2015 TAHFA & HFMA SOUTH TEXAS FALL SYMPOSIUM

Chargemaster Compliance & Revenue Capture

Presented By:
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Blue & Co., LLC Overview

- Founded in 1970
- 53rd Largest U.S. Accounting Firm (*Inside Public Accounting* - 2014)
- 320+ Employees
- $65M Firm Revenues

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Agenda

- Medicare Reimbursement - Hospitals
- Key Components of the Chargemaster
- Developing an Effective CDM Infrastructure
- Charge Capture & Compliance

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Reimbursement Hospitals – Medicare Prospective Payment

- **ACUTE INPATIENT** – Diagnosis Related Groups (DRGs)
  - ICD-9 (ICD-10)
  - HIM coders
  - Other
- **OUTPATIENT** – Ambulatory Payment Classifications (APCs)
  - CPT, HCPCS, units of service, modifiers
    - Chargemaster
    - HIM coders
    - National Correct Coding Initiative; MUEs
  - ICD-9 (ICD-10)
  - Medical necessity (LCDs, NCDs, etc.)
  - Other

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Key Components of the Chargemaster

- Chargemaster = Charge Description Master = CDM
  - Department or GL number
  - Charge number
  - Descriptor
  - Revenue code
  - CPT/HCPCS code
  - Modifiers
  - Charge amount

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Key Components of the Chargemaster

Dept #	Charge #	Descriptor	RC	CPT	Mod	Charge
3170	4401559	Flowcytometry/ tc 1 marker	312	88184		$ 128.00
3170	4400588	Flowcytometry/tc add-on	312	88185		$ 29.00
3170	4400437	Flowcytometry/read 9-15	312	88189		$ 81.00
3170	4401401	Decalcify tissue	312	88311		$ 47.00
3170	4401427	Special stains group 1	312	88312		$ 89.00
3170	4400494	Special stains group 2	312	88313		$109.00
3170	4400387	Histochemical stain	312	88314		$119.00
3170	4400512	Intraop cyto path consult 1	312	88333	59	$124.00
3170	4400486	Immunohisto antibody stain	312	88342		$48.00

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Key Components of the Chargemaster

Dept #	Charge #	Descriptor	RC	CPT	SI	Mod	Charge	I/P Usage	O/P Usage
3170	4401559	Flowcytometry/ tc 1 marker	312	88184	Q1		$ 128.00	6	30
3170	4400588	Flowcytometry/tc add-on	312	88185	N		$ 29.00	6	30
3170	4400437	Flowcytometry/read 9-15	312	88189	B		$ 81.00	6	30
3170	4401401	Decalcify tissue	312	88311	N		$ 47.00	82	212
3170	4401427	Special stains group 1	312	88312	Q1		$ 89.00	61	120
3170	4400494	Special stains group 2	312	88313	Q1		$109.00	21	40
3170	4400387	Histochemical stain	312	88314	N		$119.00		
3170	4400512	Intraop cyto path consult 1	312	88333	S	59	$124.00		
3170	4400486	Immunohisto antibody stain	312	88342	Q1		$48.00	3	37

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Hospital OPPS: Addendum B

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Home > Medicare > Hospital Outpatient PPS > Addendum A and Addendum B Updates

Hospital Outpatient PPS

- Device, Radiolabeled Product, and Procedure Edits Archive
- Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
- OPPS Guidance
- Program Transmittals
- Hospital Outpatient Program Memoranda
- Hospital Outpatient Regulations and Notices
- Addendum A and Addendum B Updates
- Annual Policy Files
- Change Request Restated Drug and Biological Payment Rates
- Archives

Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals.

Show entries: 10

Filter On:

Release Date	Subject	Year
January 2015	Addendum A	2015
January 2015	Addendum B	2015
April 2015	Addendum A	2015
April 2015	Addendum B	2015
July 2015	Addendum A	2015
July 2015	Addendum B	2015

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Hospital OPPS: Addendum B

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92986	Revision of aortic valve	J1	0083	61.1978	$4,539.22		$907.85
92987	Revision of mitral valve	J1	0229	129.8028	$9,627.86		$1,925.58
92990	Revision of pulmonary valve	J1	0229	129.8028	$9,627.86		$1,925.58
92992	Revision of heart chamber	C					
92993	Revision of heart chamber	C					
92997	Pul art balloon repr percut	J1	0229	129.8028	$9,627.86		$1,925.58
92998	Pul art balloon repr percut	N					
93000	Electrocardiogram complete	M					
93005	Electrocardiogram tracing	Q1	0099	1.0579	$78.47		$15.70
93010	Electrocardiogram report	B					
93015	Cardiovascular stress test	B					
93016	Cardiovascular stress test	B					
93017	Cardiovascular stress test	Q1	0100	3.2093	$238.04		$47.61
93018	Cardiovascular stress test	B					
93024	Cardiac drug stress test	S	0100	3.2093	$238.04		$47.61
93025	Microvolt t-wave assess	S	0100	3.2093	$238.04		$47.61
93040	Rhythm ecg with report	B					

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

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Hospital OPPS: Addendum B

Separately Payable	Payment Conditionally Packaged	Payment Always Packaged	Not Recognized
• **S, T, A-** Procedures, Tests, Other • **V -** Clinic or ER visits • **G, K, L, F -** Drugs, Biologicals, Vaccines, Blood, Brachytherapy sources • **H -** Pass-through devices • **J1 -** Comprehensive APC	• **Q1 -** STV-Packaged Codes • **Q2 -** T-Packaged Codes	• **N -** Items and Services Packaged into APC Rates	• **C -** Not paid under OPPS. Admit patient. Bill as inpatient. • **D -** Discontinued Codes • **E -** Not paid by Medicare when submitted on outpatient claims (any provider) • **B, M -** Not paid under OPPS.

For complete listing and details, see CMS-1613-FC-Addendum-D1.

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Developing an Effective CDM Infrastructure

- Without an accurate and up-to-date CDM, hospitals will not receive proper reimbursement for services rendered. Claim rejections, underpayments, overpayments, fines and penalties may result.

- Merely distributing regulations, coding/billing information to affected clinical areas RARELY achieves accurate and compliant reporting.

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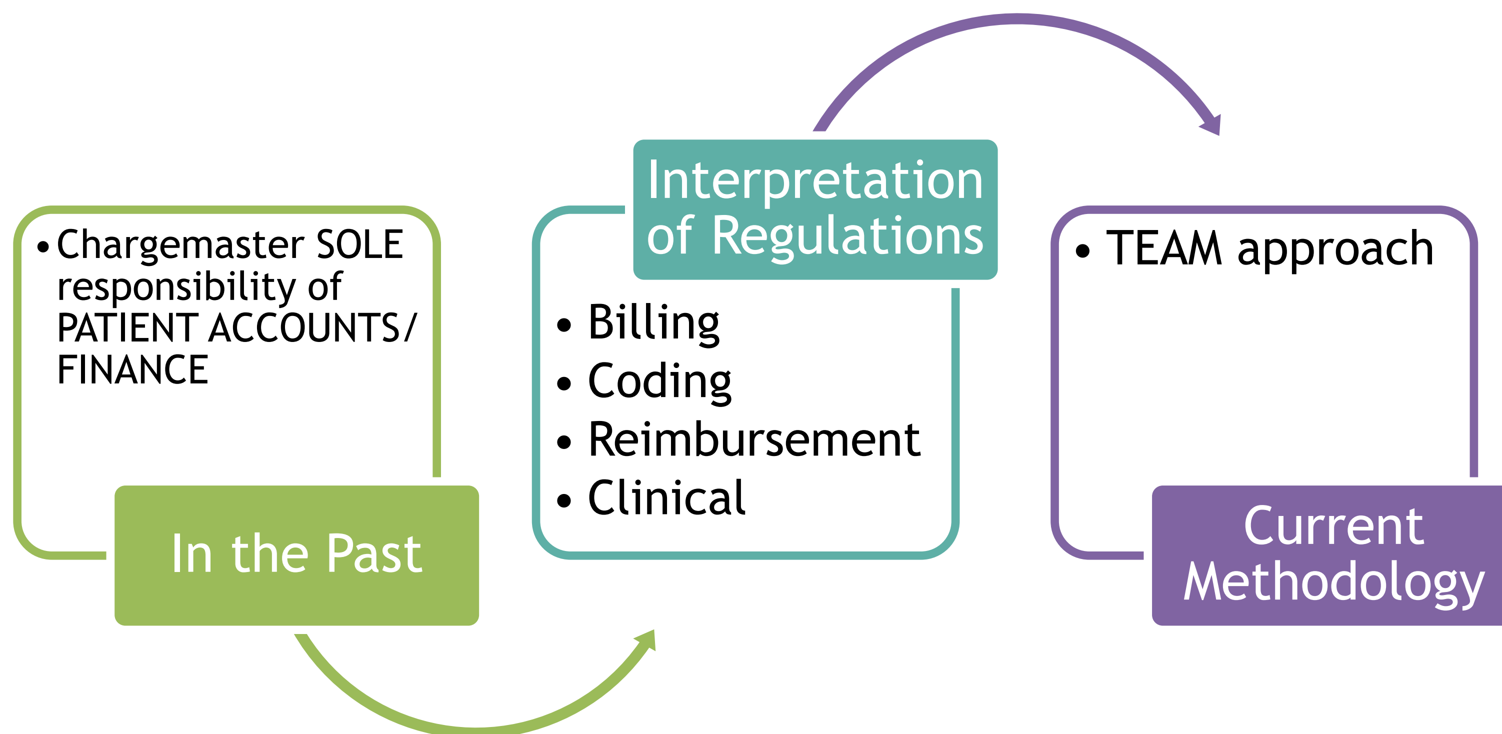
Developing an Effective CDM Infrastructure



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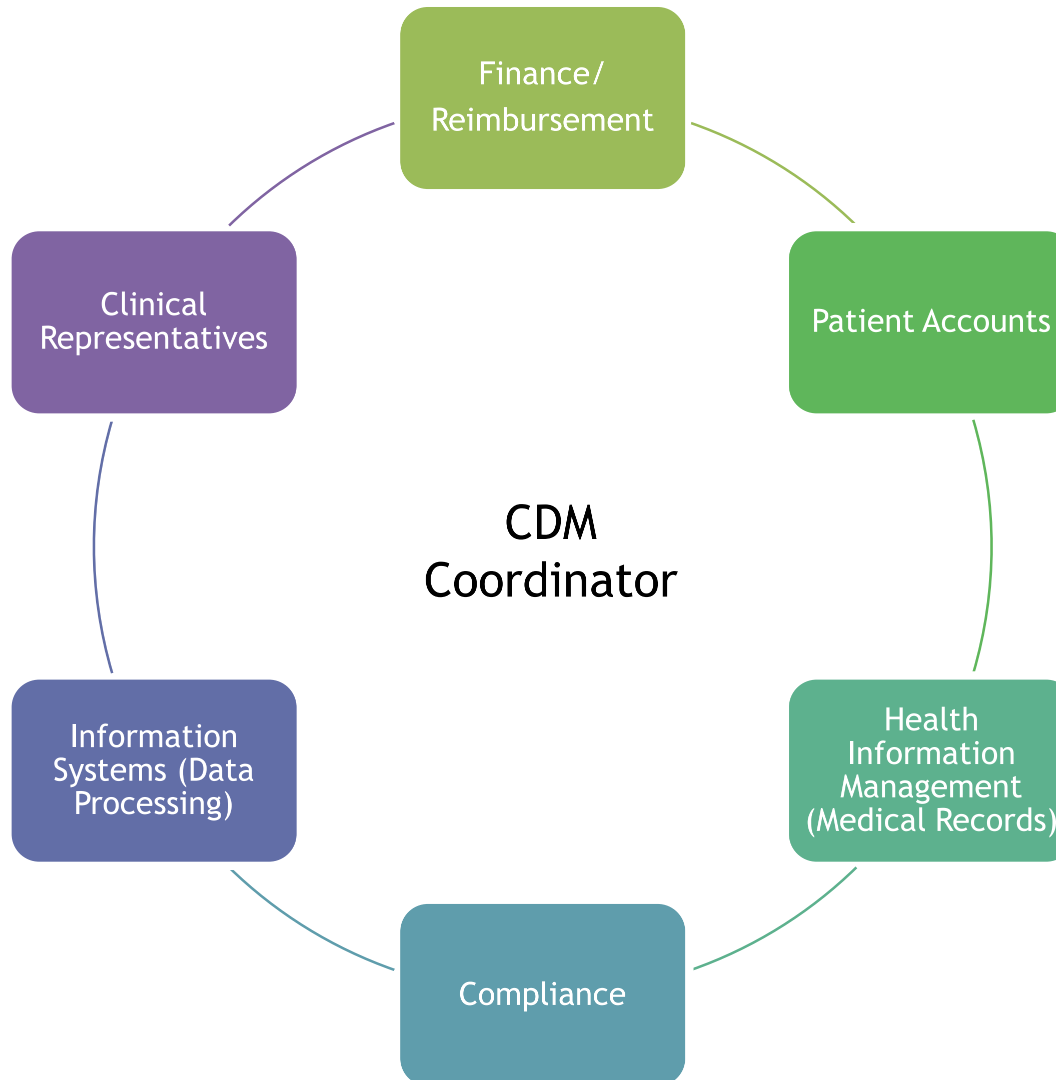
CDM Committee



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CDM Committee - Objectives

- Facilitate accurate billing in compliance with Medicare guidelines
- Improve consistency and accuracy of charge capture processes
- Reduce number of claims requiring manual intervention
- Identify opportunities for operational improvements (best practices)

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CDM Committee - Responsibilities

- Determine Services Hospital is Required to Bill
  - Hospital
  - SNF
  - Home Health
  - Rural Health Clinic
  - Professional (Physician, CRNA, etc.)
  - Other

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CDM Committee – Responsibilities

- Assess current processes and controls
- Optimize processes and formalize them into written policy
- Oversee CDM maintenance and implementation of new regulations
- Conduct on-going process improvement
- Monitor charge capture compliance
- Utilize external resources?

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Assessing Current Processes and Controls

- Updating and maintenance of the CDM
  - ✓ Annual review is imperative
  - ✓ Merge CDM + revenue usage
  - ✓ Addendum B
  - ✓ Thoroughly review CPT/HCPCS manuals before begin
  - ✓ Clinical personnel responsible
- Reviewing quarterly OPPS updates
- Utilizing Add/Change forms
  - ✓ Clinical departments to initiate
  - ✓ Obtain approvals (CDM, PFS, Finance)
  - ✓ Limited access for making changes to the CDM
  - ✓ PFS to monitor new services (edits? denials?)

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Assessing Current Processes and Controls

- Maintenance of links between modules & CDM
  - ✓ Order entry/charge screens
  - ✓ Modifier prompters
  - ✓ Pharmacy and Materials Management
  - ✓ Electronically linked charges (charge explosions)
- Statistical charges (productivity indicators?)

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Assessing Current Processes and Controls

- Rate Setting and Review
  - ✓ Annual reviews – Finance Team
  - ✓ New Procedures
    - Mark up formulas (Procedures, Supplies, Pharmacy)
    - Competition
    - Same services, same price?

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Assessing Current Processes and Controls

- Guidelines related to coding and charging
  - ✓ Modifiers (prompters, hardcoded, HIM?)
  - ✓ Where is HIM assigning codes/generating charges?
  - ✓ Charge definitions for CDM end-users
- Charge capture controls (e.g., infusions & injections)
- Supplies
  - ✓ Routine vs. separately chargeable
  - ✓ Coding (implants, orthotic devices, DME, etc.)
  - ✓ One-to-one or many-to-one relationships
- Charge reconciliation

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Assessing Current Processes and Controls

- Future regulatory updates:
  - ✓ CDM Committee to assess Monthly or Bimonthly
  - ✓ Designated individual compiles updates
  - ✓ Send to CDM committee prior to meeting
  - ✓ Invite affected departments, as needed
  - ✓ Discuss and implement controls
  - ✓ Action plan
- Implementation of payor regulations
- Develop CDM performance measures (benchmarking)
- Oversee charge capture/documentation reviews

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CDM-Related Charge Capture Compliance

- Charge Capture Documentation Reviews
  - Selection of Claims (UB-04)
    - Outpatient vs. Inpatient
    - Focused vs. Random
  - Documentation:
    - Orders
    - Documentation (medical reports, notes, H&Ps, etc.)
  - Charge Capture:
    - Ensure all reportable CPT/HCPCS codes, modifiers, units of service were accurately assigned and captured on the UB-04 claim.
    - Other revenue considerations (supplies, surgery time, observation, etc.)

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CDM-Related Charge Capture Compliance

- Charge Capture Documentation Reviews
  - Compliance:
    - For services billed, compare clinical documentation to payer guidelines for agreement.
    - Medicare:
      - ✓ National Correct Coding Initiative (NCCI)
      - ✓ CMS manuals
      - ✓ Medicare Administrative Contractor - Part A
        - Novitas Solutions, Inc.
        - Local Coverage Determinations (LCDs) – 90+
        - Medical review
        - Articles

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CDM-Related
Charge Capture Compliance

- Charge Capture Documentation Reviews
  - Verify payments received
    - Review reimbursement method or contracts for top 3 to 5 payers.
    - Pull 10 outpatient claims each, and verify payments received on remittances are consistent with contract terms.
- Benchmarking
- Education
- Controls/Tools

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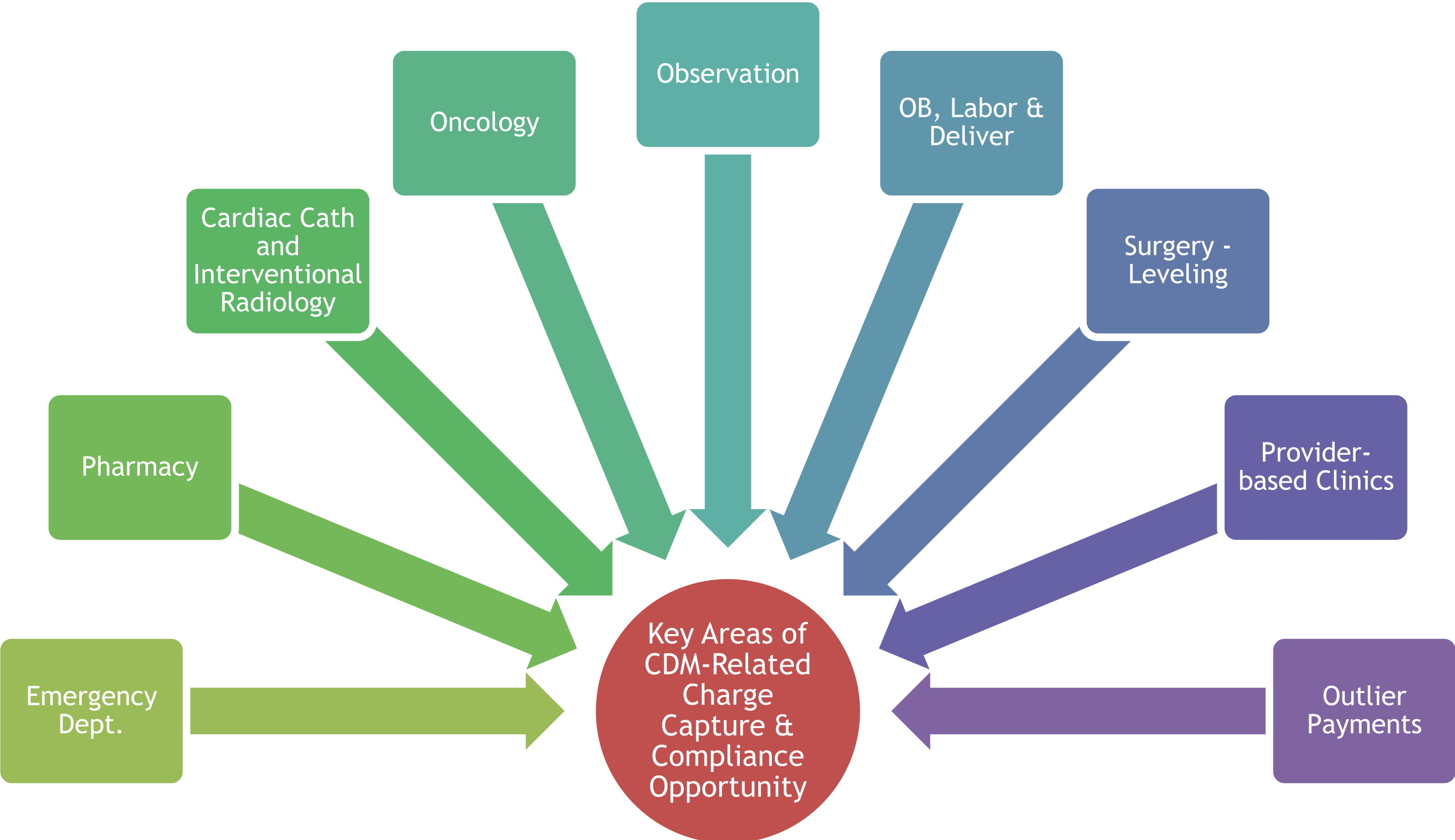
CDM-Related Charge Capture/Compliance



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Emergency Department

- Reimbursement - Medicare
  - Visit Level
  - Surgical procedures ($100 packaging threshold)
  - Immunizations
  - Infusions & injections
  - Drugs if Status Indicator G or K
  - Laboratory tests (packaged, no separate payment)
  - Radiology ($100 packaging threshold)
  - Other tests/services ($100 packaging threshold)
  - Critical care
  - Trauma team activation

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Emergency Department - Unadjusted APC Rates

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99281	ER Visit Level 1	V	0609	0.8155	$60.49		$12.10
99282	ER Visit Level 2	V	0613	1.5206	$112.79		$22.56
99283	ER Visit Level 3	V	0614	2.6747	$198.39		$39.68
99284	ER Visit Level 4	Q3	0615	4.5003	$333.80		$66.76
99285	ER Visit Level 5	Q3	0616	6.6424	$492.69		$98.54

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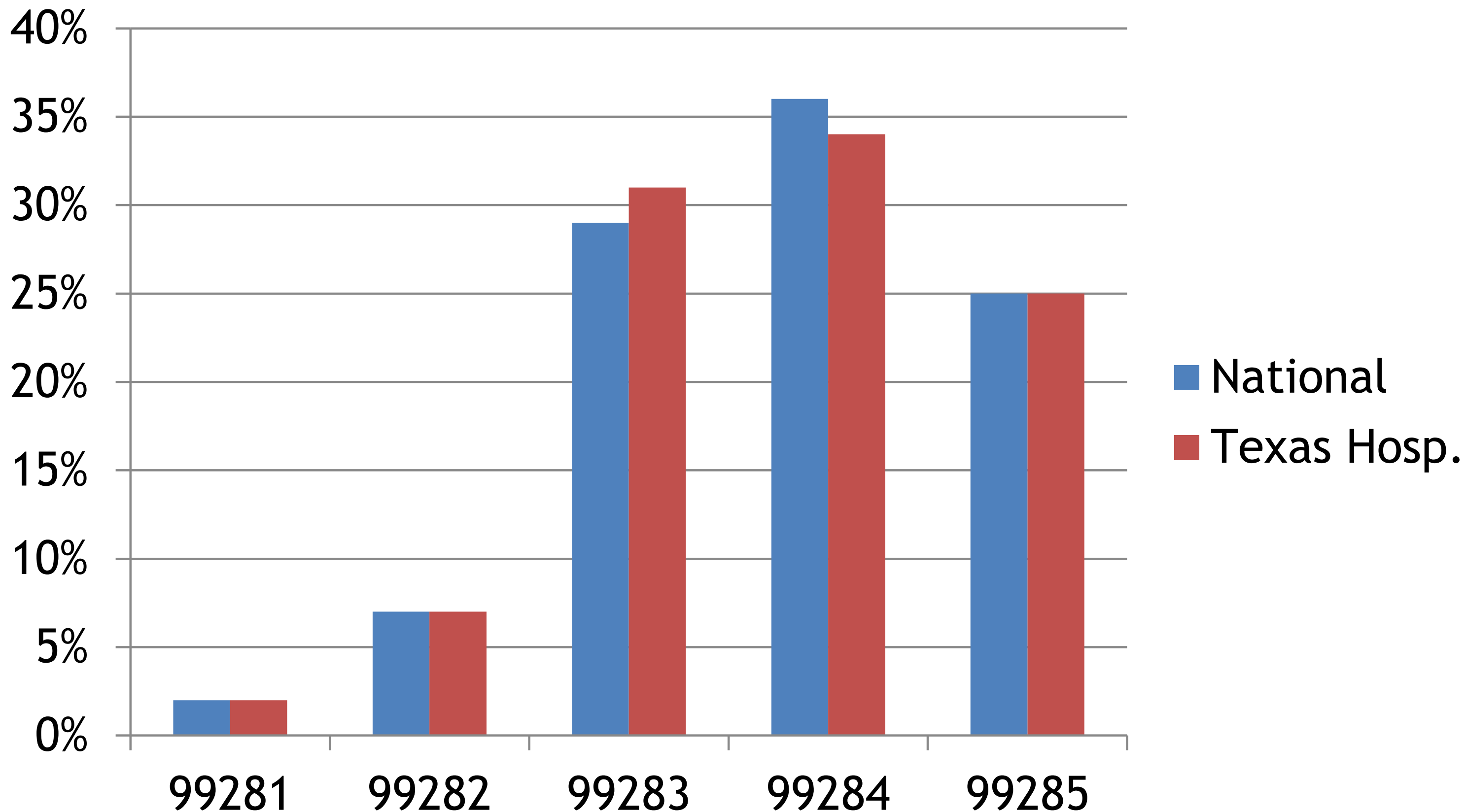
Emergency Department – Medicare Hospital Outpatients



CMS Outpatient Standard Analytical File - Medicare Patients - Calendar Year 2014

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Emergency Department

- The 11 guiding principles: CMS 2008 OPPS Final Rule

1. Follow the intent of the CPT code descriptor in that they should be designed to reasonably relate the intensity of hospital resources to the different levels of effort the code represents.
2. Be based on hospital facility resources. They should not be based on physician resources.
3. Be clear to facilitate accurate payments and be usable for compliance purposes and audits. To determine whether your guidelines are clear and usable, ask someone who uses them to explain the tool.
4. Meet HIPAA requirements.
5. Require only documentation that is clinically necessary for patient care.
6. Not facilitate upcoding or gaming.
7. Be written or recorded, well documented, and provide the basis for selection of a specific code.
8. Be applied consistently across patients in the clinic or ED to which they apply.
9. Be flexible.
10. Be readily available for FI or, if applicable, MAC review.
11. Result in coding decisions that could be verified by other hospital staff members, as well as outside sources.

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HCPCS Modifier - PO

- Modifier -PO "Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments."
- Reporting is voluntary for CY 2015; mandatory, effective January 1, 2016
- This modifier is to be reported with every HCPCS code for *all* outpatient hospital *items and* services furnished in an off-campus provider-based department of a hospital.
  - See 42 CFR 413.65(a)(2) for a definition of "campus"

HCPCS Modifier - PO

- This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.
- CMS MLN Matters article MM9097, "April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)"
- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 4, section 20.6.11

Conclusion

- CDM Committee with defined roles and responsibilities
- Development of tools and controls
- Periodic CDM reviews
- Periodic Charge Capture/ Documentation Reviews
- Benchmarking

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Scott is a Senior Manager with Blue & Co. He is a Medical Technologist and Certified Professional Coder. With over 17 years of hands-on consulting experience, Scott is responsible for planning, coordinating and performing detailed work related to chargemaster (CDM) reviews with education and training, coding and documentation reviews, surgery charge structure remodeling, and revenue cycle team development. Scott has also standardized chargemasters across multi-hospital systems. In addition, he enjoys providing education to hospitals and other healthcare organizations on many topics such as Medicare regulations, compliance, coding and reimbursement.

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