Ohio | Department of Job and Family Services

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Questions and Answers about Medicaid Hospital Peer Groups

Q: What are Hospital Peer Groups?

A: Medicaid classifies most hospitals into mutually exclusive groups. These groups are for the purpose of setting rates and making payments to the hospitals under the DRG retrospective payment system.

Q: How are Peer Groups determined?

A: The peer groups are based on the following definitions:

- Teaching hospitals – hospitals with major teaching emphasis that have certain intern- and resident-to-bed ratios and according to the number of beds.
- Children's hospitals – hospitals that primarily serve patients 18 years of age and younger.
- Rural referral centers – hospitals located in non-metropolitan statistical areas (MSAs) that are recognized by Medicare as rural referral centers.
- MSA hospitals – hospitals that are not defined as children's or teaching hospitals that are located in MSAs. The MSAs are further grouped on the basis of wage index categories as defined by Public Law "Report on Hospital Wage Index."
- Non-MSA hospitals – hospitals are those hospitals not defined as teaching, children's or rural referral cents that are not located in MSAs. These hospitals are further grouped by non-MSA hospitals with less than 100 beds and those with 100 beds or more.

Q&A *continued on p. 4*

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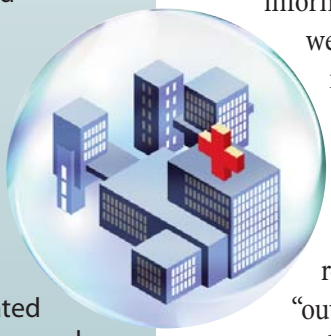
Report on Recent Hospital Peer Group Patterns

Ohio hospitals recently received a copy of their annual **2008 Pattern Analysis Monitor Report**. Permedion, an HMS company, produces this report for each hospital that submits a Medicaid claim to the Ohio Department of Job and Family Services (ODJFS) during the past year. The report examines eight indicators calculated from the Medicaid claims data as well as comparative statistics for each hospital according to the hospital's peer group. The report covers State Fiscal Years 2005, 2006 and 2007 and provides a three-year comparison.

Peer groups are defined in Ohio Administrative Code Rule 5101:3-2-072 and include categories such as children's hospitals, rural hospitals, major teaching hospitals, and others that are grouped according to MSA information. Please see the related article entitled "Questions and Answers about Medicaid Hospital Peer Groups" within this issue of the *Quality Monitor* for additional information regarding peer groups. A total number of 168 hospitals were included in this report. Active facilities not having any eligible inpatient claims during the reporting period were not included.



The results of the report identify providers that have indicators that are either significantly above or below the overall results or they are significantly above or below other providers in their peer group. A change made to this year's report was to split the results of an indicator previously entitled "outliers" into two mutually exclusive indicators: Day Outliers and Cost Outliers. Mental health, alcohol and drug addiction, transplant, delivery and newborn claims are excluded from the analysis except for the Transfer Billing indicator. Also, the number of admissions serves as the denominator for all percentages.

The total number of hospital admissions per peer group increased by 1.3% in SFY06 but plunged 19.8% in 2007. The peer groups with the highest volume of admissions were the Teaching Hospitals, followed by the Akron/Cincinnati/Dayton-Springfield group, and the MSA Columbus Group. All peer groups had their admissions decrease by at least 10% from SFY06 to SFY07.

The eight key indicators that were analyzed from the claims data include:

1) **0-1 Day Readmission:** The overall percentage of 0-1 day readmissions remained relatively flat with a 0.10% in 2005, 0.13% in 2006, and 0.16% in

Peer Group Patterns *continued on p. 2*

Peer Group Patterns *continued from p. 1*

2007.

2) **2-7 Day Readmission:** The percentage of cases of patients readmitted to the same provider for any DRG within 2-7 days increased slightly across the three years with 2-7 readmission rates of 4.19%, 4.26% and 4.64% in 2005, 2006, and 2007 respectively.

3) **Admissions Due to Complications:** The number of admissions due to complications (based on admission with primary diagnosis of ICD 996.xx, 997.xx, 998.xx, or 999.xx) increased slightly over the three-year report period. The overall percentage of admissions due to complications was 3.55% in 2005, 3.81% in 2006, and 4.01% in 2007. Across the three years, the mean percentages for admissions due to complications in the Teaching Hospital Peer Group were consistently above three standard deviations of the overall percentages. In fact, this peer group accounted for over one quarter of all admissions due to complications in the entire state in each year analyzed.

4) **Transfer Out:** The overall percent of cases coded as transfers to other hospitals slightly decreased across the three-year reporting period with a 4.33% in 2005, 3.93% in 2006, and 3.82% in 2007. In comparing individual providers against their peer group mean percentages, 12 hospitals had transfer out percentages outside the upper control limits. Fourteen hospitals had transfer out percentages three or more standard deviations below the peer group mean percentages in all three years.

5) **Transfer Billing:** In 2005, 2006, and 2007, the overall percentages of cases that are potentially transfer billing errors were 0.81%, 0.63%, and 0.58%, respectively. No peer groups were either above or below the three standard deviation thresholds for the overall totals for all three years.

6) **Cost Outliers:** The overall percentage of cases which are cost outliers (based on DRG) is increasing, with 9.34% in 2005, 10.32% in 2006, and 11.68% in 2007. This is probably due to the recent rise in lengths of stay for hospital admissions.

7) **Day Outliers:** The overall percentage of cases which are day outliers (based on DRG) has decreased markedly, with 2.31% in 2005, 1.02% in 2006, and 0.78% in 2007. No hospitals had day outlier percentages consistently outside the three standard deviation thresholds for all three years of study.

8) **Significantly Short Lengths of Stay:** Overall, the percentage of cases that are considered significantly short length of stay with respect to DRG lower trim point and/or primary diagnosis is almost non-existent by 2007, with 0.39%, 0.27%, and 0.29% in 2005, 2006, and 2007 respectively.

Hospitals can use information from the Pattern Analysis Report to develop benchmarks to improve performance and

Peer Group Patterns *continued on p. 4*

CODING CORNER

Present on Admission Reporting Guidelines

In this article of the *Coding Corner*, we provide a brief overview of the **Present On Admission Reporting Guidelines**. Effective October 1, 2007, all Inpatient Prospective Payment System (IPPS) Hospitals were required to begin submitting Present on Admission (POA) Indicator information for all primary and secondary diagnoses. For the complete guidelines, see the ICD-9-CM Official Guidelines for Coding and Reporting Appendix I.

Definition

Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, will be considered as present on admission.

General Reporting Requirements

- All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.
- POA indicator is assigned to the principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.
- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
- If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

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.

A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of the diagnoses and procedures. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not.

Denial Hierarchy Table Applied During Retrospective Review

Permedion would like to provide clarification concerning the hierarchy table used in the Ohio Medicaid Retrospective Review Program. Knowledge regarding the use of this table will assist hospitals in the correct submission of appeals and during the rebilling process.

Hierarchy Table

- Technical Denial
- Medical Necessity
- Readmission
- Transfer
- Compliance
- DRG Reassignment
- Billing Error
- Bill Audit

- No appeal for technical denials
- Appeal to Permedion
- Appeal to ODJFS

When receiving multiple denials (denials in more than one review category), the category higher in the hierarchy table takes precedence.

The hierarchy table includes eight review categories. Categories displayed in green are appealed directly to Permedion, categories in gray are appealed to ODJFS. Technical denials are issued when the hospital does not produce the requested medical record in a timely manner. There are no appeals to technical denials.

Permedion sends hospitals denial letters the last business day of the month. Each denial letter contains specific appeal instructions. Only appeals postmarked within 60 days of the original denial notification will be processed.

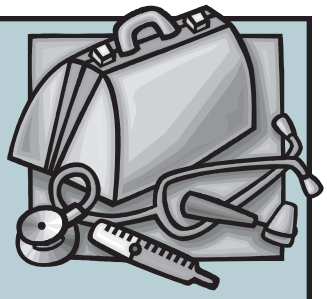
After the appeal process is completed and the denial is upheld, the hospital needs to wait for ODJFS to take back the payment and then the hospital can rebill the account appropriately. This step can take up to 150 days.

Please note that any record reviewed can result in multiple denials. The hierarchy logic is followed in these instances. A technical denial and a medical necessity denial fall at the top of the hierarchy table and thus will take precedence over other denials. If multiple denials exist, each concern needs to be appealed. For instance if there is a medical necessity denial and a DRG reassignment and only the DRG reassignment is appealed, then the medical necessity denial will still be processed according to the hierarchy and the full amount of the paid claim will be recouped. The recoupment will occur no matter what the outcome of the DRG appeal. If the medical necessity denial is overturned, then the DRG reassignment needs to be rebilled to reflect the appropriate DRG for the account.

Permedion mails a "Hospital Summary of Denials" report along with individual denial letters at the end of every month. For cases that have multiple

Hierarchy *continued on p. 4*

Medical Director *dialogue*



By David Sand, MD, MBA, FACS, CHCQM, FAIHQ
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Time was, you'd walk down a hospital hallway and hear doctors and nurses speaking about differential diagnoses, surgical and medical treatments, and diagnostic tests. Now it seems the only words you hear in a hospital are Quality, Cost, and Access. Our challenge is reconciling these three seemingly competing concepts and still remembering care must be patient-centric.

In mid-November, nearly 200 politicians, health care executives, and business leaders gathered in Columbus, Ohio for the Ohio Health Quality Improvement Institute with the aim to "identify the top 10 strategies that will transform Ohio's health care system into a high-quality, cost-effective, high-performing system that optimizes the health of Ohioans by 2013." The four topic areas for discussion were:

- Improving Patient Safety and Reducing Errors
- Promoting Health Through Personal Responsibility and Disease and Injury Prevention
- Improving Chronic Care Management
- Improving Efficiency and Decreasing Cost in the Healthcare System

Throughout this three-day meeting we all struggled with those three words above. Mostly our struggle was trying to figure out where we would get the money. There was one thing on which we could all agree: there's a lot of waste in the provision of medical care.

Since the days of Demming, Juran, and other giants in the quality movement, we've all accepted the concept that quality costs. With the looming imposition of restrictions on reimbursement for Never Events; however, the lack of quality will cost even more. Eliminating the waste is one major way each of us can improve quality, reduce cost, and make more dollars available for improving access. Easier said than

Medical Director *continued on p. 4*

Hierarchy *continued from p. 3*

denials.

For additional information about the Ohio Medicaid Utilization Review Program, please contact Ralene McNeal, Reviewer Supervisor, at 1-800-473-0802.

Medical Director *continued from p. 3*

done I know, yet each one of us individually can make a tangible and significant contribution. This is not rocket science– although if it were, most of us could still do it! What it does require is that each of us takes a brief moment to ask: How will what I am about to do help the patient? Is it really in the patient's best interest, or am I doing it to make myself feel better? Is there a better way? How can I best collaborate with my colleagues to help our patient?

**** Remember: It's all about the patient! ****

Peer Group Patterns *continued from p. 2*

ultimately improve the services provided to the Ohio Medicaid community. Contact your hospital's Utilization Review Department for a copy of your hospital's individual report.

Q&A *continued from p. 1*

- Cancer hospitals – hospitals recognized by Medicare that primarily treat neoplastic disease.

Q: Why are Akron, Cincinnati and Dayton-Springfield MSA hospitals in the same peer group?

A: Even though these hospitals are in different MSAs, they are located in MSAs with the same wage index category.

Q: When are Peer Group Classifications determined?

A: Each hospital is classified into a peer group at the beginning of each rate year based on the data it has submitted to Medicaid for the previous year. Once established, the classification will remain in effect throughout the year. Of course, there are always exceptions to this rule:

- If a hospital is designated as a rural referral center hospital by Medicare during the year, the hospital will be reclassified;
- If a new hospital is established during the year, Medicaid will assign it to a peer group;
- If hospitals merge and the merged facilities have only one Medicaid provider number, Medicaid will make a separate determination for the merger.

Q: Where can I find more detailed information on Medicaid Peer Group Classification of hospitals?

A: Further detailed information on the classification of hospitals can be found at *http://codes.ohio.gov/oac/5101:3-2-07.2* .

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