



TO: Medical Staff

FROM: Madeline Bell
Executive Vice President & Chief Operating Officer

David E. Cohen, M.D.
President, Medical Staff

Current Medical Assistance DRG regulations require that the attending physician certify in the medical record of each patient discharged from the hospital that “the identification of the principal and secondary diagnoses and the procedures performed is accurate and complete to the best of the physician’s knowledge.” The Hospital will not receive Medical Assistance reimbursement for patients whose medical records do not contain this certification. Certification will be accomplished by physician signature (or use of signature stamp) on the face sheet of the medical record. All diagnoses and procedures will be listed on the face sheet, by ICD-9-CM code number and verbal description, for physician review. Any physician disagreement with the listed information should be brought to the attention of the Medical Records Supervisor.

Further, the DRG regulations require that the Hospital have on file for each attending physician acknowledgement of receipt of the following notice. This acknowledgement is enclosed for your signature and return.

If you have any questions feel free to contact Mr. Thomas J. Todorow, Senior Vice President, Finance and Chief Financial Officer. Mr. Todorow can be reached by telephone at 215-590-3742.

NOTICE TO PHYSICIANS

Medical Assistance payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone misrepresents, falsifies, or conceals essential information required for payment of medical assistance funds may be subject to fine, imprisonment, or civil penalty under applicable Federal and State Laws.



ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received the "Notice to Physicians" concerning the penalties for misrepresentation, falsification or concealment in certification of my patients diagnoses and procedures for purposes of Medical Assistance reimbursement to the Hospital.

Name: (Please Type or Print) _____

Signature: _____

Date: _____

Please return to:

The ECMS Office (C/O Office of Medical Staff Affairs)
The Children's Hospital of Philadelphia
34th Street and Civic Center Boulevard
Philadelphia, PA 19104