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Permedion Presents at NAMPI

On Monday, August 25, 2008, Permedion and our parent company, HMS, presented to the National Association for Medicaid Program Integrity (NAMPI). The topic of the presentation was *"Clinical Reviews in Program Integrity"* and stressed the importance of a clinical approach and peer review when states conduct review activity for their Medicaid programs. The important point for hospitals is that many of these points can apply to a hospital's internal utilization review and quality improvement program.

The real message from the presentation was that with all of the review initiatives being implemented by the Centers for Medicare & Medicaid Services (CMS), it is more important than ever that state Medicaid programs maintain a review process that uses accepted processes and clinical input, and that these decisions are communicated adequately and accurately to providers.

Common factors of an effective clinical review process (either for a Medicaid program or for a health plan or provider group) are:

- **Data Mining** – Identifying claims or cases which have a high likelihood of being inappropriately billed or a quality issue.
- **Diverse Clinical Expertise** – Assigning appropriate clinical specialist and sub-specialist to cases that need that level of review.
- **Diverse Professional Expertise** – Using qualified people in the review process who efficiently process the review and effectively communicate with the provider.
- **Payor-Specific Knowledge and Experience** – Reviewers need to know the specific idiosyncrasies and rules of each health care payor to make or avoid billing errors.
- **Population-Specific Knowledge and Experience** – When performing data analysis or special projects, it is often important to know the clinical characteristics of certain populations (e.g., Medicaid claims involve a high number of mothers and babies.)

Permedion reviewed the important review categories that they have experience over various contracts. Again, hospitals frequently want to understand what a review company is looking for, how they go about finding cases, and some of the issues involved for providers.

- **Medical Necessity** – are services medically necessary and appropriate for the clinical conditions present?
- **Appropriateness of Setting** – do services provided need an acute inpatient level of care setting?

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Why are Emergency Departments Crowded?

Emergency department (ED) visits in the United States increased 28% between 1992 and 2005, according to the National Center for Health Statistics for 2007. Crowding in EDs is a nationwide problem, resulting in long waits to see a physician ambulance diversion, and as growing evidence indicates, poorer quality of care. For these reasons, a 2008 study by the American College of Emergency Physicians (ACEP)[1] attempted to understand the causes for the rise in ED visits so that programs can be created to reduce crowding and simultaneously meet the needs of these patients in other settings.

Permedion completed an *Emergency Department Utilization Study*[2] last year using data from 2000 through 2004. The purpose of the Permedion ED study was to provide comparisons of selected ED utilization from 2000 to 2004 and baseline information on the utilization of ED services prior to establishing cost-sharing co-payments. Although actual numbers can not be compared because of the difference in the indicators, databases, and analysis methodology, the comparison of the trends was interesting.

The ACEP study determined the proportion of ED visits associated with the insurance status of individuals: no insurance, private, Medicare, Medical/other public, and military. The proportion of ED visits by uninsured and Medicaid insured persons was essentially unchanged throughout the study period. The Permedion study found similar results with the percent of enrollees with ED visits remaining very stable over the 5 years ranging from 20 to 22%.

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published in cooperation with:

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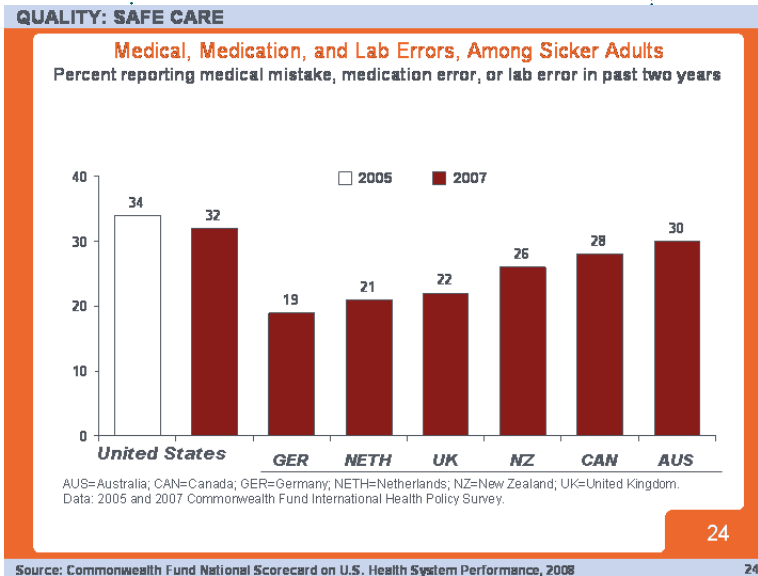
- **DRG Review** – are claims data that affect payment (diagnosis/procedure codes, date of birth, discharge status, etc.) accurate?
- **Outpatient Coding Review** – are claims coding accurate and consistent with billing directives?
- **Compliance Validation** – was the information provided prospectively accurate and complete?
- **Bill Audit** – do line item charges match services documented in the medical record?
- **Quality Review** – does the care delivered meet or exceed acceptable standards of care?

Dr. David Sand, Permedion's Corporate Medical Director (see Medical Director article) then spoke about the high cost of poor quality.

Recent findings demonstrate approximately 3% of all hospitalized patients experience a safety incident; among sicker patients that percentage is considerably higher. While the United States has made progress over the past several years, compared to other developed nations we fare poorly. The financial cost of these quality issues exceeds $1.5 billion.



Traditional thinking would suggest increased spending on technology and care would result in improved quality; however, currently there is no such relationship. As indicated in the figure on Page 3, high spending is associated with above-average and below-average quality of care, as is lower spending.

Permedion also discussed the strengths and weaknesses of prospective and retrospective review programs and which are more or less burdensome for providers. They stressed that a good working relationship between a review entity and the provider community

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CODING CORNER

Adult Sleep Apnea Syndrome

In this article of the *Coding Corner*, we provide information on the identification, signs and symptoms, treatment, and prevention of Adult Sleep Apnea Syndrome.

Definition

Adult sleep apnea syndrome refers to episodes of inadequate or irregular breathing during rapid eye movement and non-rapid eye movement sleep states. The condition is characterized by heavy snoring, movements when breathing actually stops for 10 seconds or more, excessive sleepiness during the daytime, possible insomnia, memory loss, personality change, systemic hypertension, and even impotence. Patients are mostly middle-aged, obese men. Sleep apnea affects between 2 and 10% of people. It is more common in people who are overweight, but there are many people with normal weight who have sleep apnea.

Signs/Symptoms

If you have sleep apnea, your body gets less oxygen when you sleep and you don't sleep well. Some common symptoms of sleep apnea are:

- loud snoring
- not feeling rested when you wake in the morning
- morning headaches
- tiredness and sleepiness during the day
- trouble concentrating
- anxiety, irritability, or depression
- a strong desire to take afternoon naps
- sleepiness while driving

Treatment

The most common treatment is the use of a machine that sends pressurized air into your nose and throat at night. How much pressure you will need is determined by the sleep study. Your physician will need to carefully monitor your use of this breathing machine due to adjustments that may need to be done so that it works right for you. This treatment is called continuous positive airway pressure (CPAP).

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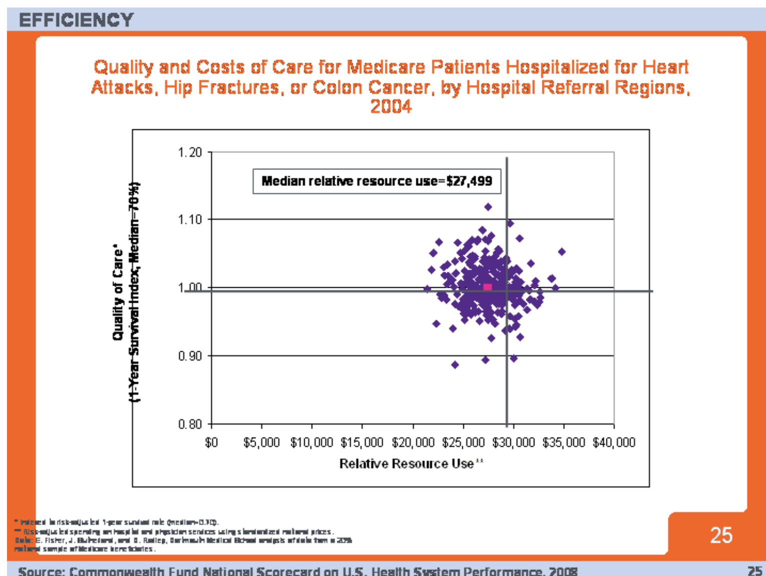
is essential for the success of any Medicaid review program.



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The ACEP study also determined the proportion of visits by income. The proportion of visits by more affluent individuals increased. The percentage of visits to ED with over 400% of the federal poverty level (FPL) increased over 7% during the study period. Visits for those with incomes less than 399% of the FPL decreased 2 to 3%. The Permedion study did not include any analysis of the visits by income.

Another indicator in the ACEP study looked at the proportion of visits by those without a usual source of care. There was a significant increase in the proportion of ED visits by those whose usual source of care was a private physician's office or clinic. However, this analysis was not stratified by type of insurance.

The Permedion study did not look at usual sources of care but showed that the percentage of Medicaid patients with a private physician/clinic visit within 30 days prior to an ED visit decreased significantly (7%) over the four year study period. This indicated that Medicaid patients sought care from a private physician/clinic 7% less in 2004 than in 2001.

The ACEP study concluded that the increase in ED use may be attributed to lack of ready access to primary care and to other structural problems in the health care system. The Permedion study found similar conclusions that were directed toward the Medicaid population: a need for primary care during the first month of Medicaid eligibility; assistance to help patients learn how to use the health care system; and more available urgent care clinics and extended hours for physicians' offices.

1. E. Weber, J. Showstack, K. Hunt, D. Colby, B. Grimes, P. Bacchetti, and M. Callaham (2008). Are the uninsured responsible for the increase in emergency department visits in the United States? Annual of Emergency Medicine. 2008: 52:2:108-115.
2. Permedion (2006). Emergency Department Utilization Study, Columbus, OH: Author.

Medical Director *dialogue*

By David Sand, MD, MBA, FACS, CHCQM, FAIHQ
Corporate Medical Director, Permedion, an HMS company

The National Association for Medicaid Program Integrity recently met in Williamsburg, Virginia. The general consensus among the representatives attending was that Program Integrity encompasses virtually all aspects of the health care delivery system, from accurate claims and proper payment, to the delivery of appropriate and necessary health care free of avoidable errors.

On July 31st of this year CMS issued a letter regarding what are commonly referred to as "never events." Identified by the National Quality Forum, these are 28 adverse events that are "serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability." CMS has urged the states, and particularly the Medicaid programs, to adopt formal amendments in law that establish non-reimbursement policies for these never events. Many states have already adopted some or all of these never events in their policies; others have urged commercial payors to do the same.

As providers, we all "know" we provide impeccable care, yet the U.S. Agency for Healthcare Research and Quality (AHRQ) just announced surgical errors cost almost $1.5 billion a year! And the costs don't stop when the patients leave the hospital. The cost of hospital care in this country is approaching $1 trillion a year (Kaiser Family Foundation), and the expense of an in-patient day has risen steadily over the past decade.

Still, we cannot ration our way to viability in our health care system and still maintain quality. Put simply, we must "do it better." For all of us in health care it is our responsibility and obligation to make certain we provide the most appropriate care, in the proper amount, in the correct setting, at the right time, to the right patient, in a manner consistent with the highest standards of our profession.

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Prevention

The following is some of the ways that you can help prevent sleep apnea:

- proper weight control
- exercise
- good sleeping habits
- no smoking
- avoid excessive alcohol use

Coding of Adult Sleep Apnea

Adult sleep apnea syndrome with mention of insomnia is coded 780.51.

Adult sleep apnea syndrome with mention of hypersomnolence or excessive daytime sleepiness is coded 780.53.

Adult sleep apnea syndrome not otherwise specified is coded 780.53.

You should also code any mention of obesity, 278.0_ or Pickwickian syndrome 278.8.

HOSPITAL BILLING FOR HOSPICE PATIENTS

The Ohio Medicaid hospice program is a benefit that is available to a terminally ill Ohio Medicaid recipient. Terminally ill is defined as a medical prognosis that gives an individual a life expectancy of six months or less if the illness runs its normal course.

Hospice care incorporates an interdisciplinary team approach that emphasizes supportive/palliative services rather than active or curative care. This team should play an integral part in the services provided to the recipient while they are in the hospital. The goal of the hospice program is to meet the physical, psychological, social, and spiritual needs of the individual and their family during the final stages of illness, dying and bereavement. When a hospice recipient presents at an acute care hospital for treatment, it is necessary for the hospital provider to be cognizant of the billing practices for this Medicaid recipient.

If a recipient elects to receive hospice care, the individual must waive Medicaid services if these services are for treatment of the terminal condition or for a condition that is related to the terminal condition for which the hospice care was elected. These services would be the financial responsibility of the hospice agency.

A recipient's Medicaid card should be labeled with the name of the hospice agency next to the individual's name. This will alert the hospital to the fact that hospice care has been elected and that there is a restriction on Medicaid coverage. It is the responsibility of the hospice agency to label the Medicaid card no later than the eighth of each month.

For any services related to the terminal illness, a hospital provider must bill the hospice agency directly. For services unrelated to the terminal illness, providers should call the hospice agency before providing any service in order to clarify the individual's

Hospice *continued on side bar*

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restricted status. Inpatient respite care is a covered service by the hospice agency if the inpatient stay is related to the terminal condition.

A Medicaid recipient receiving the Medicaid hospice benefit may choose to revoke the election of hospice services once during each benefit period. A "benefit period" is the number of days that hospice care is provided under Medicaid. The benefit periods include an initial 90-day period, a subsequent 90-day period (both of these periods are limited to one during an individual's lifetime) and an unlimited number of subsequent 60-day periods.

For additional details regarding hospital billing for hospice patients please consult the Ohio Administrative Code Rule 5101:3-56 which can be accessed via the Internet at:

http://emanuals.odjfs.state.oh.us/emanuals/.

Click on Ohio Health Plans-Provider and Hospice Services for this billing information.

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