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Prior Authorization Through MITS

The date for the Medicaid Information Technology System (MITS) to *go live* will be announced to providers very soon. When MITS is fully implemented, all prior authorization (PA) requests must be submitted via the Medicaid Information Technology System (MITS) web portal. **Paper requests will no longer be accepted**. Providers will be responsible for keying in and submitting PA requests which should help reduce errors in data entry.

MITS will allow providers to quickly and easily check the status of a PA request. The web portal will show all PA requests as approved, denied, or pending review. The MITS web portal will also allow providers to see the claims that were paid under a specific PA. The system will generate PA request approval letters (sent only to providers) and denial letters (sent to both providers and consumers).

After submitting a PA request, providers are able to submit supporting documentation via the MITS web portal, either by an electronic file upload or fax. The full process for submitting supporting documentation will be outlined during provider training sessions. Please make sure that you are scheduled for a training session. You will be notified of time and place.

The process for requesting prior authorization of transplant services and precertification requests for psychiatric inpatient admissions will remain unchanged. Permedion will continue reviewing special services, as well as hospital precertifications; however, providers will no longer contact Permedion directly for authorization numbers. Providers will submit a request for the service via the MITS web portal, where it is assigned an

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Health Care Reform: What's Quality Got to Do with It?

Everything! The Patient Protection and Affordable Care Act (PPACA) focuses on provisions to expand coverage, control health care costs, and improve health care delivery systems. Of these three concepts, the most integral to health care providers are the quality initiatives and their impact. The PPACA mandates the establishment and monitoring of quality initiatives in almost all aspects of health care.

Review of the PPACA by Sandra DiVarco, a healthcare specialist in the law firm of McDermott Will & Emery, reveals that the Healthcare Reform Law requires Medicaid and Medicare programs, along with health plans, insurers, insurance exchanges, hospitals, other health care facilities, and physicians to compile, report, and receive payments based on quality standards. For the first year, selected performance standards for measures that cover a minimum of five conditions will be established. The five conditions include: acute myocardial infarction, heart failure, pneumonia, certain surgical procedures, and healthcare acquired infections. Variations in standards will be implemented each fiscal year, with a 60-day notice before each performance period begins.

Each hospital will receive its own performance scores including an achievement score and an improvement score. Hospitals having the highest total performance scores will receive the largest "Value-Based Purchasing" Medicare incentive payments. Hospitals with the lowest scores will receive a reduction in their payments. Medicaid payment adjustments will also be implemented based on the quality measures.

Another quality initiative that links payment to quality involves hospital acquired conditions (HACs). An HAC is defined as a condition that an individual acquires during a stay in the hospital and is subject to payment restrictions under the inpatient prospective payment system (IPPS) rules. The Healthcare Reform Law states that beginning in FY 2015, payments to hospitals in the top quartile with respect to national rates of HACs will be reduced.

Individual hospital trends in readmissions will be monitored by the Office of Health and Human Services (HHS). Actual and predicted readmission rates to hospitals for several different health conditions that are associated with a high number of readmissions or high costs will be calculated. A "readmission" is defined as an admission of a patient to the same hospital from which the patient was discharged or to another hospital within 30 days or a time period specified by HHS. Starting in FY 2012, the conditions subject to this provision are acute myocardial infarction, heart failure, and pneumonia. Beginning in FY 2015, four more conditions will be added. These are chronic obstructive pulmonary

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disease, coronary artery bypass graft, percutaneous transluminal coronary, and other vascular procedures. Although it is unclear if Medicaid payments will be affected, starting in October 2010, Medicare payments will be adjusted by a predetermined algorithm dependent on the rates of readmissions. Hospitals with high readmission rates will receive adjusted lower payments for patients with these conditions.

Hospital readmission rates will be published on the Hospital Compare website. The Hospital Compare website is maintained by HHS and currently provides information helping consumers and professionals compare the quality of care that hospitals provide. It provides a list of United States hospitals which includes hospital demographics (location, hospital type) and 44 quality-of-care measures. HHS will calculate and report on the readmission rates for all patients for a hospital for an applicable condition and post this information on the Hospital Compare website.

Some other quality initiatives include the development of the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality. The Center will use research from a variety of healthcare settings to help establish best practices for quality improvement in the delivery of health care services. This should lead to proposed changes to the processes of care and redesign of systems to improve patient safety and reduce medical errors. Through this program, high-performing providers across the health care spectrum will be identified. The goal of the program is to create strategies for quality improvement through tools, methodologies, and interventions.

The PPACA contains provisions for grants to fund a demonstration program to integrate quality improvement and patient safety training into the clinical education of health care professionals. The grants are specifically earmarked for professionals in medicine, nursing, pharmacy, social work, health care administration, and other health professional programs.

There are many more changes and mandates in the new health care reform law, some are very appealing and some not so appealing. In addition to quality initiatives, the PPACA tackles fraud and abuse enforcement, insurance reforms, reimbursement, employment matters, tax-exempt status, information technology, corporate governance, and strategic alliances. Providers, consumers, and payers must understand, prepare, and translate the reform laws into specific action steps that will measure progress in responding to the health system reform changes.

CODING CORNER

Influenza Prevention

It is that time of year, the flu season is upon us once again. In this issue of the Coding Corner, we discuss ways to prevent the spreading of this viral infection.

Influenza, commonly known as "the flu," is a highly contagious viral infection of the respiratory tract. The flu is often confused with the common cold; however, flu symptoms tend to develop quickly and are usually more severe than the typical sneezing and congestion of a cold. The common symptoms of influenza are weakness, fatigue, muscle aches, headaches, fever (101 to 102 degrees), sneezing, and a runny nose. Influenza affects all age groups with the highest incidence occurring in school children. The greatest severity is in young children, the elderly, the immunosuppressed, and those patients with chronic diseases.

Influenza in combination with any form of pneumonia or bronchopnuemonia is assigned a combination code, 487.0, influenza with pnuemonia. Influenza with other respiratory manifestations such as laryngitis, pharygnitis, or respiratory infection (upper) (acute) is coded to 487.1. Influenza may also develop manifestations in body systems other than the respiratory system, such as encephalopathy and involvement of the gastrointestinal tract, which is coded to 487.2, influenza with other manifestations.

PREVENTION AND TREATMENT

- GET VACCINATED. Vaccination is the best protection against contracting the flu.
- Everyone from six months of age and older should be vaccinated against the flu as soon as the vaccine is available.
- Prescription anti-viral drugs can be used for the treatment of the virus

TAKE THESE STEPS EVERYDAY TO PROTECT YOUR HEALTH

- Wash your hands with soap and water or use an alcohol-based hand cleaner.
- Cover your nose and mouth when you cough or sneeze.
- Avoid touching your eyes, nose, and mouth.
- If you are sick with a fever, stay home until the fever has subsided for 24 hours, drink extra fluids, and get plenty of rest.
- While sick, limit close contact with others as much as possible to keep from spreading the virus.

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Forecasting the Future for EDs

Submitted by Michael Dick, MD, Medical Director of OSU East Emergency Department, Permedion/HMS Clinical Coordinator

Recently an interesting article was published in the Becker's Hospital Review titled "4 Ways Emergency Departments Will Change over the Next Five Years." The article is written by Rachel Fields and is based on the opinions of John Fontanetta, MD, chairman of the emergency department (ED) at Clara Maass Medical Center in Belleville, New Jersey. His focus is based on how EDs can change to accommodate the health reform laws and increased patient load. I have summed up the four ways of change based on Dr. Fontanetta's views.

❶ Anticipation of increase growth in ED volumes.

Dr. Fontanetta reasons that even though the universal coverage may alleviate the number of people who go to the ED because they don't have their own primary care physician, most ED visits are appropriate. People go to the EDs because it provides the needed appropriate and quick care for urgent and emergent situations. Since the health reform laws provide for the insuring of an addition 30 to 32 million people, it would follow the ED volumes will increase.

To combat the increased patient volume, Dr. Fontanetta indicates that hospitals will have to offer more emergency care. They will need intensive care units and operating rooms. They will be called upon to provide some of the care that is currently being accepted as primary care. The ED will have to provide this kind of care in a cost-effective way.

❷ EDs must build relationships with other providers.

Most ED physicians are ready and willing to treat and observe patients with legitimate emergencies. However, often the problem is that there is not anywhere to send the patient after their ED visit is over. Increased discharge efforts to send the patient to a primary care physician for follow up and preventative care are needed. Health care reform will dictate that there should be strong relationships developed between the hospital EDs and primary care physicians.

❸ Fast-track areas will be essential.

Many hospitals have created "fast-track" care in the ED for lower-acuity problems. By using fast tract areas, minor complaints can be taken care of more efficiently. However, these fast-track areas must operate independently from the main ED and be separately staffed. Even though the fast-track areas may encourage some patients to pass up their primary care physicians, Dr. Fontanetta emphasizes that the answer is not to turn patients away. If turned away, the patient may ignore a minor complaint rather than seek out a primary care physician and the ED has not protected the patient.

❹ ED observation areas are necessary.

Current and future health care reform is tightening the regulations on "appropriate admissions." As most practitioners know, admissions are not always black and white. The patient might be in acute distress on admission

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Medical Director *dialogue*

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

Recently, I have had several discussions with providers regarding the meaning of the quality of care reviews that are performed. They have specifically cited the occurrence of "known" complications and feel that these should not be identified as quality of care issues. I disagree, however.

A quality of care review is much like an after-action report once an occurrence has taken place. It may have happened in the ordinary course of therapy and may not have been avoidable, but it did happen. For example, a stroke after a Carotid Endarterectomy (CEA) is still a stroke, even if it is the only one within that provider's last 200 cases and is within the "acceptable" <1% stroke rate for providers performing CEA.

The ideal goal is to learn from these occurrences so that we may identify possible issues and make changes that lead to improvements. We need to embrace our complications and try to understand what occurred and strive to see how we can do better in the future.

Identification of such events is not a means by which to punish or single out providers to be "watch-dogged." It is offered only as an educational tool. It is a means by which to note issues that have occurred and help one to identify areas where improvements could possibly be made. Let's face it, there are no areas of human endeavor where errors do not occur. We recognize that as an elemental fact of life. But, we all are expected to learn from our mistakes. We need to heed the lesson offered by philosopher Edmund Burke (1729-1797) who said, "Those who don't know history are destined to repeat it."

A unique approach to such an undertaking has been put forward in New England. In 1987, a group of healthcare professionals including clinicians, hospital administrators, and health care

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authorization number. Permedion staff will then review the request and either approve or deny it.

The new MITS system will fulfill the need for an information technology system capable of rapidly implementing state and federal Medicaid program changes and meeting today's business needs for Ohio Medicaid. For the most current updates about provider training information, MITS functionality, tools and enhancements, bookmark the MITS web

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As indicated above, to appropriately assign the ICD-9-CM diagnosis codes for influenza, please refer to the (487.0 - 487.8) range of codes to identify the specific form of influenza.

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to the ED but after emergency treatment may be ready for discharge within less than 24 hours. For cases like this, hospitals need observation areas in their EDs so physicians can monitor their patients' conditions and then make informed decisions about admissions to the hospital or discharges to home.

In summary, current and future changes in health care will most likely lead to an increase in ED utilization. In order to operate efficiently, the EDs must have appropriate resources and facilities to care for all types of patients. They must be able to provide care to patients with lower acuity through "fast-track" or similar mechanisms, patients with high acuity via efficient admissions processes and inpatient capacity, and those in between with an observation or clinical decision unit. In addition, resources for timely follow-up with primary care and specialty referrals will be necessary to offer complete health care.

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research personnel from eight medical centers in Maine, New Hampshire, and Vermont came together to form the Northern New England Cardiovascular Disease Study Group (NNECDSG). Their mission statement notes that the NNECDSG "is a regional, voluntary, multi-disciplinary group who seek to improve continuously the quality, safety, effectiveness, and cost of medical interventions in cardiovascular disease." Working in a collaborative model during the last 23 years, they have collected and analyzed data on over 150,000 procedures. The group then meets three times per year to review data reports and to plan studies. To date, they have published well over 80 peer-reviewed articles. From their data, regional outcomes have been tracked and risk-adjusted models have been developed to develop decision making tools for clinicians and their patients. Simply by recognizing the issues that arise in the course of medical care they have been able to substantially improve the care of patients not only in their region, but around the world.

The next time a quality of care notification goes out about a pneumothorax that occurred during a central venous catheter placement, I hope that it will be received in the spirit that it is intended – collaboration toward the universal goal of improvement.

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