



Ohio medicaid QUALITY MONITOR

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SURS to Perform Second Level Utilization Denial Appeals

Starting December 26, 2006, the Surveillance and Utilization Review Section (SURS), which is contained within the Office of Research, Assessment, and Accountability (ORAA), began performing second level administrative appeal reviews for denials issued by Permedion. Permedion is the utilization review entity for the Ohio Department of Job and Family Services (ODJFS) and performs monthly retrospective review activities for hospital providers of Medicaid services.

The Bureau of Audit (BOA) within ORAA is responsible for providing audit services on behalf of ODJFS and audits county and state agencies, long-term care providers, clinics, developmental centers, and the PASSPORT program. The audit staff utilizes audit methodologies consistent with professional auditing standards in the review and audit of Medicaid payments as required in the Ohio Administrative Code Section 5101:3-1-27.

SURS, which is part of BOA, uses several types of exception reports to identify potential overpayments, abuse, or fraud. SURS also responds to complaints of questionable practices, including allegations of fraud when initiating investigations of Medicaid providers.

Performance of administrative appeals requested following a Permedion utilization denial now falls within the jurisdiction of the SURS team. This function was transferred from the Medical Operations Unit within Ohio Health Plans to SURS. It will now be their responsibility to determine that Permedion has followed correct protocols when issuing a denial to a hospital provider. SURS will also review first level precertification and billing error appeal requests.

To request an administrative appeal, follow the directions contained within the Permedion

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Understanding Post-Acute Care and Nursing Facility Placement

According to the 2003 Ohio Medicaid Profile, there were more than 80,000 Medicaid recipients in nursing facilities with expenditures of over \$2.4 billion annually. Nursing facilities are key providers of long-term care for patients who have serious disabilities and medical problems and who require 24-hour care. Studies by AARP and the Milbank Memorial Fund suggest that individuals with long-term care needs are too often placed in nursing facilities when they might be better served at a lower level of care.

The *Understanding Post-Acute Care and Nursing Facility Placement Study* looked at Ohio Medicaid Aged, Blind, and Disabled (ABD) patients not eligible for Medicare. The ABD program adheres to Ohio Medicaid's statewide rules and regulations regarding hospital transfers to nursing facilities and levels of care. This study provides a description of Ohio's non-Medicare eligible ABD patient characteristics associated with acute care hospital discharges to nursing facilities, home with home health services, and home without home health services. It also looks at hospital and nursing facility lengths of stay, costs, and appropriate nursing facility placement according to Milliman Care Recovery Facility Guidelines.

Study Quality Indicators	
1)	Patient profile reports
2)	Facility profile reports
3)	Diagnoses
4)	Length of stay in the hospital
5)	Length of stay in the nursing facility
6)	Inpatient hospital costs
7)	Nursing facility costs
8)	Recovery facility level of care

The study population included non-Medicare eligible, Ohio Medicaid ABD patients who were discharged from an inpatient hospital in State Fiscal Year 2003 to home, to home with orders for home health follow-up, or to a nursing facility. Administrative data was compiled for the entire study population. A random sample of 250 records of patients discharged to a nursing facility was selected from this population for one of the indicators - recovery facility level of care.

The study population consisted of 65,753 inpatient discharges. The patients' ages ranged from 0 to 102, with an average age of 46. The average age of those discharged to home was 45; to home with home health services, 49; and to nursing facilities, 52. Females represented 60% of the study population, which reflected the general Ohio Medicaid population. A slightly lower percentage of females were discharged to a nursing facility (52%) than to home (59%) or to home with home health (64%). The race distribution for all three types of

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discharges was similar, with the largest race group being Caucasian, followed by African American.

The table below summarizes the results of this study.

Patients discharged to home accounted for 74% of the population, while 11% were

discharged to home with home health and 14% to a nursing facility. National statistics on hospitalization indicate that about 11% of hospital-discharged patients go to long-term care facilities.

The top four major diagnostic categories (MDCs) for patients discharged to home were circulatory (21%), respiratory

(17%), digestive (10%), and nervous (8%) system diagnoses. Patients discharged with home health services were similar with circulatory (19%), respiratory (16%), musculoskeletal and connective tissue (10%), and digestive (8%) system diagnoses. Patients discharged to nursing facilities were slightly different with respiratory (16%), circulatory (15%), nervous (13%), and musculoskeletal and connective tissue (11%) system diagnoses.

The ABD population consists of 23% of Ohio Medicaid eligibles and consumes 75% of the Medicaid health care spending, so it is not surprising that the MDCs for the majority of the hospital admissions represented chronic debilitating diseases.

Patients discharged to home had an average length of stay (LOS)

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Discharged to:	Home	Home Health	Nursing Facility
Percentage of patients	74%	11%	14%
Most common major diagnostic category	Circulatory system	Circulatory system	Respiratory system
LOS in hospital	5 days	8 days	10 days
LOS in nursing facility	---	---	25 days
Inpatient hospital costs	\$7,115	\$10,713	\$13,671
Nursing facility costs	---	---	\$2,484

Level of care required after hospital discharge:	Home Care	Custodial Care	Skilled Care
Percentage of patients in nursing facilities	1%	4%	96%

CODING CORNER

Warning Signs of Dementia

In this article of the Coding Corner, we provide information on the identification and coding guidelines, causes, and common signs of dementia.

Dementia (294.1x - 294.9) is a condition of the brain that makes it hard for a person to remember, learn, and communicate. Eventually, this makes it hard for a person to take care of themselves.

Dementia may also change a person's mood and personality. At first, memory loss and trouble thinking clearly may bother the person. Later on, disruptive behavior and other problems may begin. The person who has dementia may not be aware of these problems.

Dementia is caused by the destruction of brain cells. A head injury, stroke, brain

tumor, or a disease like Alzheimer's can damage brain cells. Some people have a family history of dementia.

COMMON SIGNS

Dementia causes many problems for the patient and their family. Some common signs of dementia are listed below:

- recent memory loss
- difficulty performing familiar tasks
- problems with language
- time and place disorientation
- poor judgment
- problems with abstract thinking
- misplacement of belongings
- changes in mood
- personality changes
- loss of initiative

CODING GUIDELINES

Dementia (294.1x) has been expanded to specifically identify the presence or absence of behavioral disturbances such as aggressive behavior, violent behavior, wandering off, or combative behavior. The dementia classified in subcategory 294.1x is due to direct physiological effects of a general medical condition. Dementia is characterized by the development of multiple cognitive deficits such as memory impairment and cognitive disturbances such as aphasia, apraxia, or agnosia. When assigning codes 294.10 and 294.11, code first the underlying disease associated with the dementia.

Always query the attending physician to ensure appropriate coding/sequencing.

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of five days, while patients discharged to home with home health had a longer average LOS of eight days. Patients discharged to nursing facilities had the longest average LOS of almost ten days.

Discharges from nursing facilities were concentrated among patients with stays of less than 30 days (72%). Twenty-one percent were discharged between 30 and 90 days after admission and 6% were discharged after 90 days. Nationwide statistics show almost identical LOSs of 73% of stays with fewer than 30 days, 20% of stays 30 to 90 days, 7% of stays longer than 90 days, and 0.5% of stays longer than 1 year.

The average charge for a hospital stay in the United States is over \$11,000. In this study, average costs for patients discharged to home totaled \$7,115; to home with home health services, \$10,713; and to nursing facilities, \$13,671. These findings support the premise that increased hospital costs indicate higher DRG payments for more severe illnesses with longer lengths of stay. However, further investigation of DRG relative weights and resource consumption is needed to verify the reasons for the increased costs.

The average cost per day in the nursing facilities was \$101, and the average cost per stay was \$2,484. CDC statistics reveal an average basic charge per day of \$105 for Medicaid nursing facility residents.

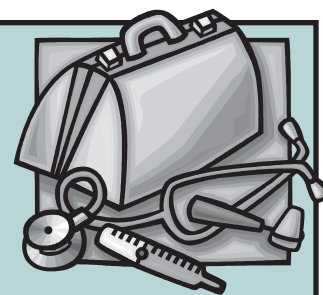
Using the Milliman Care Guidelines to determine level of care, this study found that 96% of the patients discharged to nursing facilities required skilled medical and/or rehabilitative care. Nearly 4% required only custodial care, and 1% required no care.

The findings of this initial study of appropriate nursing facility placement for the Ohio Medicaid ABD population support the following specific recommendations:

- Disseminate the results of this study to practitioners and providers to provide a better understanding of the utilization and costs of health care services for non-Medicare eligible patients in Medicaid's ABD program.
- Perform a study to determine why hospital lengths of stay are longer for Ohio Medicaid ABD patients requiring long-term care services after discharge.
- Provide additional analysis of cost information focused on DRGs and resource consumption.
- Conduct an additional investigation of the Ohio Medicaid ABD patient care needs at the time of discharge to a nursing facility to determine if long-term care services could have been delivered at an alternative level of care other than a nursing facility. Include factors such as funding, family and physician support, regulations, and availability of community programs to determine the best setting for these patients.

For more information about this study or to request a copy of the report, please contact Sue Hackett, Permedion's Quality Assessment Service Line Manager, at 1-800-473-0802, Ext. 3374.

Medical Director dialogue



by Mary Applegate, MD
Medical Director, Ohio Health Plans, ODJFS

Medicaid Program Offers Alternative to Nursing Home Care

As mentioned in the introduction of our *Understanding Post-Acute Care and Nursing Facility Placement Study*, individuals with long-term care needs are too often placed in nursing facilities. One of the study's recommendations is to conduct additional investigation to determine if long-term services could have been provided at an alternative level of care. As of last year with the new assisted living waiver, this task may have become easier.

In order to expand the options available to Medicaid-eligible people with disabilities who need long-term services and support, Ohio now covers assisted living services through a Home and Community Based Services (HCBS) waiver. Beginning July 1, 2006, Ohio offered another long-term care option for certain people with Medicaid. The Assisted Living Waiver Program pays the costs of care in an assisted living facility. The consumer is responsible for "room and board" expenses (an amount designed to be covered by an individual's Social Security benefits).

Assisted living combines a home-like setting with personal support services to provide more intensive care than is available through home care services. Assisted living facilities provide Medicaid adults with an option to nursing facility care that is both less expensive and less restrictive.

Assisted living residences vary considerably, but most provide meals, housekeeping, laundry, transportation, and social activities. They also offer personal care, such as assistance with eating, bathing, grooming, and personal hygiene. Some nursing care is also provided, including medication administration and dressing changes.

The Columbus Dispatch published an article in December 2006 about Franklin County's first participant in Medicaid's assisted living program. The article states she is enjoying life thanks to a change in Ohio Medicaid rules that pays for

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denial letter. Mail appeals to **ORAA-Bureau of Audit, Surveillance and Utilization Review, PO Box 182582, Columbus, Ohio, 43218-2582**. Send claims resubmitted as a result of a retrospective review decision to **ODJFS, Provider Services Section, PO Box 1461, Columbus, Ohio 43216-1461**.

For additional information about the SURS unit and the appeal process, contact ORAA at (614) 466-7936.

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assisted living. She exercises several days a week, dances, visits with friends and follows her beloved Ohio State Buckeyes. Her family says that the assisted living program is a perfect fit for their mother.

Some of the people in our study may have had no choice except to live in a nursing home. Now with the expansion of Medicaid's long-term care program, the assisted living waiver offers residents more independence and privacy.

Change of Address for Appeal Letters

Please note that there is a new address for second level Permedion appeals. The correct address to mail the appeal is identified in the Permedion denial letter. First level appeals on precertification and billing errors and second level (administrative) appeals are affected by this change. Effective December 26, 2006, send these types of appeals to:

**Ohio Department of Job and Family Services
ORAA-Bureau of Audit
Surveillance and Utilization Review
PO Box 182582
Columbus, OH 43218-2582**

Permedion (350 Worthington Road, Suite H, Westerville, Ohio 43082) will continue to receive first level appeal letters for medical necessity, transfers, and DRG reassignment denials.

Keeping Hospital Providers Informed, By Keeping Permedion Informed

Permedion strives to keep their contact person database up-to-date with current facility information. It is important that the right person receives the right information from Permedion.

To keep your facility's contacts current, a "Change of Contact Form" is accessible on Permedion's web site. Simply go to www.permedion.com and click on the **Ohio Medicaid** link to the left of the screen. On the next screen, click on the **Ohio Medicaid Change of Contact Form** link. Mail or fax completed forms to Peggy Fouty at Permedion (see lower right corner of form).

Follow these instructions:

- Complete **ENTIRE** form with the requested information (include Medicaid provider number and e-mail address for electronic notifications).
- Check the appropriate box for the type of change of contact.
- Have the CEO of your facility sign the form.

The form is also used to notify Permedion of e-mail addresses or of a hospital name change. The form is always accessible on Permedion's web site. All providers are encouraged to submit a form to Permedion whenever there is a change in contact. Provider name changes must also be submitted to ODJFS in order for their provider file to be accurate. Please keep Permedion informed on all changes, and Permedion will keep you informed on important notifications!

<p>EXAMPLES OF ITEMS SENT TO EACH CONTACT</p> <p>Utilization Review (UR) Contact Denial packets, appeal determination letters, and medical record request lists. The UR contact also receives other quarterly and annual reports.</p> <p>Quality Contact Quality packets and quality appeal letters.</p> <p>Chief Executive Officer (CEO) Contact Notification that medical record request lists have been sent to UR contact.</p>

CONTACT INFORMATION

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