Associated California Health Centers

CONCEPTS

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(Coding, cont. from p. 1)

was expanded to include review of certain ambulatory care provided, most notably ambulatory surgery centers' services.

In addition, PROs in seven states are pilot testing physician office claims review. The pilot project is to review medical necessity and appropriateness of care rendered in physician offices (Part B claims). The data gathered from these seven states (WI, IN, AZ, WA, NC, CN, and UT) will allow HCFA to determine how physician office/clinic records can be reviewed.

In California, the two fiscal intermediaries should have their ICD-9-CM code editors for Part B claims in place and functional soon. HCFA requires the fiscal intermediaries to identify:

1. Invalid ICD-9-CM Codes (code 250 or 250.0 for Diabetes);
2. Invalid fourth and fifth digits (300.0 for Depression);
3. Age conflicts (senility in 12 year olds, pregnancy in 80 year olds); and,
4. Sex conflicts (pregnant males).

In other health car facilities, when PROs find invalid codes, payment is denied or the billing returned, unpaid, for correction.

Clinics also need to be aware that the coded material they submit is being used by HCFA and their subcontractors to devise, and revise, their physician payment system. Hospitals, with the advent of DRGs, experienced the results of their

Clinic director calls for national health plan

MFHC Director Sullivan testifies at congressional hearing

Testifying recently before the House Committee on the Budget, Task Force on Human Resources, Merced Family Health Center Executive Director Mike Sullivan called for the implementation of a National Health Plan to assure equal access to all U.S. residents.

The August 24 hearing, chaired by Barbara Boxer (D- San Rafael) was also attended by Representatives Gary Condit of California and Mike Espry of Mississippi.

Sullivan, who was one of 11 speakers at the hearing, spoke about three key issues:

1. The implementation of a National Health Plan, with financing weighted toward prevention and primary care;
2. The need to integrate rural America's special health care requirements into the National Health Plan. Rural Americans must achieve equal access to physician resources, especially primary care MDs. To that end, a National Physician Service or obligation would have to be incorporated into a National Health Plan; and,
3. The availability of continued and increased grant financing to fill in the gaps of care needed by a growing underserved and uninsured population of high risk special people.

Following a description of services offered by his clinic system, Sullivan urged the committee to remember to focus on where the uninsured and underinsured will go for health services, not just who will pay for such care.

"I happen to think that the community health center can and should serve as a perfect model for such a system," said Sullivan.

Clinics are being urged to begin taking steps now to minimize the impact of the APG system on clinics by:

- Following ICD-9-CM and CPT4 coding guidelines;
- Using current codes: update your ICD-9-CM codes as soon as errata are published and purchase CPT 4 annually;
- Using the patient record to code. It is difficult to impossible to code correctly with only the superbill;
- Using correct codes on the super bill. Choose to eliminate some codes from the superbill to encourage

The data you submit now is being used to formulate payment policies for the future. Take this opportunity to invest in your coding staff, and invest in your payment future by submitting correct codes. Consider sending coding personnel who have no training, or those in need of advanced training, to one of the California Medical Records Association's coding workshops (see "Coding Seminars," p. 4). The investment may be worth your while as generators of clinic coding data run into fewer implementation