Ohio medicaid QUALITY MONITOR

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Documentation is Key:
Guidelines for Selection of Principal and Secondary Diagnoses

The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Other/secondary diagnoses are defined as those conditions that coexist at the time of the admission or develop subsequently or affect patient care for the current hospital episode. Diagnoses that have no impact on patient care during the hospital stay are not reported even when they are present. Diagnoses that relate to an earlier episode and have no bearing on the current hospital stay are not reported.

Complete and accurate physician documentation in the medical record is key to assigning and billing the appropriate principal and secondary diagnoses for the hospital. When reviewing the medical record, all aspects of the record need to be utilized to accurately assign the diagnosis codes. Some examples are vital signs, laboratory tests (blood and urine cultures), radiology results, operative reports, physician progress notes and consultation reports. If at any time you are unsure of a diagnosis, then the attending physician needs to be queried.

A perfect example of this is the diagnoses of **Sepsis** versus **Urosepsis**. Physicians tend to use these terms interchangeably. It is the coder's responsibility to query the physician to accurately assign the correct ICD-9-CM code. Urosepsis meaning sepsis is coded (995.91) and urosepsis meaning a urinary tract infection is coded (599.0) with two different DRGs assigned.

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Who goes to the Emergency Room?

The Ohio Department of Job and Family Services (ODJFS) implemented co-payments for non-emergency services provided in an Emergency Department (ED) beginning January 1, 2006. The co-payment for non-emergency services provided in the ED is described in rule 5101:3-2-21.1 of the Ohio Administrative Code (2005). The rule also lists the exceptions to the co-payment requirements.

The *ED Utilization Study* provides baseline information on the utilization of ED services prior to establishing cost sharing co-payments for non-emergency ED services. The study describes the Ohio Medicaid population's use of hospital ED services and comparisons from 2000 to 2004.

5 Year Trend Showed Urgent and Emergent Visits Increasing

The study population included Ohio Medicaid recipients enrolled in fee-for-service programs for at least one month from CY 2000 - CY 2004. A retrospective review of available administrative claims data was conducted. Logistic regression analysis was used to identify patient and visit characteristics significantly related to the classification of an outpatient ED visit as resulting from presenting problems that were determined to be of low to medium urgency.

During the five-year study period (2000 - 2004), there were over 3.8 million Ohio Medicaid ED visits. The study showed that in the five-year average, 13% of the ED visits were coded using CPT codes of 99281 indicating minor problems, 35% were coded as 99282 indicating low to moderate severity problems, and 35% were coded as 99283, indicating moderate severity problems. The code 99284 was used for 13% of the ED visits, indicating the problems were determined to be severe enough to require urgent evaluation CPT code 99285, indicating immediate significant threats that were considered emergent, was used for 4% of the ED visits. The five-year trend showed ED visits resulting from urgent and emergent presenting problems were increasing, 11% to 16% and 3% to 5%, respectively.

Using all the information obtained from the results of the quality indicators, risk models were constructed to identify patient and ED visit characteristics that were significantly related to the probability of a patient presenting to the ED for a problem that was determined to be of low to medium urgency. Although separate models were constructed for patients who were eligible for the ED co-payment and for those who were not eligible, many of the patient and visit characteristics for both groups appeared similar.

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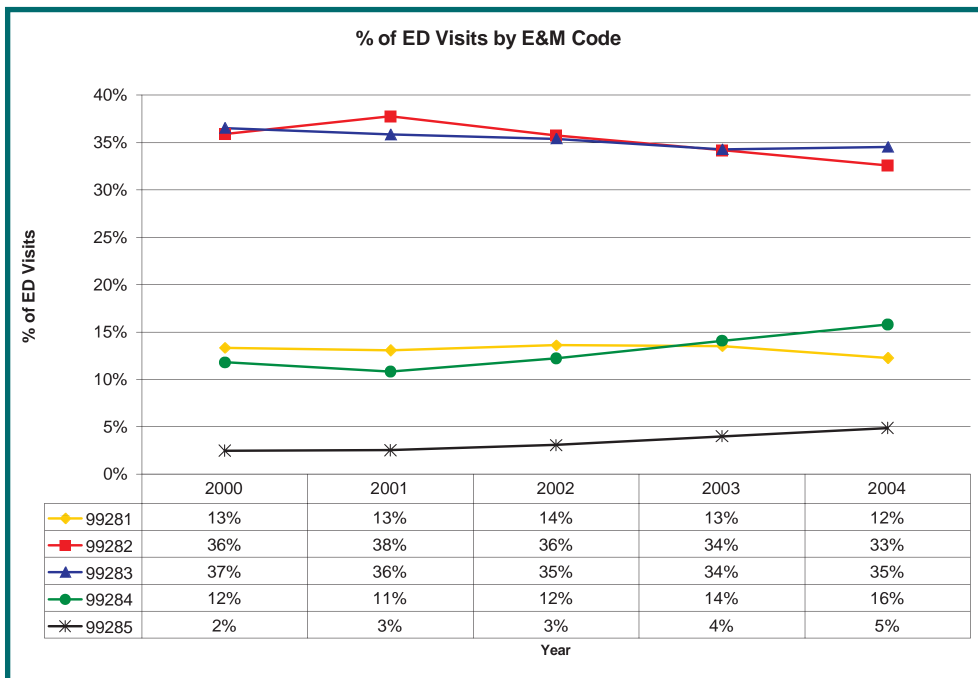
ED Utilization *continued from p. 1*

Patients, eligible for the ED co-payments, who were most likely to seek ED care for problems that were determined to be of low to medium urgency, were as follows:

- Patients who were younger (for each year increase, the visit is more likely to be urgent/emergent)
- Patients covered under the Covered Families and Children (CFC) aid program
- Patients who had a physician visit within 30 days prior to their ED visit
- Patients who lived in the Southwest region
- Patients who had a primary diagnosis in the musculoskeletal and connective tissue category

Patients not eligible for the ED co-payments, but most likely to seek ED care for problems that were determined to be of low to medium urgency, were as follows:

- Patients who went to non-MSA EDs
- Patients who were 21 years of age and younger
- Patients who were White
- Patients who had fewer than seven months of continuous eligibility
- Patients who were covered under aid programs CFC and Children's Health Insurance Program (CHIP)



	2000	2001	2002	2003	2004
99281	13%	13%	14%	13%	12%
99282	36%	38%	36%	34%	33%
99283	37%	36%	35%	34%	35%
99284	12%	11%	12%	14%	16%
99285	2%	3%	3%	4%	5%

ED Utilization *continued on p. 3*

CODING CORNER

Evaluation and Management Coding for Emergency Department Visits

In this article of the Coding Corner, we provide information on the 2007 CPT guidelines for coding/billing of Emergency Department (ED) visits.

CPT codes 99281-99288 are used to report evaluation and management services provided in the ED. No distinction is made between new and established patients in the ED.

An ED is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

The Evaluation and Management codes for the ED and the three key components needed for each are listed below:

99281 Emergency Department Visit: Presenting problem is self-limited or minor

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

99282 Emergency Department Visit: Presenting problem is of low to moderate severity

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity

99283 Emergency Department Visit: Presenting problem is of moderate severity

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity

99284 Emergency Department Visit: Presenting problem is of high severity and requires urgent care by the physician but does not pose any threat to life

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity

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- Patients who had a physician visit within 30 days prior to their ED visit
- Patients who lived in the Central region
- Patients who had a primary diagnosis in the musculoskeletal and connective tissue category

RECOMMENDATIONS

The findings of this initial study of ED utilization in the Ohio Medicaid population support the following findings and assumptions:
Consider the use of the risk models presented in this study as an alert and monitoring system to assist in identifying patients who are at risk for using the ED for problems that are determined to be of low to medium urgency.
Perform a similar study within the next two years, using 2006-2007 data. The results of the study can be used to determine if the introduction of cost sharing has impacted ED utilization by the Medicaid population.
Disseminate the results of this study to providers, highlighting the following findings: • Over 52% of recipients visited an ED during the first month of Medicaid eligibility. This may indicate lack of knowledge or limited access to other sources of outpatient care for new Medicaid patients. The initial need and eligibility for Medicaid services may be established through an ED visit. There appears to be a need for primary care during the first month of Medicaid eligibility. Providers should be prepared to help their patients learn how to use the health care system. • Review of the geographical regions revealed that the southeast region of Ohio consistently had the highest ED utilization and visit rate where presenting problems were determined to be of low to medium urgency. The single largest ED provider was a rural referral center in southeastern Ohio. Additional information regarding access is warranted. Making urgent care clinics more widely available and keeping physicians' offices open for extended hours may provide options for the Medicaid patients in this region.

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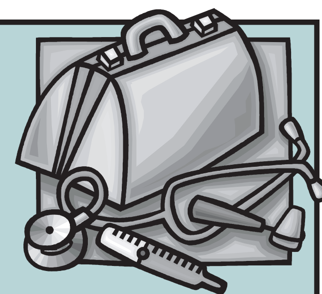
99285 Emergency Department Visit: Presenting problem is of high severity and does pose an immediate threat to life

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

Complete and accurate physician documentation in the medical record is key to assigning and billing the appropriate Evaluation and Management codes for the hospital.

Medical Director *dialogue*



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

The problem with emergencies is that you can't always tell if it is an emergency. For example, a 60 year-old man with chest pain goes to the ED. The ED physician orders a diagnostic work-up that includes a detailed history and examination, an assessment of the pain, a 12-lead EKG, continuous cardiac monitoring, serial cardiac markers, and possibly anti coagulation studies and CT scan. The final diagnosis is indigestion. Without a thorough evaluation, neither the ED physician nor the patient could know whether the patient was having a heart attack or indigestion.

Under the Emergency Medical Treatment and Labor Act of 1986, any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition." In other words, even if the ED physician knows the problem is not an emergency, he must evaluate every patient who comes to the ED for care.

It is well known that visits to the ED by Medicaid recipients for non-emergency problems are common and contribute to rising health care. The CDC (2005) indicates that ED rates are highest for Medicaid enrollees at 810 visits per 1,000 persons and lowest for patients with private insurance at 215 visits per 1,000 persons.

Costs aren't the only reason inappropriate use of the ED is a problem. Continuity of care suffers when care is provided in an ED rather than in the office or clinic where the patient is known and the medical record is accessible. Emergency physicians have limited records of current medications and tests that have been performed and their results.

Reducing unnecessary visits to the ED, without discouraging patients with possible emergencies from seeking care in the ED, is not an easy task. However, patient education on the difference between emergency care and urgent care and

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where to obtain each would help significantly. Now that many Ohio Medicaid enrollees are in managed care plans and cost-sharing initiatives are in place, the plans, clinics, case workers, and practitioners have opportunities to provide education to assist the patient through the health care system.

Report Reveals Hospital Peer Group Patterns

Ohio hospitals recently received a copy of their annual *Pattern Analysis Monitor Report*. Permedion produces this report for each hospital submitting a Medicaid claim to ODJFS during the year. The report examines seven indicators calculated from the Medicaid claims data as well as comparative statistics for each hospital according to the hospital's peer group. The report covers State Fiscal Years 2004, 2005, and 2006 and provides a three-year comparison.

Peer groups are defined in Ohio Administrative Code rule 5101:3-2-072 and include categories such as children's hospitals, rural hospitals, major teaching hospitals, and others that are grouped according to MSA information. The total of 168 hospitals were included in this report. Active facilities not having any eligible inpatient claims during the reporting period were not included.

The total number of hospital admissions per peer group increased by an average of 1.7% per year over the reporting period. The number of admissions is the denominator for all the percentages reported. The peer groups with the highest volume of admissions were the Akron/Cincinnati/Dayton-Springfield group, the teaching hospitals, and the MSA Columbus group.

There are seven key indicators that were analyzed from the claims data and include:

0-1 Day Readmission: The overall percentage remained relatively flat with 0.12% in 2004, 0.10% in 2005, and 0.17% in 2006.

2-7 Day Readmission: The percentage of patients readmitted to the same provider for any DRG was stable across the three years with 2-7 day readmission rates of 3.92%, 4.19%, and 4.30% in 2004, 2005, and 2006 respectively.

Peer Groups *continued on Side Bar*

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Admissions Due to Complications: The number of admissions due to complications has increased slightly over the three-year report period. The overall percentage of admissions due to complications was 3.48% in 2004, 3.55% in 2005, and 3.82% in 2006.

Transfer Out: The overall percent of cases coded as transfers to other hospitals were slightly increased across the three-year reporting period with 4.17% in 2004, 4.33% in 2005, and 3.89% in 2006.

Transfer Billing: In 2004, 2005, and 2006, the overall percentage of cases that were potentially transfer billing errors was 0.95%, 1.10%, and 1.02% respectively.

Cost Outliers: The overall percentage of cases which are cost outliers (based on DRG) seems to be increasing, with 7.93% in 2004, 9.34% in 2005, and 10.28% in 2006.

Day Outliers: The overall percentage of cases which are day outliers (based on DRG) seems to be decreasing with 2.35% in 2004, 2.30% in 2005, and 1.02% in 2006.

Significantly Short Lengths of Stay: Overall, the percentage of cases that are considered significantly short length of stay is almost nonexistent by 2006. For 2004, 2005, and 2006 the percentages are 2.96%, 0.39%, and 0.25%.

Hospitals can use information from the *Pattern Analysis Monitor Report* to develop benchmarks to improve performance and ultimately improve the services provided to the Ohio Medicaid community. Contact your hospital's Utilization Review Department for a copy of your hospital's individual report.

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