Ohio Job & Family Services

Ohio medicaid QUALITY MONITOR

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Nursing Facility and Waiver Functional Assessment Study

The Office of Ohio Health Plans is working towards a system of long-term care that maximizes choice and promotes community integration. The objective is to expand Ohio's capacity to serve Medicaid consumers with long-term care service and support needs in the community.

According to the 2005 Ohio Medicaid Profile, over 86,000 Medicaid recipients were in nursing homes with expenditures of over $2.7 billion annually. This accounts for almost 22% of total Medicaid expenditures. Currently, Ohio Medicaid's long-term care system is progressing toward greater flexibility in choosing long-term care options. An array of waiver programs is available to serve people in alternative care settings who otherwise would need nursing home care.

One such program is PASSPORT. The PASSPORT program serves people 60 years of age and older in their homes. Another waiver program, the Ohio Home Care Waiver, is a limited-enrollment, cost-capped program of home and community services for people under age 60 with serious disabilities and unstable medical conditions.

Identification of long-term care needs and the preferences of consumers and family members for non-institutional care will provide important information to help prevent or delay nursing facility placement. The Ohio Department of Job and Family Services (ODJFS) and Permedion are developing a study on **Nursing Facility and Waiver Functional Assessment**.

This study will assess patient characteristics, levels of care, and long-term care needs and services among consumers residing in nursing facilities, or enrolled in the PASSPORT or the Ohio Home Care Waiver.

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The following is an open letter to Ohio providers from Dr. David Sand, Permedion Medical Director. In this letter, Dr. Sand details the review processes used by Permedion in performing retrospective reviews for Ohio Medicaid.

Dear Provider:

From time to time, we receive inquiries regarding the physician reviewer's role in the utilization review process of Permedion reviews. In order to understand this role, it is helpful to provide a brief background about the purpose of the utilization management program, the review process, the referral and identification of potentially adverse events, and the response to appeals.

ODJFS is responsible for the ongoing administration of the implementation and management of a quality and hospital utilization management program for Ohio Medicaid as designated by the Centers for Medicare and Medicaid Services (CMS). ODJFS contracts with Permedion, an HMS company, for the continued development, implementation, and management of the statewide utilization and quality review program for institutional services. Permedion is compliant with all the regulations as stated in the Ohio Administrative Code, is fully accredited by URAC, and maintains a Quality Improvement Organization (QIO)-like status.

The retrospective review program monitors appropriate utilization of services. A post-payment review includes medical necessity of inpatient admissions, appropriateness of setting, readmissions and transfers, DRG validation, appropriate time of discharge, and quality of care.

An experienced registered nurse (RN) performs a retrospective review of the targeted medical record. The RN uses the CMS Quality Indicators to determine the quality of care and the current version of Milliman Care Guidelines to determine the medical necessity and appropriateness of setting for an inpatient hospital stay. Milliman Care Guidelines are a focused summary of the current best medical evidence and are updated annually. If the criteria are met, the RN approves the case. When the medical information provided does not meet the standards of these criteria or if the RN is uncertain that the standards are met, the information is sent to an Ohio-licensed physician reviewer.

Permedion uses Ohio-licensed physicians who are conversant with the standards of practice within Ohio. There are currently more than 70 physicians who represent 33 specialties and subspecialties. In addition, the physicians are actively practicing in urban and rural settings within Ohio and meet URAC standards for physician reviewers. They are qualified by experience, clinical expertise, and knowledge obtained within their specialty practice, and are

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proficient in the performance of quality reviews. All physicians are evaluated through our internal quality control process for timely, accurate decisions. They are screened for conflict of interest with assigned cases and are credentialed initially and every two years following.

When performing the initial review from the RN, the physician reviewer (PR) receives the RN's evaluation of the case with information indicating why the case does not meet the Milliman Care Guidelines. The PR reviews the RN's summary and the entire medical record. The review decision is based on facts available to the admitting physician at the time of admission.

The PR reviews the case from the medical record as events occurred, and not from the retrospective view of the end result. The outcome of the patient's admission does not determine the need, or lack of need, for admission. The case is also evaluated for quality concerns. The PR's determination is based on the professional and prevailing practices and care in the Ohio medical community, individual patient needs, local practice patterns, and Medicaid directives. The PR considers the merits of each case individually and uses the facts documented in the medical record to support the determination.

If the provider disagrees with the PR's first level determination, the provider or practitioner may appeal. The provider must document the request for an appeal, the reason for the appeal, and ideally submit additional information in support of the disagreement. A portion of appealed determinations is reversed in favor of the provider when additional supporting documentation is provided.

The appeal letter and supporting information may be sent to Permedion via fax or mail within an appeal time frame that is provided on the initial denial letter. When an appeal is received, the medical records and all supporting documentation are sent for a second-level physician review.

The second-level physician is peer matched by board specialty and is actively practicing. The entire medical record and all additional documentation are reviewed de novo. Any additional information submitted by the provider in response to the first level review decision is considered in reaching the new determination.

The PR will address the relevant reasons for disagreement and will document the facts that support the final decision to uphold or overturn the first level determination. All issues provided in the provider appeal letter will be reviewed by the physician; however, only those pertinent to the case will be addressed in Permedion's appeal response. As in the first level review, the PR's determinations are based on the professional

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CODING CORNER

Risks of Hypothermia

In this article of the Coding Corner, we provide information on the identification, signs and symptoms, risk factors, complications, and treatment of hypothermia.

Definition

Hypothermia occurs when more heat escapes from your body than your body can produce. Signs and symptoms of hypothermia may include gradual loss of mental and physical abilities. Severe hypothermia may lead to cardiac and respiratory failure and even death. Each year, nearly 700 people in the United States die of hypothermia due to prolonged exposure to cold air or cold water temperatures.

Signs and Symptoms

- shivering, stumbling, mumbling
- slurred speech
- abnormally slow rate of breathing
- cold, pale skin
- fatigue, lethargy

Risk Factors/Complications

Risk factors that can make you more vulnerable to hypothermia and its complications include:

- advanced age/very young age
- mental impairment
- alcohol and drug use
- certain medical conditions
- water temperature/conditions
- frostbite
- loss of limbs
- coma

Treatment

- move the person out of the cold
- remove wet clothing
- insulate the person's body from the cold ground (do not apply direct heat)
- monitor breathing
- share body heat
- provide warm beverages (do not give alcoholic beverages)

Coding of Hypothermia

To appropriately assign the ICD-9-CM code for the diagnosis of hypothermia, assign (991.6) for accidental hypothermia. Hypothermia that is not associated with

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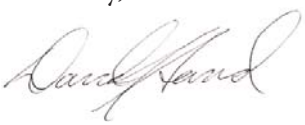
Letter to Provider *continued from p. 2*

and prevailing practices and care in the Ohio medical community, individual patient needs, local practice patterns, and Medicaid directives.

Infrequently, the provider/practitioner may still disagree with the second level physician's determination. Although in the case of non-quality issues the second level physician's clinical decision is final (quality reviews are entitled to three levels of physician review), the provider/practitioner can request an administrative review from ODJFS. This review consists of a review of the utilization review process, dates, and timeliness of the review decisions. An administrative review does not involve clinical information or further clinical review, nor is it performed by a physician.

It is important to note that ODJFS' quality and utilization review program provides an objective review of medical services to enhance the quality of medical care for the Ohio Medicaid recipient, considering medical outcomes, medical necessity, and cost-effectiveness as the primary foundation of quality care. As ODJFS' contractor, Permedion's goal is to improve the quality of medical care for the Ohio Medicaid population by determining whether healthcare services are of appropriate intensity and quantity, provided in the most appropriate setting, are consistent with accepted professional and prevailing practices and care in Ohio, and by providing feedback to health care providers.

Sincerely,



David J. Sand, MD, MBA, FACS, CHCQM
Medical Director, Permedion, an HMS company

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The study objectives are:

- To determine variations and frequencies in physical, clinical, and level of care characteristics of consumers receiving nursing facility, PASSPORT, and Ohio Home Care Waiver services.
- To determine associations of consumer characteristics with placement group through multinomial logistic regression analysis.
- To determine what associated factors or events precipitate admissions to nursing facility and long term care waiver programs through descriptive analysis.

A retrospective review of available administrative data will be conducted, including the following Ohio Medicaid data sources:

- Recipient Master File
- Inpatient Hospital Claims
- Nursing Facility Claims
- Home Health Care Claims

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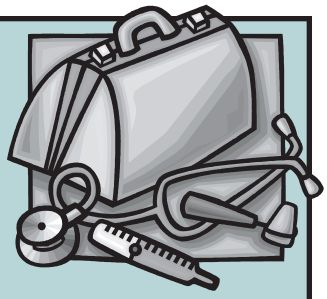
Medical Director *dialogue*



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

The Quandary of Quality Improvement Research

Recently, researchers, Pronovost, Needham, Bernholtz, et al (NEJM, Feb. 2007) at Johns Hopkins University, coordinated a quality-improvement research project aimed at reducing intravenous catheter-related infections in ICUs at Michigan hospitals. The study evaluated routine recommendations by the Centers of Disease Control and Prevention. They included full-barrier infection precautions, hand washing, using disinfectant to clean the patient's skin, avoiding the femoral site if possible, and removing unnecessary catheters.

Needless to say, the results showed a dramatic decrease in catheter-related infections. At the baseline, the hospitals had a median of 2.7 infections per 1000 catheter-days; after 3 months, the median had dropped to 0, and it remained there for 18 months.

After the results were published, the Office for Human Research Protections (OHRP), the federal agency charged with overseeing human-subjects research, investigated and found that Johns Hopkins had failed to obtain consent of the subjects. As a result of OHRP's investigation, the Johns Hopkins institutional review board voluntarily halted research on this quality-improvement program.

A few weeks after the OHRP's decision, an article appeared in the New York Times (Dec. 2007) about the investigation of this quality-improvement project. Shortly afterwards, OHRP issued a statement expressing its new conclusion that Michigan hospitals may continue to implement the checklist developed by Pronovost et al. "without falling under regulations governing human subject research." The OHRP indicated that institutions can freely implement practices they think will improve care as long as they don't investigate whether improvement actually occurs.

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low environmental temperature (chills, not otherwise specified) is coded (780.99). The identification of the specific complication of hypothermia such as frostbite (991.0-991.3) should also submitted as a secondary diagnosis.

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- Emergency Mental Health Claims (Inpatient and Outpatient)

RN reviewers will abstract additional study data from the following sources:

- Comprehensive Assessment/Referral Evaluation (CARE) tool
- Level of Care (LOC Assessment - JFS form 3697)
- PASARR (SMI/MRDD Identification Screen (JFS form 3622)
- Minimum Data Set (MDS)
- Program Eligibility Assessment Tool (PEAT)

A summary of study results will appear in the Quality Monitor once completed. Permedion will also post the entire report to *www.permedion.com*.

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In Dr. M. Baily's article, "Harming through Protection" (NEJM, Feb. 2008), she concludes that "collaborative research and improvement activities require supervision. AHRQ, the state hospital association, hospital managers, and local staff members should all evaluate such projects before taking them on, with a primary focus on their effort on patients' well-being. This kind of supervision must be in place and working well regardless of whether an activity qualifies as human-subjects research."

Billing a Claim that is Exempt from Precertification

The Ohio Administrative Code (OAC) Rule 5101:3-2-40 addresses the guidelines for precertification of selected procedures. Precertification of non-psychiatric cases is performed by Permedion, an HMS company. This OAC rule reviews the circumstances in which a procedure might be exempt from the precertification process.

Exclusions from precertification include but are not limited to emergency admissions, (with the exception of emergency psychiatric admissions), substance abuse admissions, maternity admissions, recipients enrolled in managed care, services provided in hospitals which are located in noncontiguous states, and patients who are jointly eligible for Medicare and Medicaid and who are being admitted under the Medicare "Part A" benefit. Other exclusions include persons whose Medicaid eligibility is pending at the time of admission or who make application for Medicaid subsequent to admission, and those who are eligible for benefits through a third party insurance.

To bill a claim for a procedure that normally would require precertification but is considered exempt, the condition code "AN" needs to be added in Form Locator #24-30. The use of this condition code should prevent the rejection of the claim since no precertification number will be entered onto the claim in Form Locator #63 (treatment authorization number). The condition code "AN" should only be used if there is a legitimate exclusion from precertification as noted above. Please consult OAC Rule 5101:3-2-40 for the complete exclusion list or go to Permedion's web site at *www.permedion.com* and link to the Precertification Manual, which reviews all of the policies and procedures that relate to the precertification process. On a monthly basis during retrospective review activity, Permedion will select cases that have been billed using the condition code "AN" to be certain that it has been utilized appropriately.

For additional information on hospital billing instructions, refer to the ODJFS Web site: *http://emanuals.odjfs.state.oh.us/emanuals/*. Select Ohio Health Plans-Provider, Hospital Handbook, and Billing Instructions.

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