

▼ FRAUD & ABUSE ALERT ▼

NOTE: From time to time, *FOCUS* will publish announcements from the CPG Patient Billing Office and Office of Compliance to alert physicians and staff to government regulations regarding billing codes and procedures. Strict attention must be paid to these regulations to avoid payment denials and/or charges of Medicare fraud or abuse.

DOCUMENTATION OF MEDICAL NECESSITY: SCREENINGS MUST BE BILLED AS SUCH AND NOT AS MEDICAL TREATMENT

- * Documentation supporting the medical necessity for Medicare services, such as ICD-9 codes, must be submitted with each claim.
- * Claims submitted without such evidence will be denied as being not medically necessary.
- * When a screening service is ordered by a physician in the absence of illness, injury, or symptoms, it is considered screening regardless of the test result.
- * The listed ICD-9 code must indicate the service is for screening. Subsequent services that occur due to an abnormal result would be coded according to the resulting diagnosis. It is not appropriate to list the abnormal result ICD-9 code as documentation for the reason for the test when the test was ordered for the purposes of screening for a condition; even if the condition screened for is diagnosed as a result of the screening test. 

Here are some examples:

1. If a patient in the "high-risk" group for thyroid disease visits a physician for an annual exam and presents without symptoms or current thyroid disease and the physician orders a TSH, the TSH must be listed with a screening diagnosis (e.g. V70.0 routine general medical exam, V70.3 medical exam for administrative purposes, or V70.9 unspecified general medical exam). This is true even if the patient has an abnormal TSH result and is diagnosed with a covered condition. 
2. If a patient presents for an annual exam and the physician orders a 12-lead ECG. If the patient does not have symptoms or a condition that necessitates the diagnostic test, the service must be listed with the screening ICD-9 code. This is true even if the patient is in a "high-risk" group for cardiac trouble and has an abnormal ECG result.

REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION: NON-PHYSICIAN PRACTITIONERS MUST NOW COMPLY AS WELL

Per the Balanced Budget Act of 1997, Medicare policy has added a new provision effective Jan. 1, that:

- * requires non-physician practitioners to provide diagnostic codes for items and services furnished by the practitioner. (This is already required for physicians.)
- * requires physicians and non-physician practitioners to provide diagnostic or other medical information when ordering certain items or services furnished by another entity if such information is required by the Secretary (or the Secretary's fiscal agent) in order for payment to be made to the entity furnishing the item or service. This requirement applies to orders for clinical laboratory tests and other diagnostic procedures, durable medical equipment, braces and prosthetic devices.

**** For more information:** Contact Susan Feller, Government Reimbursement Manager, 456-4544; sfeller@cpg.mcw.edu or the Compliance Office at 257-5059.

▼ RECENT MEETINGS ▼

The Billing & Collections Committee met on Dec. 3, 1997.

* **TOPIC:** Committee continued its discussion of departmental involvement in the billing process (decentralization). Guidelines which had been sent to Dr. Eversman were reviewed with some minor changes made. The committee continues to support increased departmental involvement in the charge capture and entry process with appropriate controls.

The Committee met again on Jan. 6, 1998.

* **TOPIC:** The Committee discussed the general state of progress in improving billing and collection efforts. Incremental improvements have been noted, yet overall faculty satisfaction with the efforts is perceived as unchanged and low. Specific topics were discussed which might lead to improved departmental capabilities and understanding of the billing process including:

- * improved access to IDX data by departments

- * suggested models for use of departmental staff in the billing process
- * on-site batching in clinics
- * formats for monthly department/CPS meetings.
- * **THE NEXT STEP:** These topics will be discussed at the next meeting for specific recommendations.



The CPG Guidelines and Outcomes Committee met on Friday, Dec. 19.

* **BACKGROUND:** The Practice Guidelines and Outcomes Committee meets monthly to discuss ways to implement specific sets of treatment protocols for each clinical area, as well as specific ways to measure clinical outcomes for each area. This trend has come about in response to the rise in managed care organizations, which are more likely to approve payment for services that can be clearly documented as meeting desirable protocols and achieving certain outcome measurements.

* **LATEST UPDATE:** The Dec. 19 discussion was led by Jennifer Robertson, RN. The group addressed activities in the last half of 1997 and plans for 1998, including:

- * **CHALLENGE:** There is a need for further study of Health Employer Data & Information Set (HEDIS) clinical outcome measurements in the MCW clinics.
- * **WHY:** HEDIS measurements are set by the National Committee for Quality Assurance, an accreditation body for managed care organizations similar to the Joint Commission for Hospital Accreditation.
HEDIS measurements are fast becoming a standard among managed care organizations, and following them will help the CPG to negotiate future managed care contracts.
- * **THE NEXT STEP:** The collection and analysis of specific data requested by managed care organizations.
- * **CHALLENGE:** The Committee intends to continue to cooperate with Horizon and other organizations to develop and implement USEFUL clinical guidelines.
- * **THE NEXT STEP:** The Committee is currently addressing guidelines pertaining to asthma and low back pain. It is also attempting to compile an "inventory" of guidelines and outcome measurement projects being conducted by MCW departments.
- * **NOTE:** Limited staff support may be available for promising projects. The Committee welcomes inquiries. Contact James Casanova, MD, Committee Chair, at 257-7992; casanova@mcw.edu.
- * **CHALLENGE:** The Committee intends to work further with affiliated hospitals to achieve a more coordinated and "seamless" approach to quality management and outcomes measurements.
- * **THE NEXT STEP:** Further work to link the hospitals' inpatient pathways with the CPG's outpatient-based guidelines.
- * **IN OTHER BUSINESS:**
 - * The Committee will further assess its informatics needs.
 - * New members have joined the committee, bringing expertise in epidemiology, outcomes research, and marketing.
- * **FOR MORE INFORMATION:** Contact James Casanova, MD, Committee Chair, 257-7992; casanova@mcw.edu.

▼ TWO ADDITIONAL HCFA SESSIONS ARE AVAILABLE ▼

Two additional HCFA documentation sessions have been scheduled for those clinical faculty members, residents and fellows who did not attend one of the 20 sessions previously held.

The sessions have to do with the 1998 Documentation Guidelines for E&M services. They are:

- * Tuesday, Feb. 10, 7 a.m. to 8 a.m. in Helfaer Auditorium at Froedtert
- * Wednesday, Feb. 25, 5 p.m. to 6 p.m. at Children's Hospital Auditorium.

This is your printed version of *FOCUS*. E-mail copies were transmitted earlier. Faculty and staff who would like to receive *FOCUS* electronically but do not have an e-mail account may contact the Information Services Help Desk at 456-8648.

FOCUS is prepared by the Office of the Senior Associate Dean for Clinical Affairs for physicians and staff in the Medical College Clinical Practice Group.

Editor and Writer: Kay Nolan

Phone: 456-5822

Fax: 456-6550

E-mail: knolan@mcw.edu