



Ohio medicaid QUALITY MONITOR

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Quality Monitor E-newsletter

Welcome to the first Ohio Medicaid *Quality Monitor* e-newsletter! If you are reading this newsletter, you are one of the majority of hospital providers who provided Permedion their current e-mail address! The Nielsen's ratings (2004) indicate that informative, convenient, and timely e-newsletters are often preferred over other media.

The Ohio Medicaid *Quality Monitor* e-newsletter allows delivery of Medicaid study results, changes in health plan policies, utilization review information, and coding guidelines directly to your in box. You can easily forward it to others who may be interested in the entire newsletter or articles on specific topics, whether or not they are within your organization.

With the ever-increasing information overload, users are often reluctant to sign up for more e-mail. The advantage of receiving our e-newsletter is that it can be simply read and deleted, saved as a file for future reference, or viewed again on our website at www.permedion.com.

The *Quality Monitor* will arrive quarterly and will contain health care related Medicaid news and activities. **Please check your spam filter to make sure it does not block delivery of this newsletter.** E-mail questions you have on the *Quality Monitor* mailing to medicaidsupport@permedion.com. A hard copy of the newsletter can also be requested.

Another exciting change is the implementation of the new online precertification process. Just log onto www.permedion.com and click on the link for **Ohio Medicaid** (left side of page). You will be directed to the Ohio Medicaid page; select the yellow "Precert Registration" link box to become a registered user. If already registered, you will be directed to a secure site to enter the needed information for the precertification request.

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published in cooperation with:



Ohio Medicaid Study Results: Congestive Heart Failure

Congestive heart failure (CHF) is a common disorder resulting from cardiomyopathy due to a variety of causes, including coronary artery disease. The primary symptoms of the disorder include dyspnea and fatigue, reduced exercise tolerance, fluid retention, and peripheral edema. According to the American Heart Association (AHA), more than 5 million Americans have CHF, with 550,000 new cases diagnosed each year.

As the frequency of CHF increases, so does the number of strategies and pharmaceuticals available to treat the disease. Following Agency for Healthcare Research and Quality (AHRQ) and AHA heart failure guidelines provides substantial opportunities to improve outcomes.

Results Summary	Patients in ECM Counties	Patients in Non-ECM Counties
Diagnosis of CHF	1,544	1,010
Hospitalizations	219 ¹	144 ¹
Emergency department visits	48 ¹	30 ¹
Readmissions for cardiac-related conditions within 30 days	6%	5%
ACE inhibitors	71%	74%
ARB or hydralazine/isosorbide	35%	35%
Dose of ACEI >=50%	80%	65%
Dose of ACEI >=100%	49%	37%
Beta-blockers	73%	76%
Beta-blockers for patients with EF<40	92%	93%
LVF assessment	68%	67%
Spironolactone for patients with AHA/ACC III or IV classification	47%	56%
Daily aspirin	63%	57%
Pneumococcal vaccine	20%	19%
Influenza vaccine	18%	24%
Depression screening	45%	51%
Counseling – daily weight monitoring	15%	13%
Counseling – sodium intake	31%	23%
Counseling – medication compliance	59%	50%
Counseling – smoking cessation	52%	50%
Claim data accuracy	87%	81%

1. per 1,000 people per year

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CHF Study *continued from p. 1*

In collaboration with ODJFS, Permedion developed and coordinated the CHF Study to determine if Ohio Medicaid Aged, Blind, and Disabled (ABD) recipients with CHF are receiving treatment according to the standards of AHRQ, AHA, and CMS' Chronic Care Improvement Program. 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 had been planned, were designated the ECM eligible group and all remaining were designated the non-ECM eligible group. The ECM program was planned to be available primarily in urban counties. The non-ECM counties were mostly rural.

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



The pneumococcal and influenza vaccination rates were low for CHF patients in both the ECM and non-ECM groups.

diagnosis of CHF. A random sample of 747 visits was selected from this population. A total of 598 medical records were produced for the study.

The average age for recipients in ECM counties was 56 years old; non-ECM 54

years old. Females represented 60% of the ECM sample and 62% of the non-ECM sample. The ECM sample contained 55% African-American and 42% Caucasian. The non-ECM sample contained 84% Caucasian and 15% African-American.

Twenty-one quality indicators provided the focus of this study. See the table on *Page 1* for a summary of the results.

Approximately 1% of the Ohio Medicaid ABD adult population had an episode of care for CHF in SFY 2003. Considering that the elderly are more prone to developing CHF, the low rate was not surprising since the study population was relatively young. ECM counties had about 53% more heart failure 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 CHF is more prevalent in African-Americans and they tend to develop the disease at a younger age.

CHF Study *continued on p. 3*

CODING CORNER

Postmyocardial Infarction Syndrome

In this issue of the Coding Corner, we provide information on the identification, risks for developing, and treatment of postmyocardial infarction syndrome.

Postmyocardial infarction syndrome (411.0), also known as Dressler's syndrome, is a complication that can occur following a heart attack or heart surgery. It occurs when the sac that surrounds the heart (pericardium) becomes inflamed. An immune system reaction is thought to be responsible for Dressler's syndrome, which can develop several days or weeks after heart injury.

Dressler's syndrome causes fever and chest pain, which can feel like another heart attack. It is easily treated with medications that reduce inflammation. Dressler's syn-

drome is far less common than it used to be; however, once you have the condition, it is likely to recur.

SIGNS AND SYMPTOMS

- Chest pain
- Shortness of breath or pain when breathing
- Fever
- Left shoulder pain
- Leukocytosis

COMPLICATIONS

Two rare but serious complications of Dressler's syndrome are:

- Cardiac tamponade occurs when fluid builds up around the heart and presses on it, reducing its

ability to pump well.

- Constrictive pericarditis develops from repeated inflammation of the sac around the heart (pericardium).

Other complications include:

- Pleurisy (inflammation of the membranes around the lungs)
- Pleural effusion (buildup of fluid around the lungs)



CHF Study *continued from p. 2*

The study found that the patients in the ECM counties had a CHF-related hospitalization rate of 219 per 1,000 people, which was significantly higher than the 144 per 1,000 hospitalization rate in non-ECM counties and higher than the nationwide CHF admission rate of 198 per 1,000. In ECM counties, the CHF-related ED visit rate was 48 per 1,000 people, which was significantly higher than the 30 per 1,000 in non-ECM counties. Race, the heart failure severity, and access to services may be causes of the ECM counties' higher rates. Further investigation of these variables may be warranted.

ACE inhibitors were used by 71% of the patients in ECM counties, compared to 74% in the non-ECM counties. The angiotensin receptor blocker (ARB) or hydralazine/isosorbide utilization rate was approximately 35% for both the ECM and non-ECM groups. The utilization rate for any one of these three types of medications was fairly high in both groups—86% in ECM and 90% in non-ECM counties.

Beta-blocker use was similar for patients in ECM and non-ECM counties (73% vs. 76%). When only patients with an ejection fraction (EF) <40%, which indicates a weakened heart muscle, were considered, the rate increased for both groups, at 92% in ECM counties and 93% in non-ECM counties.

Daily aspirin was used by 63% of the ECM patients, compared to 57% of the patients in non-ECM counties. Both rates were higher than the 40% rate published by the ADHERE national registry.

Educating heart failure patients about the importance of vaccinations should be a priority. CDC recommends that all adult heart failure patients receive a pneumococcal vaccine at least once. The pneumococcal vaccination rate was low in both the ECM (20%) and the non-ECM rate (19%) groups. Ohio's overall pneumococcal vaccination rate is 65%.

Influenza vaccinations were received by only 18% of the ECM group and 24% of the non-ECM group. Ohio's overall influenza rate is 68%.

RECOMMENDATIONS

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

- Educate health care providers to target minorities for heart failure assessment, since the disease is more prevalent in these groups.
- Encourage providers to prescribe medications to their patients in compliance with ACC/AHA guidelines (see *Medical Director Dialogue*).
- Educate providers and patients about the safety and benefits of pneumococcal and influenza vaccines.
- Encourage providers to provide heart failure education to their patients at each office visit. Educational materials should be easy to understand, focus on managing the disease, and be available in other languages, video for those who have difficulty reading, and audio for those who have difficulty seeing.

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

Acute Coronary Syndrome Guidelines - They Really Work!

Health care providers are bombarded daily with imperatives to follow evidence-based guidelines. Less commonly we are presented with conclusive evidence regarding the real life outcomes of compliance (or non-compliance) with these guidelines.

The recent publication of an observational analysis of hospital care and outcomes in 350 United States centers, comprising 64,775 patients enrolled in the CRUSADE (*Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes with Early Implementation of the ACC/AHA Guidelines?*) National Quality Improvement Initiative (Peterson ED, et al. JAMA. Apr 26, 2006; 295(16): 1912-20) clearly demonstrates the implications of guideline compliance for non-ST elevation myocardial infarction acute coronary syndrome.

This retrospective analysis looked at the relationship between adherence to the American College of Cardiology/American Heart Association (ACC/AHA) class 1 guideline-recommended therapies and risk-adjusted in-hospital mortality rates. Composite adherence was further analyzed in terms of adherence to individual guidelines. Factors involved in care process adoption and practice were examined as well.

The therapies assessed are well known and fall into two classes: acute medications (ASA, any heparin, beta-blocker, clopidogrel, IV glycoprotein IIb/IIIa inhibitor) and discharge medications (ASA, clopidogrel, beta-blocker, ACE inhibitor, statin). Additionally, secondary prevention measures were examined (dietary consulting, smoking cessation consulting, cardiac rehabilitation referral). Even in institutions with high overall adherence, compliance with individual therapies varied widely.

Analysis revealed the following: Mortality in the lowest adherence quartile was 6.31% and decreased to 4.13% for the highest adherence quartile (P<0.001). For every 10% increase in

Medical Director *continued on p. 4*

E-newsletter *continued from p. 1*

Comments from hospital personnel who use this process have been very favorable, as it is extremely easy and saves time.

We hope that you will enjoy the new electronic and web-based features and look forward to providing more web features in the future.

Medical Director *continued from p. 3*

composite guideline adherence at a given hospital, there was a 10% decrease in likelihood of in-hospital mortality (risk-adjusted, odds ratio 0.90, 95% CI, P<0.001).

What made the top hospitals better than the others? Even after adjustment for factors such as age, race, socioeconomic status, hospital tertiary care capability, and invasive vs. conservative treatment strategy, the link between guideline adherence and outcome persisted. The authors suggest that guideline adherence is likely a proxy measure for an institution's quality culture, and that features including administrative support, physician leadership, initiative champions, feedback, and teamwork were predictors of overall hospital quality process driven care.

All of this should come as welcome news. Not only is a tangible improvement in patient care possible, this process-driven philosophy can be generalized to other quality initiatives and the very real benefits are within reach for us all.

TIP OF THE DAY

Inpatient Admission vs. Observation Status

For a patient to be designated with an inpatient status, the patient must stay beyond midnight. For example, if the patient is in the hospital from 9:00 a.m. to 5:00 p.m., these services cannot be billed as inpatient services.

A patient who is placed in an observation status, however, may also stay beyond midnight. According to the Ohio Administrative Code 5101:3-2-21, payments for observation services can be made for up to two consecutive days. Payments for observation services will be made in accordance with Appendix F of this code.

CPT Codes That Require Precertification

The Ohio Medicaid Utilization Review Program requires precertification for designated elective surgical procedures. The list of procedures requiring precertification is updated periodically and providers will be notified by ODJFS when these changes occur. Changes will also be posted to www.permedion.com, the web site for Permedion, the utilization review entity for ODJFS.

Precertification for Ohio Medicaid services is based upon the CPT code performed by the physician. If the CPT code is not on the precertification list, then the procedure does not require precertification. However, if a hospital provider performs a procedure for which the CPT code does not require precertification but falls within an ICD-9 code that does require precertification, a condition code should be used on the UB-92 to prevent a billing error. The condition code AN (exemption from precertification) should be placed in Form Locator Number 24 on the UB-92. This exemption code is effective only for services on or after October 1, 2005.

An example of a procedure that would require this kind of a condition code would be CPT code 58956 (total abdominal hysterectomy for malignancy with bilateral salpingo-oophorectomy with total omentectomy). This procedure is billed under ICD-9 code 68.4, which is a code that requires precertification for some of the other hysterectomy codes such as 58150.

Complete hospital billing instructions can be found within the Ohio Medicaid Hospital Provider Handbook. These billing instructions are based on the rules that are contained within the Ohio Administrative Code. Billing instructions and hospital rules can be found in Chapter 5151:3-2 of the Ohio Administrative Code, and can also be accessed by visiting the web site <http://emanuals.odjfs.state.oh.us/emanuals> and selecting "Ohio Health Plans - Provider," "Hospital services."

Direct billing questions to the Claims Department of ODJFS at 1-800-686-1516.

CONTACT INFORMATION

Permedion • Sue Hackett, Project Manager
 • 350 Worthington Rd., Suite H • Westerville, OH 43082 • 614/895-9900 • fax 614/895-6784
 • www.permedion.com • shackett@permedion.com

Ohio Department of Job and Family Services – Office of Ohio Health Plans
 • Lynne Lyon, Contract Administrator • 30 E. Broad St. • 27th Floor • Columbus, OH 43215-3414
 • 614/466-6420 • fax 614/466-2908 • www.jfs.ohio.gov

350 Worthington Rd., Ste. H
 Westerville, OH 43082

