	17%
Influenza vaccine	27%	22%
Depression screening	50%	50%
Counseling — nutrition	36%	44%
Counseling — medication compliance	51%	49%
Counseling — smoking cessation	46%	57%
Claim data accuracy	86%	86%

1. per 1,000 people per year

The occurrence rate of foot exam for patients in both ECM and non-ECM counties was 46%, considerably lower than the national and state rates of 69% and 66%, respectively. Patients in ECM counties had a hospitalization rate for lower extremity complications of 22 per 1,000, while patients in non-ECM counties had a rate of 21 per 1,000. Both rates are slightly higher than the national rate of 19 per 1,000.

The HbA1c screening rate was 72% in ECM counties and 74% in non-ECM counties, both of which are very similar to the national and state rates of 71% and 72%, respectively. In ECM counties, 43% of patients with an HbA1c screening had controlled HbA1c (with levels less than or equal to 7%), while 26% of patients with an HbA1c screening had poorly controlled HbA1c

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Diabetes study *continued from pg. 3*

(with levels greater than 9%). Approximately 44% of patients in non-ECM counties had controlled HbA1c, while 21% had poorly controlled HBA1c.

The study found that 28% of patients in ECM counties and 30% of patients in non-ECM counties had controlled blood pressures (less than 130/80). These rates are very similar to the national rate of 27%.

The pneumococcal vaccination rate was very similar in the ECM (19%) and non-ECM (17%) groups. Considering that diabetics are likely to have immune function abnormalities that place them at greater risk for complications from pneumococcal disease, these rates seem very low.

The study showed that 27% of the patients in ECM counties received an influenza vaccination within a year of the selected visit, while 22% of the patients in non-ECM counties received one. Again these rates seem low, making vaccinations an integral component of patient education.

Patients in ECM and non-ECM counties had similar rates of counseling in each of the three areas included in the study. Smoking cessation had the highest rate of education (ECM 46%, non-ECM 57%) while nutrition counseling had the lowest (ECM 36%, non-ECM 44%). All the rates seem low considering the importance education plays in managing diabetes. Educating diabetics about making smart lifestyle choices (i.e., watching what they eat, taking their medications, and stopping smoking) should be a priority.

The findings of this baseline study of the quality of care received by the Ohio Medicaid ABD adult population with diabetes support the following recommendations:

❶ Educate health care providers to target minorities for diabetes assessment, since the disease is more prevalent in these groups.

❷ Encourage providers to monitor and control complication risk.

❸ Educate providers about the safety and benefits of pneumococcal and influenza vaccines.

❹ Encourage providers to provide diabetic education to their patients at each office visit. Educational materials should be easy to understand, focus on managing the disease, available in other languages, video for those who have difficulty reading, and audio for those who have difficulty seeing.

CODING CORNER

Diabetes Mellitus: Type I vs. Type II

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 *Diabetes Mellitus*.

Diabetes Mellitus has two forms. *Type I* is caused by inadequate secretions of insulin by the pancreas. *Type II* is caused by the body's inability to respond to insulin.

Both have similar symptoms, including excessive thirst, hunger, urination, and weight loss. Laboratory tests that detect glucose in the urine and elevated levels of glucose in the blood usually confirm the diagnosis. Treatment of patients with *Type I* requires regular injections of insulin. *Type II* patients can be treated with diet, exercise, oral medication, or injection.

Only about 10% of diabetics are juvenile-onset *Type I*. The primary factor that distinguishes *Type I* from *Type II* is the absence of naturally occurring insulin within the body. *Type I* diabetics require insulin injections to survive. *Type II* diabetics may improve their health with insulin injections, and may even come to require insulin, but the administration of insulin has no bearing on code selection for diabetes. A patient with *Diabetes Mellitus Type II* is always coded as having *Type II*, even when the medical record states the patient requires insulin.

Example

A *Type I* diabetic female is seen in the emergency department and is diagnosed with hypoglycemia. The physician identifies that the patient has been compliant with her prescribed insulin dosage.

Code assignment: *Diabetes with Other Specified Manifestations, Type I, Not Stated as Uncontrolled* (250.81) **and** *Adverse Effect of Insulin and Anti-diabetic Agents* (E932.3).

Coding Clinic for ICD-9-CM advises the coder to query the physician for clarification if the documentation is not clear regarding the type of diabetes. If there is any conflicting information, then the code assignment is based on the type of diabetes documented. Without further clarification of the type of diabetes, the default is *Type II*.

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with the allowable Medicaid payment minus the applicable co-payment and any third party resources available to the patient.

Notification of rule through this newsletter, a forthcoming HHTL (3352-05-012) and referenced rule pertain to the FFS Medicaid program. For instructions and information regarding Medicaid recipients who are members of a managed care plan, please consult your managed care contract or contact your managed care plan.

The Ohio Department of Job and Family Services has a web page that provides valuable information about Ohio Medicaid with topics ranging from payment policies to forms for ordering additional handbooks. The web address for the Ohio Department of Job and Family Services is: http://jfs.ohio.gov/. The Office of Ohio Health Plans' web page is http://jfs.ohio.gov/ohp/.
OAC rule 5101:3-2-21.1 and 5101:3-1-09 can be accessed from the following web address:
http://jfs.ohio.gov/ohp/bhpp/handbook/index.stm. Select "Ohio Health Plans Provider Handbooks" and then select "Ohio Health Plans- Provider" and "Hospital Services." The appropriate rule can be selected from the menu on the left side of the screen.

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combination with oral anti-hyperglycemic agents, demonstrated clear benefits over oral agents alone. Again, pulmonary function testing demonstrated no differences between groups. In another recent study, Rave, et al (Diabetes Care. 2005 Oct;28(10):2400-5) demonstrated similar pharmacokinetic and glucodynamic dose responses for inhaled and subcutaneous insulin. The end result is that this should definitely improve the glucose control in a select group of diabetics!

Send Us Your E-mail Address

Permedion is embracing the age of electronic communication as we begin to use e-mail correspondence whenever possible. However, we need your assistance!

We envision being able to electronically submit monthly letters that inform a hospital CEO about routine utilization review of Medicaid records. We will also use e-mail instead of the traditional "snail mail" for the quarterly Ohio Medicaid *Quality Monitor* which you are currently reading. Future applications will include e-mail notification to providers that secure confidential information is ready to view on Permedion's Web site at *www.permedion.com*. Permedion does not have any current plans to use e-mail notification for anything that would involve HIPAA protected recipient information.

Permedion will need to keep a current database of e-mail addresses for the following individuals at each hospital: the CEO, the designated UR contact person, and the quality contact person. We request your assistance in providing us with this information and making sure all information is current. Additionally, if your organization uses spam filtering, contact your I.T. department to verify that messages from Permedion are allowed. This will ensure that you receive communications in a timely, efficient manner.

A "change of contact form" is available at *www.permedion.com* and can be used to update e-mail addresses, telephone numbers, fax numbers, and names of individuals located within your facilities. A form can also be requested by calling 1-800-473-0802 and asking for Keight Eplin. We have included a copy of the "change of contact form" in this issue of the Quality Monitor.

Permedion looks forward to the age of electronic communication and appreciates your cooperation as we anticipate smooth sailing into this new endeavor.

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