Ohio medicaid QUALITY MONITOR

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Change to Permedion's DRG Reassignment Process

The method by which a DRG reassignment is calculated will be changing for reviews completed by Permedion as of October 1, 2007. **The appeal process for denials, however, will remain the same**. Permedion, the utilization review entity for the Ohio Department of Job and Family Services (ODJFS), reviews medical records for medical necessity and billing errors in addition to monitoring for correctly assigned DRGs.

Currently, when a DRG is reassigned by Permedion, the dollar difference between the originally assigned DRG and the corrected DRG is recouped. The provider does not have to submit a corrected claim. Going forward, the entire amount of the DRG payment will be recouped, thus requiring the provider to rebill the claim with the corrected DRG in order to receive payment. If a case is also denied for medical necessity only one recoupment of claim dollars will occur. A medical necessity denial always supersedes any other denial type that might have been identified through case review.

Claims resubmitted as a result of a retrospective review decision should be sent to:

Ohio Department of Job and Family Services
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461

Please refer to the Ohio Department of Job and Family Services Hospital Provider Handbook, Hospital Billing Instructions. These instructions can be accessed at: *http://emanuals.odjfs.state.oh.us/emanuals*.

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PERMEDION

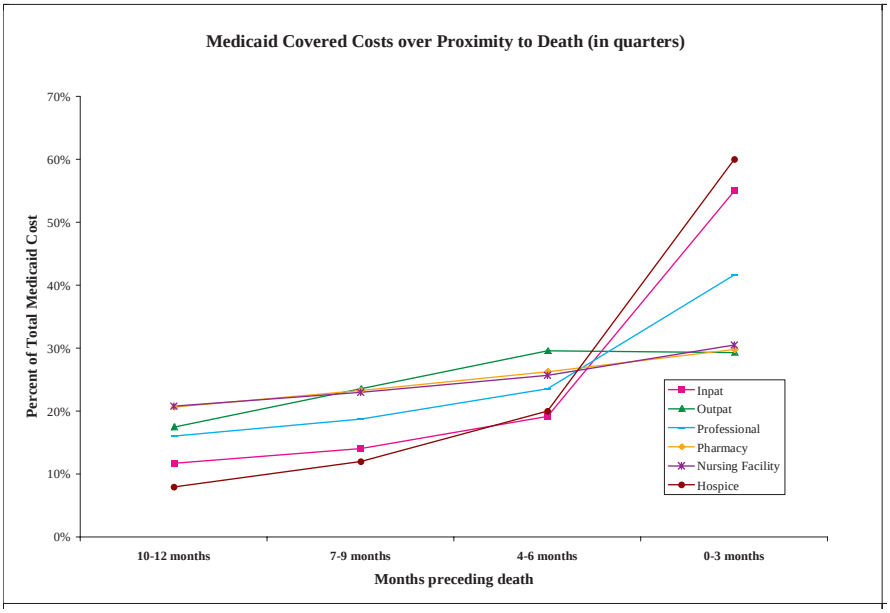
Closing the Chart: Examining the Use of Health Care Services at the End of Life

When approaching the end of life, many people draw heavily on the health care system in the form of clinical services, counseling, and practical assistance with both medical and nonmedical needs. It is essential to understand how the Medicaid health care system can serve dying patients and identify the system characteristics that contribute to good care. Such an understanding depends on analysis of the data and research to help provide the basic information needed to develop steps that will ensure appropriate and reliably excellent care.

The *End of Life Study* provided ODJFS with a better understanding of the utilization and cost of health care services of the dying patient. Patient profiles, the use of services, and costs including both acute and palliative care settings were evaluated using Medicaid claims data.

The study population included 18,330 Aged, Blind, and Disabled (ABD) recipients who expired during SFY 2003. There were approximately 426,675 Medicaid eligibles in Ohio's ABD program, making the death rate 4%. It is important to note that the study population was composed of a medically high-risk group with 78% being 65 years and older. The average age at the time of death was 77 years old. The average death rate of the general population over 65 is 5% and the average life expectancy is 78 years old.

The study analyzed types and volume of professional claims, which included services such as physician visits, vision and dental services, physician services, nursing facility (NF) services, injections, durable medical



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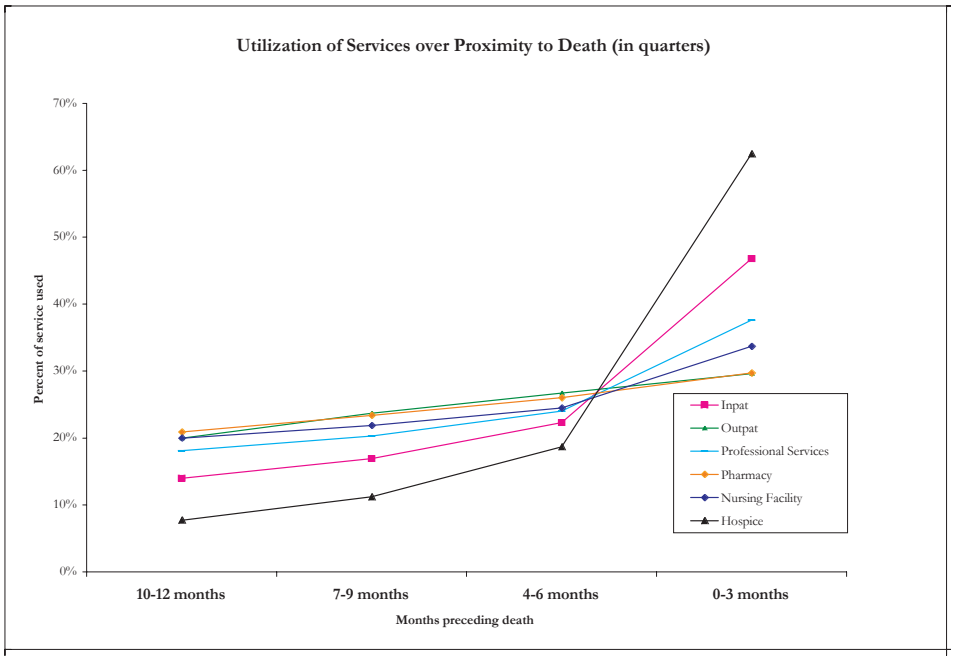
equipment, and supplies. The most frequent primary and secondary diagnoses reflected chronic diseases and conditions. The diagnoses were very similar to those found by the Centers for Disease Control and Prevention (CDC) to be the leading causes of death among persons age 65 and older. The average professional reimbursement for the year prior to death was $6,230 per patient with the median of $2,012. The services in the final 3 months of life accounted for 38% of all the utilization in the study period.

Types and volume of hospital outpatient claims, which included clinic, pathology/laboratory, radiology and surgical outpatient services, and ED visits without hospital admissions were analyzed. The average outpatient hospital reimbursement for the year prior to death was $4,018 per patient with the median of $1,322. The services in the final 3 months of life accounted for 30% of all the utilization in the study period.



A total of 90% of the study population received at least 1 Medicaid covered pharmacy prescription in the year prior to death. The most frequently prescribed drugs were Furosemide, Prevacid, Lorazepam, and Zoloft. The average pharmacy reimbursement for the year prior to death was $3,787 per patient

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CODING CORNER

Alzheimer's Disease

In this article of the Coding Corner, we provide information on the identification, signs and symptoms, risk factors, treatment, and complications that patients face when diagnosed with Alzheimer's Disease.

Alzheimer's disease is a diffuse atrophy of cerebral cortex; causing a progressive decline intellectual and physical functions, including memory loss, personality changes and profound dementia.

Alzheimer's disease is the most common cause of dementia, which is the loss of intellectual and social abilities severe enough to interfere with daily functioning. Dementia occurs in patients with Alzheimer's disease because healthy brain tissue degenerates, causing a steady decline in memory and mental abilities. About 4 million older Americans have Alzheimer's, a disease that usually develops in people age 65 or older. This number is expected to triple by the year 2050 as the population ages.

SIGNS

Most people with Alzheimer's share certain signs and symptoms, which may include the following:

- Increasing, persistent forgetfulness
- Difficulties with abstract thinking
- Difficulty finding the right word
- Disorientation
- Loss of judgment
- Difficulty performing tasks
- Personality changes

COMPLICATIONS

In advanced Alzheimer's disease, people may lose all ability to care for themselves, which can make them more prone to additional health problems such as pneumonia, infections, and complications from falls.

There is no cure for Alzheimer's disease, but the physician may prescribe drugs to improve symptoms such as sleepiness, wandering, anxiety, agitation, and depression.

CODING ALZHEIMER'S DISEASE

To appropriately assign the ICD-9-CM code for Alzheimer's disease assign 331.0 along with 294.10-294.11 to identify

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with the median of $2,819. The prescriptions in the final 3 months of life accounted for 30% of all the prescriptions in the study period.

During the study period, there were 2,696 ABD patients with 8,135 Medicaid-covered acute hospital stays during their last year of life. On average, a patient had three hospital stays with an average length of stay of eight days. Frequent diagnoses were heart failure and shock, chronic obstructive pulmonary disease and respiratory system diagnoses with ventilator support. The inpatient average admission reimbursement for the year prior to death was $33,683 per patient, with the median of $19,662. Approximately 40% of the hospital stays had an admission through the ED. Of the 2,696 patients with hospital admissions, 32% of them died in the hospital.

During the study period, there were 13,586 individual ABD patients with NF encounters. As death approached, the frequency of NF encounters increased approximately 60%. The average estimated length of stay was 10 months. The average NF reimbursement for the year prior to death was $34,087 per patient. The average cost per month remained fairly constant throughout the year prior to death and averaged $3,032.

During the study period only 25% of ABD patients received hospice services and the overwhelming diagnoses of the study population were chronic diseases. Since this study does not include Medicare data, it is likely that some of the study population may have been eligible for and received Medicare hospice benefits. The Dartmouth Study (2006) stated that the average hospice enrollment rate for Ohio was 33% and the national average rate was 27%. The average reimbursement per hospice patient during the year prior to death was $4,219. The frequency of hospice encounters increased 80% in the last 6 months of life and 60% in the final quarter of life.

A comparison of the utilization of the different health care services to the proximity of death showed that all services increased significantly as death grew closer. The average cost per patient was $40,059 during the last year prior to death. The Ohio Medicaid Report 2005 stated that Medicaid spending for all ABD individuals was approximately $17,800 per eligible for SFY 2003.

The *End of Life Study* is a descriptive summary that used several databases (ODJFS DDS data, master recipient file, and pharmacy and claims databases) to obtain descriptive data for a 12-month period prior to death. The analysis results should be used with careful consideration of their limitations. Only Medicaid-covered services and costs were available for analysis. As such, the results do not include services and costs provided by Medicare or private insurances.

The findings of this initial study support disseminating the results to practitioners who treat end-of-life patients, highlighting the following findings and assumptions:

1) As death grew nearer, there was an increase in the number and costs of all services. This indicates there may be a need for the practitioner to assess patient outcomes and perceptions of care when the end of life is inevitable in order to establish more accountability for provider and system performance.

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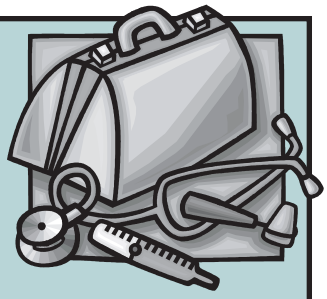
Medical Director *dialogue*



by Guest Writer - Michael Dick, MD
Director of Quality Studies, Permedion and Director of Emergency Services, Ohio State University East

In October 2004, an article titled "Not in My ER, Not in My Nursing Home" by Linda DeFeo, MD, appeared in the American College of Emergency Physicians News publication. The article described the emergency physician's frustration and nursing facility, family and patient's confusion that often accompany the dying process.

An 80-plus year old patient, post CVA with dementia and a feeding tube was brought by ambulance from the nursing home with "change in mental status." The patient had a Do Not Resuscitate (DNR) on her chart. When the private physician was called and asked what she wanted the ED physician to do, her reply was "DNR does not mean do not treat."

The ED physician did the "million dollar" workup including a CT scan and a lumbar puncture, all of which were negative. The patient spent 10 hours in the ED before getting an inpatient bed.

Further investigation by Dr. DeFeo revealed that most health care providers, lawyers, patients and families agreed that terminal patients should not be transported to EDs, particularly when their advance directive asks for palliative care only. Studies published in the Journal of Palliative Medicine, October 2003, and Journal of the American Geriatric Society, May 2002, confirmed that educating patients and families altered their decisions at end-of-life situations. They showed that families could learn that transport to the ED was not always in the patients' best interest.

Dr. DeFeo's article included three standards that would be useful in developing educational programs:

1) Nursing homes that care for terminally ill patients should be mandated to have whatever resources are necessary to provide palliative care without transport to the hospital.

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2) Families should be educated on what it means to have their loved one treated in the ED at the end of life.
3) Physicians who care for these patients should have mandatory classes on end-of-life.

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dementia with and without behavioral disturbance. If unsure of the diagnosis, always query the attending physician to ensure appropriate code assignment.

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2) The majority of the end-of-life diagnoses reflected chronic diseases and conditions. Practitioners should strengthen the quantity and quality of disease management, education, and communication about end-of-life care with patients and families.

3) All of the patients who died in the hospital had an admission type of "Emergency" or "Urgent." This may indicate the need to recognize the value of the caring function of medicine when curing and life-prolonging functions will be futile.

4) Use the information obtained from this study to assist in reviewing the need to integrate palliative and hospice care and conventional medical treatment rather than viewing them as completely separate entities.

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 (614) 895-9900, Ext. 3374.

Ohio Medicaid Quality of Care Findings

Permedion, as the utilization review entity for Ohio Medicaid, completed the semiannual analysis of quality concerns for the calendar year (CY) 2005. These quality concerns were identified during routine retrospective review activity of targeted records for ODJFS. The reporting period takes into account the lag time involved in the investigation and final determination of quality concern issues.

The report includes quality concerns for each hospital, as well as hospital peer groups. The peer groups are designated by ODJFS for reporting purposes.

The overall percentage of *Level 1* (trended) quality concerns increased from CY 2004. *Level 1* identifies medical mismanagement without a potential for significant adverse effect on a patient. Nine peer groups had a slight increase in their trended quality concern rate, five had a slight decrease and two remained the same.

The overall percentage of confirmed quality concerns (*Level 2* and *3*) was significantly higher than the previous year. *Level 2* is defined as medical mismanagement with the potential for significant adverse effect to the patient, while with *Level 3* there has been a significant adverse effect to the patient. Ten peer groups had a slight increase in their confirmed quality rate, while only three peer groups had a slight decrease, and two remained the same.

All quality concerns are identified through physician review. In CY 2005, 93 were identified as *Level 2* quality concerns compared to 41 in the previous year. Six *Level 3* concerns were identified this reporting period compared to only three last period.

Permedion provides hospital providers with a monthly "Preliminary Summary of Quality of Care Findings" report in addition to individual quality letters. For more information on Permedion's quality of care review program, please contact Maureen Riley, Utilization Review Service Line Manager, at (614) 895-9900.

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