Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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Welcome New Project Manager

Permedion welcomes Sue Butterfield RN, BSN to the position of Project Manager for the Ohio Medicaid Utilization Review Program. She replaces Maureen Riley RN, BSN who has held the position for over four years and who remains with Permedion serving in other roles.

Sue joined Permedion eight years ago as a utilization review nurse in a Kentucky Home Health Prior Authorization project. Since 2003 she has served as the Independent Medical Review Service Line Manager. In this role, she has coordinated third level appeals of adverse determinations for 12 state departments of insurance and quality of care peer reviews for more than 50 clients including hospital associations and state licensing boards. She has experience in reviewing, evaluating, and processing cases to assess the appropriateness/level of care, medical necessity, experimental/investigational status, and quality of care provided to Medicare beneficiaries, Medicaid recipients, and commercial health plan enrollees .

Sue has had a diverse nursing career for more than 25 years. She received her Bachelor of Science in Nursing from The Ohio State University and has been a Certified Case Manager since 2001. She has 5 years experience as a Nurse Manager of the Infectious Diseases Unit at The Ohio State University Hospital and 18 years as an Obstetric & Gynecology nurse. More recently, she has worked as a High Risk Obstetrics Case Manager for HealthPower, an Ohio managed care HMO, and a Catastrophic Case Manager with the Ohio Health Group.

Questions regarding the Ohio Medicaid Utilization Review Program should be directed to Sue Butterfield's attention at (614) 895-9900, Ext. 3428, fax at (614)•895-6784 or (614) 839-2628, or via e-mail at sbutterfield@hms.com.

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When Every Code Counts

The Emergency Department (ED) reimbursement is a highly specialized area. Since the implementation of the Outpatient Prospective Payment System (OPPS), the Centers for Medicare and Medicaid Services (CMS) has required hospitals to report facility resources for ED visits using CPT evaluation and management (E&M) codes. At the same time, CMS recognized that the CPT ED E&M codes do not adequately describe the intensity and range of ED services by hospitals because they reflect physician activities. Therefore, CMS instructed hospitals to develop their own internal guidelines for reporting ED E&M visits.

According to current literature, one of the best known models for determining ED visit levels is AHA/AHIMA Guidelines. These guidelines were developed through a request from CMS for an independent expert panel. The intent was to develop consistent code definitions and guidelines to be used by the Medicare and Medicaid program for facility-based evaluation and management services.

At present, there is no Ohio Medicaid utilization review for accuracy of coding of services for ED visits. Because of the various models used by hospitals, it is difficult to measure the assignment of the facility E&M codes. However, review of ED E&M coding assigned to represent rendered services, as compared to the AHA/AHIMA Guidelines provides some needed information on the accuracy of ED facility coding.

This study provides information that assists in monitoring the accuracy of facility ED E&M coding. It provides evaluation of the codes assigned to represent the intensity and resources of rendered services during ED visits for patients who were discharged to home or left the hospitals against medical advice (AMA).

The study population included the following Ohio Medicaid recipients:

- Recipients enrolled in a fee-for-service program at the time of service, and
- With claims that included either a 99284 or 99285 E&M code (the two ED visit E&M codes with the highest intensity of service and payment, see Coder's Corner for detailed definitions), and
- With date of service between 1/1/2007 and 12/31/2007, and
- With discharge status of home, home-health, or left AMA

A simple random sample of 480 cases was selected from this population.

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ED E&M *continued from p. 1*

Review of the ED medical records involved identifying the hospital interventions and contributory factors that were part of the ED visit. These were assigned to one of the three levels of facility ED E&M codes as designated by the AHA/AHIMA Guidelines. The results were compared to the hospital's assigned codes. The results revealed that 63% of the codes that were coded as high intensity codes of 99284 and 99285 by the hospitals were in agreement with a review using AHA/AHIMA Guidelines. According to AHA/AHIMA Guidelines, the remaining 37% of the high intensity code should have been coded at a lower level. Six percent of the cases supported a mid level code (99283) and 31% supported low level codes (99281 and 99282).

These results should be evaluated with caution. Although the AHA/AHIMA Guidelines is the most highly recommended set of guidelines, CMS does not mandate that they should be used in assigning E&M facility codes. Hospitals are allowed to use their own guidelines as long as they reasonably relate to the intensity of facility resources.

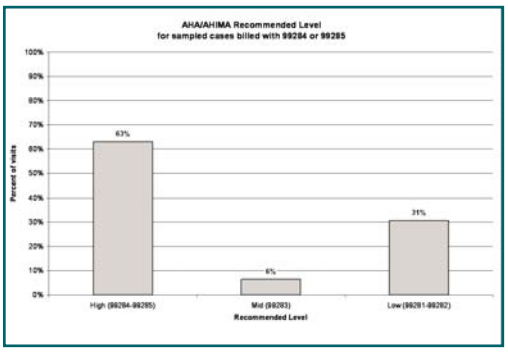

Figure 1. AHA/AHIMA Recommended Level for Sampled Cases Billed with 99284 or 99285

The estimated reimbursement difference between the codes assigned through AHA/AHIMA Guidelines supported review and the actual billed codes was calculated. Ohio Medicaid would have saved an estimated $2.6 million from the decreased use of high intensity codes. However, this study reviewed only visits with hospital assigned 99284 and 99285 codes. The results cannot be used to estimate the amount that payments for cases with the lower intensity codes may have increased or decreased if AHA/AHIMA guidelines had been followed. Another issue in determining savings by using the AHA/AHIMA guidelines is the CMS statement that it has not and will not develop national coding guidelines for the use of facility E&M facility codes.

CMS is regularly reevaluating hospital outpatient visit patterns of reporting through the annual analysis of claims data. In the Federal Register, CMS 2006, one of the guidelines for evaluation is that the overall distribution of codes should result in a normal curve and documentation guidelines should support the result. It is reassuring to note that the analysis of the Ohio Medicaid study population revealed a

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CODING CORNER

Facility E&M Coding

In this issue of the *Coding Corner*, we would like to follow-up on the "When Every Code Counts" article. The **Appropriate Emergency Department Coding Study** provides information that assists in monitoring the accuracy of facility ED E&M coding.

As indicated in the study, the results revealed that 63% of the codes that were coded as high intensity codes of (99284 and 99285) by the hospitals were in agreement with a review utilizing the AHA/AHIMA Guidelines. The remaining 37% of the high intensity code should have been coded at a lower level. Six percent of the cases supported a mid level code (99283) and 31% supported low level codes (99281 and 99282).

CODE DESCRIPTION OF HIGH INTENSITY CODES 2007

99284: Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose and immediate significant threat to life or physiologic function.

99285: Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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ED E&M *continued from p. 2*

normal bell shaped curve of 6% of the facility ED codes were 99281, 22% were 99282, 43% were 99283, 21% were 99284, and 7% were 99285.

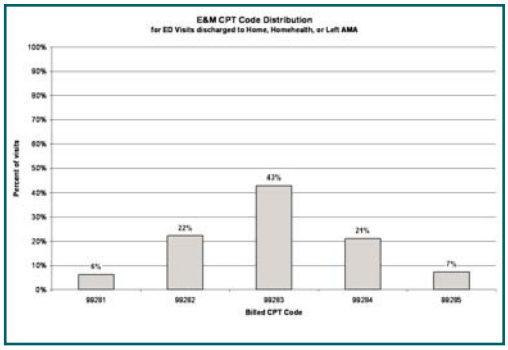


Figure 2. E&M CPT Code Distribution

Additional analysis was completed to determine if there was a difference in the recommended service intensity levels between visits documented in electronic medical records and those documented in the traditional hard copy format. The results indicated that there was no difference (p=0.9727).

Recommendations

Disseminate the results of this study to ED staff and hospital coders highlighting the following recommendations:

The facility ED E&M codes must accurately capture interventions performed and hospital resources consumed during an ED visit. Since documentation must support the services provided and reported, nursing documentation is very important when selecting the appropriate E&M codes. Hospital coders usually assign E&M codes. Even with using internal hospital guidelines, there may be differing interpretations on how they should be used and coded.

It is also recommended that the hospitals should review their internal guidelines to determine if they comply with the principles listed by CMS (2008). Since there is no guarantee that the tool a hospital develops for itself will accurately reflect the resources used, this review could determine if the hospital's established criteria reflects the intensity of services.

Because there are no mandatory guidelines to determine facility ED E&M level of service, it is recommended that further review of medical records that includes sampling of all five facility E&M codes be completed. A review of the medical records based on each hospital's current guidelines should be done. This would indicate if the hospital assigned codes relate to the hospital's current internal guidelines and intensity of care.

Complete study results and references will soon be available at *www.hmspermedion.com*.

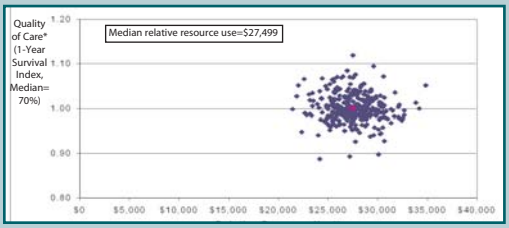
Medical Director *dialogue*

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

"You get what you pay for." Right? That's what the conventional wisdom says. It also says, "You can't teach an old dog new tricks," but then again "You're never too old to learn."

Recent data from the Dartmouth Atlas of Healthcare has shown that hospitals performance on quality of care is not associated with the intensity of their spending.

As we consider the various methodologies for healthcare reform, we would do well to recognize that the cost of care varies widely around the country. Additionally, the quality of care received has little to do with that cost. The graph below is an often used example of how widely cost and quality vary throughout the country for standard disease processes.



Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004

Indeed, when Medicaid considers health care reform, we need to focus on bringing all hospitals and physicians in line with evidence-based medicine. This effort will help to decrease variability, streamline the delivery of care and make the most efficient use of our limited resources.

Yes, that's right. I said "limited resources." Now more than ever, we are being forced to face the fact that we have limited resources. With 45 million uninsured people, and nearly a quarter of those belonging to the middle class, it is increasingly urgent to address the problems of healthcare delivery. Alexis de Tocqueville stated, in his book Democracy in America, that America "will never change until the middle class is

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affected." He was right. In fact, most people in the middle class receive their health insurance as a benefit from their employer, a source of coverage that has been put in jeopardy by the economic recession. Moreover, health insurance and medical care have become less affordable with rising insurance premiums and medical costs that have outstripped the growth of wages. Along with cost-sharing requirement increases, we are beginning to see widespread public sentiment in favor of health care reform.

Perhaps, now is the time. Maybe, we will be able to get the escalating costs of healthcare under control and even make some significant changes to our system. The devil is in the details, of course, but there is no more money in the system, and people don't want higher taxes, so we can't spend our way to a solution. Quality and efficiency with decreased variability are key elements in finding a lasting solution. No one wants to deny appropriate care; on the contrary, we want to, and need to, provide the right care, at the right level and at the right cost. The simple fact is the dog already knows the tricks. We just need to use them in order to get what we paid for.

Coding Corner *continued from p. 2*

An example of one of the cases reviewed in the study is described as follows:

A 58-year old female presented to the ED with complaints of rectal bleeding and purulent drainage. There were no complaints of fever, chills, or abdominal pain. She did have a history of Crohn's disease. The physical examination revealed the abdomen to be soft and nontender. The rectal examination was deferred to the surgical resident. The appropriate laboratory studies were obtained and were normal. The x-ray of the chest and abdomen showed no abnormalities. The CT scan of the abdomen and pelvis revealed mild inflammatory disease and no abscess or fistulous tracts. The patient was discharged to home from the ED in good condition with a diagnosis of rectal bleeding.

In this case, the facility billed the E&M code to a High intensity code of 99285 and by utilizing the AHA/AHIMA guidelines it was recommended that this claim should have billed to a Low category code of (99281 or 99282). Monitoring the accuracy of your facility's ED E&M coding assignments needs to reflect the resources and rendered services provided to the patient during the ED visit.

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