Ohio | Department of Job and Family Services

# Ohio medicaid QUALITY MONITOR

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## OAC Rule Changes

In July 2009, the Amended Substitute House Bill 1 of the 128th General Assembly, commonly called the "Budget Bill" directed changes on how Ohio Medicaid reimburses some services provided to nursing facility (NF) residents. Therefore, the Ohio Administrative Code (OAC) Rule 5101:3-34-01.3 has been amended to accommodate these changes.

Previously, Ohio Medicaid reimbursed the providers of transportation, physical, occupational, and speech language pathology/audiology therapy services to Medicaid NF residents, on a fee-for-service basis. The OAC changes, effective August 1, 2009, make the NFs responsible for providing these services to their Medicaid residents and they are reimbursed for the services through the NF per diem rates.

When a hospital provides any of these services, such as therapy or transportation, to a NF resident in an outpatient setting, it must submit an invoice to the NF for reimbursement. This includes any cost sharing obligations for Medicare.

The concept of making the NFs responsible for providing transportation and physical, occupational and speech language pathology/audiology therapy to the Medicaid NF residents will provide opportunities to improve coordination of services. It will also create incentives for more effective utilization of health care expenditures.

Information regarding this OAC rule can be found in Medicaid Handbook Transmittal Letter No. 3340-09-01, October 30, 2009 and Hospital Handbook Transmittal Letter No. 3352-10-01, January 1, 2010. Questions pertaining to this

***OAC Rule*** *continued on p. 4*

## Hospital Payments are Linked to Patient Safety

Medical conditions that a patient acquires while hospitalized add enormous costs to medical care and result in significant number of deaths (Nolte & McKee 2008, CMS 2006, 2008a, 2008b). In an effort to address the costs and quality issues, The Center for Medicare and Medicaid Services (CMS) introduced an initiative to curtail payments to hospitals for specific conditions that a patient acquires while hospitalized and that could be "reasonably prevented" by following established evidence-based guidelines.

CMS has promulgated a list of hospital acquired conditions (HACs) for which additional payments are withheld if the condition was not present on admission (POA). Medicare will also not allow higher DRG payments due to HACs (CMS 2008a, 2008b).

State Medicaid agencies have been given the authority to similarly deny payment for these HACs (Coffey, Milenkovic, & Andrews 2006). CMS has encouraged the States to adopt a State Plan Amendment to avoid both the Medicaid primary and secondary payor payments for CMS-denied events.

Our study was part of Ohio Medicaid's efforts to pay for better care, with regard to quality, outcomes, and overall costs of care. It was developed to determine the prevalence of CMS' selected HACs in the Ohio Medicaid fee-for-service (FFS) population. It also provided information that would assist in determining if a policy, similar to Medicare's quality program of no longer paying for the additional costs of certain preventable conditions acquired in the hospital, should be implemented.

A simple random sample of 480 cases was selected from Ohio Medicaid FFS claims meeting the following inclusion criteria:

- FFS program at the time of service
- Claim qualified as a potential selected HAC[1] based on CMS' Hospital Acquired Conditions and National Coverage Policy for FY2009
- Date of discharge between 1/1/2007 and 12/31/2007

[1] A *potential* selected HAC was identified when the diagnosis on the hospital claim was on CMS' Hospital Acquired Conditions list. However, this does not indicate that it is a hospital acquired condition. The medical record was reviewed to determine if the diagnosis was present on admission to the hospital or if acquired during the hospital stay. If acquired during the hospital stay, it was a *confirmed* HAC.

***Patient Safety*** *continued on p. 2*

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***Patient Safety*** *continued from p. 1*

The study focused on the following indicators:

- *Potential* CMS Selected HAC Volume and Cost
- *Confirmed* Selected HAC Volume and Cost
- Timing of *confirmed* Selected HAC

For calendar year 2007 admissions, the initial analysis revealed that the total number of potential selected HACs was 4,494, 6% of the claims. Ohio Medicaid FFS spent $74.6 million on stays that included potential CMS' selected HACs that are included in the updated CMS no-payment policy.

After the review of the sample medical records, 1.8% (7 cases) of the selected diagnoses were confirmed CMS selected HACs. The largest category of potential selected HACs was the Falls and Trauma category, which included burns and electric shock. This category made up almost 70% of the cases reviewed (271) and 2% were confirmed HACs (5). The other two cases with confirmed selected HACs included an infection and a thrombus following orthopedic procedures.

The sampled cases represented roughly $5.5 million dollars in reimbursement. The 2% of admissions, which included confirmed selected HACs, represented $149,000 of the $5.5 million.

Extrapolating the sample results to the overall population, it is estimated that 80 admissions would have had confirmed selected HACs with total reimbursement of $2,008,752. Removal of the diagnosis/

***Patient Safety*** *continued on p. 3*

| Selected HAC | Admissions with Potential HACs | Total Paid for Reviewed Admissions | Admissions with Confirmed HACs | % of Admissions with Confirmed HACs | Total Paid for Admissions with Confirmed HACs |
|---|---|---|---|---|---|
| Falls and Trauma | 271 | $4,757,025 | 5 | 2% | $45,536 |
| Manifestations of Poor Glycemic Control | 103 | $537,771 | 0 | 0% | $0 |
| Catheter-Associated Urinary Tract Infection | 15 | $136,622 | 0 | 0% | $0 |
| Infection following Certain Orthopedic Procedures | 1 | $78,744 | 1 | 100% | $78,744 |
| DVT and PE following Certain Orthopedic Procedures | 1 | $24,680 | 1 | 100% | $24,680 |
| Infection following Bariatric Surgery | 1 | $2,743 | 0 | 0% | $0 |
| TOTAL | 392 | $5,537,585 | 7 | 2% | $148,960 |

CODING CORNER

# Hospital Acquired Conditions "Never Events"

In this issue of the Coding Corner, we would like to follow-up on the article presented in this issue of the Ohio Medicaid Quality Monitor on *"Hospital Payments are Linked to Patient Safety."* As a result of this study, we would like to provide a summary of the coding guidelines for reporting (POA) present on admission/ (HAC) hospital acquired conditions/ never events.

As indicated in the ICD-9-CM Official Guidelines for Coding and Reporting, the POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance to the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

For discharges occurring on or after 10/1/2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission and the selected HACs are the only major complication/comorbidity (MCCs) and complication/comorbidity (CC) on the claim.

The following is the selected FY08 IPPS Rule list of hospital acquired conditions and/or Never Events:

- Air embolism
- Delivery of incompatible blood products
- Object left during surgery
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Mediastinitis after CABG
- Falls, fractures, dislocations, intracranial and crushing injury/burns
- Pressure ulcers

The following is the additional FY09 IPPS Rule list of hospital acquired conditions and/or Never Events:

- Surgical site infections
- Glycemic control
- Deep vein thrombosis/pulmonary embolism

***Coding Corner*** *continued on p. 3*

**Patient Safety** *continued from p. 2*

procedure codes associated with the identified confirmed selected HAC and re-grouping the diagnoses and procedures did not result in any savings.

Comparable data is not readily available since the selected HACs are on Medicare's "no-payment" list for fiscal year 2009. However, using the Medicare Provider Analysis and Review (MedPAR) data set for 2006, the Thomson Reuter's Study (Wilson, 2008) identified patients with conditions on the CMS' selected HACs list. The code for vascular catheter-associated infection was not included since it was not introduced until 2008. The Reuter's study determined that nearly 4% of the total discharges had one of the complications analyzed in the study. Almost 6% of the discharges with complications were designated as having the complication occur during the hospital stay. It should be noted that any comparison of the Thomson Reuter's Study and the Ohio Medicaid Study should be done with extreme caution since patient demographics and diagnoses vary significantly between Medicare and Medicaid.

Further analysis for our study revealed that for all of the seven cases, the confirmed selected HAC occurred between the second and seventh day of the admission. This is not surprising since the median length of stay of the sample cases was four days.

The current grouper, MS-DRG (Medicare Severity – Diagnostic Related Group) Version 15, classifies each case into a DRG based on the primary diagnosis, a hierarchy of secondary diagnoses and procedures, patient demographics, and discharge status. The algorithm used for Version 15 does not include codes that were not in effect from 10/1/97 to 9/30/98 and has limited recognition of multiple complications, comorbidities, and subgroups. However, a mapping process is followed to assure that newer codes are included. Ohio Medicaid also uses additional state-specific DRGs for newborns.

This study serves to provide information that will assist in monitoring the prevalence of CMS' selected HACs and determine Ohio Medicaid should implemented a similar policy. The findings of this study support the following recommendation:

Disseminate the results of this study to Ohio Medicaid providers and policy makers and include the following information. The sampled cases in this study represented approximately $5.5 million dollars in reimbursement, $149,000 of which was associated with admission which included a selected HAC.

Overall, after medical record review, 2% of the potential selected HAC cases were identified as confirmed selected HACs. Removal of the diagnosis/procedure codes associated with the confirmed selected HACs did not result in a DRG change for any of the admissions due to the current MS-DRG Version 15 Grouper being utilized for payment determinations. The introduction of the POA billing indicator will help identify the CMS selected HACs and will aid to avoid payments on recipients who are dual eligible. However, with the current DRG grouper, it would be unlikely that the DRG assignments for Ohio Medicaid non-dual eligible recipients' stays with confirmed selected HACs would change.

# Medical Director *dialogue*

*By Anthony J. Beisler, MD, MBA, FACS*
*Assistant Medical Director, Permedion*

## Nonpayment for Never Events – A Tool for Quality Improvement?

Many hospitals and providers have voiced concern regarding the new policies of some states requiring nonpayment or reduced payment for Never Events. Several large studies have been done to look at the occurrence rates of these Never Events. The good news is the total number of events found was very small. This finding is consistent with what many have believed: **Never Events occur very infrequently**.

Since nonpayment for preventable adverse events first started in January of 2005, by HealthPartners HMO in Minnesota, state and federal nonpayment policies have begun to align. Ohio Medicaid currently does not have a policy for nonpayment on Never Events. Given the small number of these events that actually occur, there is not a large cost savings to be found by enacting a nonpayment policy. However, hospitals should take a serious look at the 28 events that are deemed as Never Events by the National Quality Forum (NQF) and examine their patient safety policies and procedures to assure that they do all they can to reduce the likelihood of one of these events occurring at their facility.

Many national organizations have taken a stand on Never Events and have offered reasonable and rational advice. The Leapfrog Group has put forth a suggested policy for hospitals to embrace. Its five key parts are as follows:

1. Apologize
2. Report The Event
3. Perform Root Cause Analysis
4. Waive Associated Costs and Fees
5. Make the hospital policy on Never Events available to anyone who wants it.

The goal of any policy in regard to Never Events is not punishment. It is a reminder that we as

**Medical Director** *continued on p. 4*

***OAC Rule*** *continued from p. 1*

information should be e-mailed to hospital_policy@jfs.ohio.gov or addressed to:

**Ohio Department of Job and Family Services**
**Office of Ohio Health Plans**
**Bureau of Policy & Benefit Management**
**Hospital Benefit Unit**
**PO Box 182709**
**Columbus, OH 43218-2709**
**614-466-6420**

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***Coding Corner*** *continued from p. 2*

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

***Medical Director*** *continued from p. 3*

practitioners and hospitals need to do all we can to prevent egregious errors. The goal is to make the healthcare environment as safe as possible for those who depend on us for care. Providing our best effort to enhance patient safety is more than just a goal, it is our duty - to our patients, to our coworkers and to ourselves.

## How to Resubmit a Claim After a Denial

A frequently asked question from Ohio Medicaid providers is how to resubmit claims as a result of a retrospective review denial. Per Ohio Administrative Code rule 5101:3-2-40, a retrospective review by Permedion may determine that the location of service was not medically necessary, but the services rendered were medically necessary.

In this instance, the hospital may bill ODJFS on an outpatient basis for those medically necessary services rendered on the date of admission. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed on the outpatient claim. The outpatient claim may be submitted with the accompanying documents:

- A copy of the reconsideration and/or the administrative decision affirming the original decision
- A copy of the remittance advice recouping payment for the medically unnecessary admission
- A copy of the original decision
- Condition Code C3 recorded on the outpatient claim

Claims resubmitted as a result of a retrospective review decision, may be sent with the above documents to the following address:

**Ohio Department of Job and Family Services**
**Provider Services Section**
**P.O. Box 1462**
**Columbus, Ohio 43216**

Please place a copy of Permedion's denial letter on top of the resubmission. To ensure that your resubmission is accurate, refer to the Permedion denial letter for information about the reason for the original denial.

Please use the above address for claim resubmissions only. Do not send appeals to this address. If you need to speak with someone regarding a claim resubmission, please contact Provider Services at 1-800-686-1516.

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