Teamwork and Compliance Go Hand in Hand

by Patricia L. Ruppersburg, ART

Compliance is an issue that has earned much respect from healthcare professionals. It has become imperative to all HIM professionals to focus on providing the best possible solution for compliance. The ultimate goal: to create a scenario in which compliance supports the existing healthcare industry. From an HIM perspective, the compliance issues surrounding the coding and billing arena entice us to open our imaginations and work with our facilities' departments and ancillary divisions to meet established compliance standards.

To address compliance issues at my facility, I studied our coding issues, concentrating on outpatient billing—specifically for the lab tests Medicare had recently begun that required appropriate documentation and specific diagnoses to indicate medical necessity for reimbursement. After analyzing the situation, I began working closely with the laboratory and business office directors to coordinate a plan that ensured normal operation within the compliance rules and regulations.

Laying the Groundwork

At that time, our procedure for registering outpatients was divided between the laboratory and the business office. Laboratory staff registered all non-patients (those patients who sent a specimen for testing, but did not physically visit the facility). The business office registered all other patients. Our first efforts were directed at two employee populations: registration clerks from the laboratory and business office departments, and coders in the medical information services (MIS) department. We educated these groups on the diagnoses and ICD-9 codes that rendered the use of specific lab tests acceptable for Medicare reimbursement. One event that simplified this process was the requirement created the year before by our business office that a diagnosis be submitted with all orders that were given to the patient(s). Since our hospital was already receiving a diagnosis, the registration clerk would check the order to confirm that the diagnosis was an acceptable one for the test being ordered. If a test was ordered without a matching diagnosis, the clerk would investigate, calling the physician's office to see if there was an additional diagnosis or signs or symptoms that would render the test approved by Medicare. If a call to a physician's office was necessary, the date, information obtained, and the signature of the clerk was documented on the registration slip. This slip was ultimately sent, with the signed orders and results of testing, to MIS for coding purposes.

The next step was to revise physician order forms into a format that would help designate tests that required a specific diagnosis to justify medical necessity. We inserted a column for ICD-9 codes alongside the test being requested and a space at the bottom of the form to indicate the narrative diagnosis (see Exhibit 1 below). The revision eliminated a step for the office staff: they no longer needed to check each individual lab test request to see if it fell into the "medically necessary" category. In addition, it showed the physician offices and other healthcare facilities that we sincerely wanted to help them understand the process so that all involved parties could benefit.

Spreading the Word

Meanwhile, the laboratory director sent out copies of the Medicare bulletins, a Medicare Advance Beneficiary Notice form (see Exhibit 2 below), and a copy of the hospital's revised physician's order form to all medical staff members, nursing homes, and skilled nursing facilities that we served. Along with these informational mailings was a full explanation of the changes being implemented and the rationale behind them. Furthermore, the physician offices (including office staff) received the same information that was furnished to the hospital's registration clerks and coders.

We also determined which physicians had high volumes of outpatient testing and which physicians had difficulty rendering diagnoses with his or her orders. Once we completed the list, the laboratory director and I set up appointments with those physicians' offices. Our goal was to discuss and educate the office staff (and physician, if possible) on a face-to-face basis. During these site visits, we addressed the medical necessity of the specified lab tests, the new order forms, and the advance beneficiary notice. Besides successfully further promoting our attainment rate of appropriate diagnoses for test billing

purposes, this gesture alleviated much of the anxiety and stress generated by a lack of knowledge about, and understanding of, the new regulations.

During these office site visits, we made ourselves available to answer questions about the new regulations or any other coding issues that they had with the assignment of ICD-9 codes. Needless to say, this improved our working relationships with these facilities and provided them with a resource for future coding and billing issues. The office managers and staff members at each facility were encouraged to call our facility with any questions or concerns after our visit. For the facilities we did not visit, we sent our business cards and informed them of our open-door policy.

Making It Stick

The final step was to bring in a consultant for two educational sessions at the hospital. The sessions were offered to all physicians, their office staff, and nursing home and skilled nursing home staff. We received tremendous response to this gesture. The sessions covered the following topics:

- a rudimentary explanation of the new regulations from HCFA
- how to understand HCFA's bulletins
- the necessity of completing the advance beneficiary notice
- how to explain the advance beneficiary notice to the Medicare population
- an overview of the Health Insurance Portability and Accountability Act

Each session had a question and answer period with open discussion for the group to express its concerns. From this emerged a request for future classes to help the staff at the physician's offices and nursing homes with coding issues. The first of these classes has already taken place.

Currently, each time new tests are added to the medical necessity list, the order forms will be evaluated (revisions will be made depending on the extent of the changes) and new education and training will be offered. There will also be constant monitoring of the entire process. Revisions and adjustments will be made as we continue to measure the program's success.

exhibit 1

Laboratory Outpatient Testing Physician's Orders

DATE:_____ BIRTHDATE:_____

PATIENT NAME:_____ SOCIAL SECURITY NUMBER:_____

PLEASE DO THE FOLLOWING TESTS:
Physician, please write ICD-9 code to the left of each desired test

Date of Order	ICD-9 Code	Orders * denotes ICD-9 codes required due to medical necessity
		Amylase
		BUN
	*	CBC (no differential)
	*	CBC (with differential)
		Creatinine
	*	Fasting Blood Sugar
	*	Glucose Tolerance Test (FASTING) ____Hrs.
	*	Hematocrit
	*	Hemoglobin
		Pregnancy Test
	*	Prothrombin Time Type of anticoagulant:
	*	PSA
		Triglyceride
		Urinalysis
	*	Urine Culture
		PANELS
		Comprehensive Metabolic Panel (sodium, potassium, chloride, BUN, creatinine, glucose, T. protein, albumin, calcium, T. bilirubin, alk phosphatase, AST)
		Electrolyte Panel (sodium, potassium, chloride, carbon dioxide)
		Basic Metabolic Panel (sodium, potassium, chloride, carbon dioxide, BUN, creatinine, glucose)
	*	Lipid Panel (cholesterol, triglyceride, HDL cholesterol, LDL, VLDL)
	*	Thyroid Panel (T4, T3 Uptake, T7)
	*	Thyroid Panel with TSH (T4, T3 Uptake, T7)
		Others: (please list any additional tests desired with ICD-9 codes)

ATTENTION PHYSICIAN: Please provide ICD-9 codes for the tests ordered on this requisition to document the medical necessity for these tests. Be careful when ordering panels to ensure the medical necessity of all tests contained within the panel. The Balanced Budget Act of 1997 requires physicians to provide diagnostic information when ordering tests for which reimbursement from the Medicare program will be sought. Medicare may deny payment for tests which do not meet that definition. The patient must be informed of potential denial of payment and must sign the Advanced Beneficiary Notice (ABN) (available under separate cover). Please contact the laboratory if you have questions or require guidance on these issues.

DIAGNOSIS:

PHYSICIAN'S SIGNATURE:

exhibit 2

Medicare Advance Beneficiary Notice (ABN)

Medicare will only pay for items and services it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular item or service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that item or service. We believe that, in your case, Medicare is likely to deny payment for:

TEST REQUESTED

_____ Digoxin $59.80
_____ Blood Glucose $26
_____ Hemoglobin: A1C $43.50
_____ Hemogram (CBC) $38
_____ Prothrombin Time (PT) $27.40
_____ Prostatic Specific Antigen (PSA) $92.50
_____ Urine Culture, Bacterial $43.50

THYROID FUNCTION TEST

_____ Thyroid Panel $92
_____ Thyroid Panel with TSH $104
_____ Thyroid Stimulating Hormone (TSH) $79.50
_____ Thyroxine, Total (T-4) $54.50
_____ Thyroxine, Free (Free T-4) $65
_____ Triiodothyronine (T-3) Uptake $50.50

CHOLESTEROL TESTING/LIPID PROFILE

_____ Cholesterol, Serum, Total $41.50
_____ HDL, Cholesterol $26
_____ Lipid Panel $108.50
_____ Triglycerides $31

_____
Other Procedures (Please Specify)

REASON CLAIM WILL BE DENIED: Please initial the checked item.

❑ Medicare does not usually pay for this service for the diagnosis we received with this order.
❑ Medicare considers this test to be experimental and for research or investigational use only. Medicare does not usually pay for experimental tests.
❑ Medicare has established a limitation on the number of times this test can be ordered within a certain period. We do not know when you last had this test done.
❑ Other_____

PATIENT CAUTIONS DO NOT SIGN BLANK "ABN" FORM

Do not sign this form unless the test(s) are clearly marked and initialed by you above and unless a reason why the laboratory thinks they will be denied payment by Medicare is clearly checked off and initialed by you. Sign either the "Agreement to Pay" or "Refusal to Have the Laboratory Test Performed" below. You should receive a copy of this form when it is completed.

Please initial here to indicate you received your copy: _____ Date:_____
If you decide to receive these services you have the right to have a claim submitted to Medicare for this service.

AGREEMENT TO PAY

The effect of signing this "agreement to pay" is that you will receive the laboratory test identified on this form and you will be personally responsible for payment to the facility.

I have been notified by the laboratory that it believes, in my case, Medicare will not pay for the tests identified above, for the reason stated. I understand that I have the right to decide whether or not to have the test identified above performed. I have decided to have the test identified above performed. I agree to be personally and fully responsible for the payment.

Signed:_____ Date:_____

REFUSAL TO HAVE THE LABORATORY TEST PERFORMED

The effect of signing this "refusal" is that you will not have the laboratory test performed.

I have been notified by the laboratory that it believes, in my case, Medicare is likely to deny payment for the tests identified above, for the reason stated. I understand that I have the right to decide whether or not to have the test identified above performed. I have decided not to have the test identified above performed because I am not willing to be personally responsible for the payment.

Signed:_____ Date:_____

White Copy Lab Yellow Copy Patient Pink Copy Physician

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