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Ohio Medicaid
Quality Monitor

Ohio Medicaid Billing Rules Related to Readmissions within One Calendar Day

Ohio hospitals will receive faster reimbursement when Ohio Administrative Code rules are followed at the time of the initial billing for Medicaid hospital services.

Chapter 5160-2-65 Inpatient Hospital Reimbursement spells out rule 5160-2-02 of the Administrative Code. It "requires that a readmission within one calendar day of discharge, to the same institution, is considered to be one discharge for payment purposes so that one DRG payment is made. If two claims are submitted, the second claim processed will be rejected. In order to receive payment for the entire period of hospitalization, the hospital will need to submit an adjustment claim reflecting services and charges for the entire hospitalization."

This mandate includes Medical/Surgical discharges followed by an Acute Inpatient Rehabilitation Unit admission (within one day) at the same hospital.

Permedion Retro Review Nurses doing C4 Within-One-Day-Readmission Referrals

1. If one of the hospital stays is within a distinct part of a psychiatric unit and is coded with a psychiatric DRG, and the other stay is within a medical unit with a medical DRG, then a C4 referral is not appropriate.

2. If the second stay is to a distinct part of an Inpatient Rehabilitation Unit within the same hospital as the first medical/surgical stay and the two hospitalizations have not been combined, a C4 referral is appropriate.

3. The C4 within-one-day-readmission referral to a physician reviewer generally takes priority over other possible referrals on the same cases. Examples of other referrals that would not be sent simultaneously include an A2 referral for one of the stays, a C1 H&P referral for the second stay, or a C1 quality premature-discharge-causing-readmission referral for the first stay.

4. A C11 premature-discharge quality referral can be added to the first stay if the review nurse finds evidence that the facility discharged prematurely.

5. The C4 referral is put on both cases. If only one of the charts was requested by Permedion during the same review month, a C4 referral is not appropriate. If both charts were requested by Permedion, but the Review Nurse has received only one of the charts in the review queue, the Project Specialist should be contacted.

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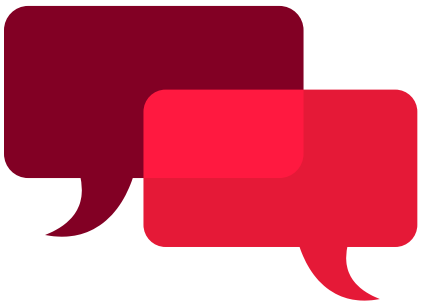

Medical Director Dialogue – Continuity of Care, Part 2

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

Recently, I have had the misfortune of having two close family members admitted to two separate hospitals with major health issues. Both required significant interventions and then were eventually transferred to skilled nursing facilities. Both had multiple physicians from different specialties involved in their care. Unfortunately, both cases also had significant issues with poor communication. There was inadequate communication from the providers to the family decision makers, inadequate communication between providers from different specialties, inadequate communication between facilities during transfers, and inadequate communication regarding follow-up visits and the ongoing plan of care.

In short, I was disappointed in how our modern healthcare system functions in reality. I didn't see the promise of electronic health records (EHR) enabling improved communication via Healthcare Information Exchange (HIE) come to fruition. In fact, I saw decreased levels of communication occurring instead. When presenting for outpatient follow-up after discharge from the inpatient setting, we would find there had been no direct communication regarding the findings, plan, or recommendations from the previously treating physician. The situation was continually confused and uncertain regarding the plan and responsibilities across sub-specialty disciplines. As a family member, I was distraught. As an actively practicing physician, I was disgusted. As a Medical Director, who is Board Certified in Health Care Quality Management, I was alarmed.

I believe that EHR technologies are a tool and, as such, represent only part of the solution; however, currently they are not fulfilling their promise to revolutionize healthcare delivery. Therefore, physicians need to be overtly engaged assuming a proactive role to ensure that relevant documentation is received in a time-appropriate fashion. Additionally, nurse case managers, are needed to act as a "central hub" in the system to coordinate the flow of information and can also serve as a point of contact for families and patients trying to navigate the maze of modern healthcare.

Unfortunately, none of these concepts seemed to be evident in the real world. Rather, the transition of care appeared to be a disjointed and disorganized mess, which resulted in duplicated diagnostics, endlessly repetitive steps in care delivery, missed hand-offs, and iatrogenic complications.

Our system of medical care is getting more complex. That fact makes it even more important that the system be keyed into the quality issues that surround continuity of care. I will grant you that I am reacting to a case series of two–anecdotal at best. That said, healthcare reform is currently failing miserably in addressing these basic issues.

Coding Corner

ICD-10-CM CODING GUIDELINES FOR NEOPLASMS

In this article, we continue to review the changes to the Official Coding Guidelines that will take effect with the implementation of ICD-10-CM in October of 2015.

CHAPTER 2: NEOPLASMS (C00 - D49)

All neoplasms are classified in this chapter, whether they are functionally active or not. An additional code from Chapter 4 may be used to identify functional activity associated with any neoplasm.

There have been some changes in the classification system regarding neoplasm coding. A few are listed here:

- Codes moved from other chapters to Chapter 2, for example, Waldenstrom's macroglobulinemia
- Heading changes, for example, Malignant neoplasm of retroperitoneum and peritoneum moved from Malignant neoplasms of digestive organs and peritoneum to Malignant neoplasms of mesothelial and soft tissue
- Melanoma in situ has a unique category, DO3 (previously in ICD-9-CM category 172, Malignant melanoma of skin)

The following is an example of a change to the Coding Guidelines that will impact how to code/ sequence the diagnosis of anemia associated with malignancy once we begin to code with ICD-10-CM:

In the Official Coding Guidelines for ICD-9-CM for anemia associated with malignancy, when the admission/ encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code for the malignancy. Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy. If anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented, assign codes for both conditions.

In the Official Coding Guidelines for ICD-10-CM for anemia associated with malignancy, when the admission/ encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

With the postponement of the implementation of ICD-10-CM, it will be imperative that the ICD-10-CM Coding Guidelines be reviewed by the coding staff so that they are aware of any changes which will ensure that the appropriate code assignment is made in ICD-10-CM.

OhioMedicaid
ICD-10 Project Update

COMPLIANCE DATE & BILLING

- Ohio Medicaid is on schedule to meet the implementation compliance date of 10/1/15.
- The compliance date is based on Date of Service for Outpatient/Professional Services and Date of Discharge for Inpatient Services.
- Providers cannot bill ICD-9 and ICD-10 codes on the same claim; only one code set per claim will be allowed. Outpatient/ Professional services that are billed in span dates (from/through) will need to submit two claims: one claim with ICD-9 codes and one claim with ICD-10 codes.
- There is no transition period ; 10/1/15 is a hard date for compliance. However, because of timely filing rules ICD-9 codes will continue to be accepted after go-live for claims with Dates of Service/Dates of Discharge prior to 10/1/15.
- Paid claims that need adjustment will follow the same compliance date guidelines If the claim was originally filed with ICD-9 codes and the Date of Service/ Date of Discharge was prior to 10/1/15 we will continue to accept that claim through the appeal process with ICD-9 coding.
- All providers that use ICD-9 on a claim will be required to use ICD-10 on a claim.

WHAT PROVIDERS SHOULD DO

- Stay updated on Medicaid ICD-10 information:

1. Medicaid ICD-10 webpage: www.medicaid.ohio.gov/PROVIDERS/ Billing/ICD10.aspx
2. FAQs, Q&A, and Provider Billing guidance can be found at the Medicaid webpage.
3. FFS RAs
4. ODM MITS Web Portal
5. Email messages from Provider Associations and Clearinghouses
6. Manage Care Plan provider field representative and the Manage Care Plan ICD10 webpage.
7. Email Medicaid ICD-10 questions to: ICD10questions@medicaid.ohio.gov

- Practice coding in ICD-10. Providers have indicated that coding staff discovered that practitioners need to include more detailed information in the medical record in order for the coder to properly code the claim.
- Ensure your vendors (EHR/Clearing House) are compliant. Contact your vendors to see if you can test with them.
- Update your super-bill; some national provider associations are assisting with this.
- Train your staff. One option is the CMS-sponsored Medscape Education ICD-10 Training Modules (http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html). The modules are online, free, and qualify for CME/CE credits.

1. Transition to ICD-10: Getting Started
2. ICD-10: A Roadmap for Small Clinical Practices
3. ICD-10: Small Practice Guide and Medium Practices
4. ICD-10: A Guide for Large Practices

- Be cautious regarding where you receive ICD-10 information – inaccurate information has been disseminated.

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