



Championship Revenue Cycle:
Passion & Purpose



Management of Chargemaster and Charge Capture - Keys to Success

Thursday, January 18th, 2018
Gillette Stadium Clubhouse

Jon Menard, COC, CPC
Consulting Manager
Bolder Healthcare Solutions

Championship Revenue Cycle:
Passion & Purpose



Agenda

1. Charge Description Master (CDM)
 - What is the CDM?
 - How to have a clean and compliant CDM
 - What are the risks associated with everyday maintenance of the CDM?
2. Charge Capture
 - Importance and complexity of charge capture processes
 - Risks associated with charge capture deficiencies
 - Connecting the CDM and charge capture





Charge Description Master (CDM)

- What is it?
- Essentially, a comprehensive list of procedures, supplies, devices, drugs, and other items for which a distinct patient charge exists.
- CDM may also include statistical tracking line items, payment and adjustment codes, other data.
- Master file is maintained within the hospital information system(s) and is interfaced with other applications to support the charging of items and services.



Charge Description Master (CDM)

- Some describe the CDM as “the life blood of the revenue cycle”, or the “backbone” or “central revenue cycle mechanism.”
- Whatever the term used to describe it, the CDM is fundamental to revenue generation and the charge capture process.
- Maintenance of the CDM is critical to the financial success of any institution.



Who is responsible for the CDM?

- Every hospital is different – much depends on the size and resources of the facility
- Examples:
 - Large health system – CDM Manager, team of CDM analysts
 - Mid-sized hospital – CDM Coordinator
 - Small facilities – Responsibility of PFS director, along with EVERYTHING ELSE?



Keys to CDM Success

- Regardless of where the responsibility ultimately lies, the **first** key to CDM success is OWNERSHIP
- Does the person, or people, responsible for the CDM “own” the file?
- Or is CDM management a secondary task/responsibility that is done “on the side” or “when there is time”?



Keys to CDM Success

- Change to the CDM is constant.
- Attention to the file is required for annual and semi-annual CPT changes, quarterly HCPCS changes, new services, obsolete services, regulatory and third party payer requirements.
- Not keeping up with changes for even a short period of time can lead to compounding issues within the CDM file.



Keys to CDM Success

- The second key to CDM success is COLLABORATION
 - The CDM contains elements that are both financial and clinical in nature.
 - Finance cannot maintain the file without the assistance of clinical departments, and vice versa.
- Example: Complicated changes to lab drug screen codes for 2015 - 2017



Keys to CDM Success

- Are clinical department heads aware of what is in their CDM file? Do they keep up with changes?
- Is there continuous communication between clinical departments and the “owner” of the CDM?
- Are departments held accountable for their charges? Review of revenue and usage reports?



Keys to CDM Success

- In addition to the clinical departments, other parties greatly impacted by the CDM include:
 - Business office/PFS
 - HIM
 - IT
 - Compliance
 - Finance
- Each of these areas should have a line of communication with the person or people responsible for the CDM.



CDM Risks

- Charging for wrong items/services
- Not charging for items/services
- Reporting incorrect number of units
- Denials or claims rejections – many reasons
- Fines or penalties
- Automation – a single error may be duplicated hundreds or thousands of times before being identified



Handling Annual CDM Changes

- Every year the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) delete, revise and introduce new CPT and HCPCS codes.
- What is the process for handling annual changes?
 - Purchase of CPT/HCPCS books? Review of data files (AMA releases around Sept 1, CMS releases early Nov)? Seminars/webinars?
- Are changes being implemented on time? Changes not ready by the first of the year can lead to major problems with denials and claims being held in scrubbers – or claims being held.



Continual Changes Throughout the Year

- What about the constant barrage of changes that are needed in the CDM throughout the rest of the year, outside of the annual code changes?
 - New services
 - Obsolete services
 - Changing regulatory and payer requirements

- Is there a policy for charge master additions, deletions, revisions?

- Is it followed?

- Are changes logged?



CDM Revision Policy

- There should be a standardized form for additions, revisions, deletions

- Completed by individual requesting the charge

- Has fields for dept, charge description, CPT/HCPCS code, price, etc.
 - Fields are completed and reviewed by appropriate parties (CDM coordinator, finance, compliance, IT)
 - What is the approval process/turnaround time?
 - Does someone follow the new charge through to third party remittance when first established?





Basic Risk Areas and How to Avoid Them

- Simple, everyday charge master maintenance tasks, if done incorrectly, can lead to major risks
- On the following slides, we will discuss some common risk areas and how to avoid them



Charge Descriptions

- Accurate charge descriptions are important
- Often limited by space constraints
- Descriptions should match the definition of the corresponding CPT/HCPCS code assigned in the CDM
- Slight inaccuracies or vagueness can lead to incorrect charges being reported, which may lead to dramatic differences in reimbursement



Other Charge

- Standardized descriptions
 - Use standardized verbiage that appropriately describe items/services and are understood by all that use the charge (e.g., specimen source, number of views, unit of measure, etc.)
- Abbreviations – make sure they are clear
 - Example: “Diphenhydramine 1 ml SYR” – Does this mean syrup? Syringe? Each would be billed very differently (injectable drug versus self-administered drug)
- Timed codes
 - Biller per hour? Per 15 minutes? Does description specify?



Revenue Codes

- Four digit numeric codes established by the National Uniform Billing Committee (NUBC) that categorize/classify line items in the CDM
- Example: 0420 – Physical Therapy, 0301 – Lab Chemistry, 0250 – Pharmacy
- How do you choose revenue code assignments?



Revenue Codes

From CMS (Medicare Claims Processing Manual, Chapter 4, Section 20.5):

Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.



Why are Revenue Codes Important?

- Cost reporting
 - Revenue codes are cross-walked to certain cost centers on the cost report
- Claim edits
 - Some CPT/HCPCS codes must be reported with a specific revenue code in order to get reimbursed by certain payers (e.g., Medicare requires revenue code 0770 for some preventive services)
- Reimbursement
 - Some commercial payers base payment on revenue code assignment rather than CPT/HCPCS codes (fee schedule, case rate, per diem?)



Modifiers

- Two digit alpha or numeric character that can be appended to a particular CPT or HCPCS code to provide additional information about that code
- Modifiers may be “hard coded” in the CDM or can be “soft coded” by HIM or other staff
- Who should assign modifiers? HIM? Departmental staff? Billers?
- Some modifiers can safely be coded in the CDM. Examples:
 - Laterality (LT, RT, 50)
 - Informational (GP, GO, GN)
 - Payer required (GY)



Modifiers

- Other modifiers can be very risky to have hard-coded in the CDM and are not recommended. Examples:
 - Separate and distinct services (25, 59, or L1 for labs)
 - Repeat lab tests (91)
 - Discontinued procedures (73, 74)
- These modifiers describe *clinical situations* and require a certain expertise when determining when it is appropriate to assign
- These modifiers may circumvent NCCI edits, or impact reimbursement amounts





Modifiers

- Have a set policy in place documenting which modifiers are included in the CDM and which are not
- Ensure that staff adding modifiers understand the significance of the modifiers and requirements for their use
- Only hard-code modifiers when the situation they are describing is true **100% of the time**



Pharmacy

- Major risk area in CDM due to constant changes
- HCPCS codes:
 - Who assigns? Many times Pharmacy manages their own CDM.
 - When new drugs are added to formulary, are HCPCS codes always looked up?
 - Many drugs have specific HCPCS codes, many of which are separately reimbursed by Medicare and other payers
 - No HCPCS code = no reimbursement
 - Drug may not have HCPCS code when first created – who monitors updates?





Pharmacy - Drug Unit Multipliers

- Drugs are billed in units defined by HCPCS descriptions
 - Example: J1741 “injection, ibuprofen, 100 mg”
 - 500 mg vial would be billed as 5 units of J1741
- Who assigns multipliers?
- Where are they housed? CDM? Formulary?
- Are these reviewed when codes change?



Pharmacy - JW Modifier

- Effective 1/1/2017, JW modifier is required to identify drug waste when administered from single-dose vials.
- How is this handled? In the CDM? In the formulary?
- Is the process updated when HCPCS codes change on a quarterly basis?



Pharmacy - Self-Administered Drugs

- Self administered drugs – not covered by Medicare Part B
- How are these identified in the CDM?
- If assigned to revenue code 250, may be getting billed to Medicare “masked” as a covered drug – compliance issue
- Should be assigned to revenue code 637 (some hospitals use 259)
- Mechanism should be in place to either bill to Medicare Part B as non-covered, or to not bill to Medicare at all



Supplies

- Does person creating charges for supplies understand the definition of billable patient supplies?
 1. Medically necessary and furnished at the direction of a physician or other practitioner
 - Does not include personal convenience items (e.g, slippers, personal care items, or routine items such as drapes, pads, cotton balls, urinals, bed pans, gauze, etc.)
 2. Single use/disposable
 - Cannot charge for reusable supplies
 3. Patient identifiable
 - Medical record documentation must support the use of the item
- Is there a policy for charging for supplies?



Pricing

- Is there a standard methodology that is used consistently?
- Do prices for the same services vary from department to department?
 - Differences in prices would need to be justified
- Are prices reviewed against payer fee schedules?
 - Charges priced too low can result in less than optimal reimbursement
 - Charges priced too high may be challenged by some payers
- Annual price increases? Be mindful of current trends in hospital pricing. Price transparency, defensible pricing, etc.



Obsolete Items

- Departments should regularly review their charges and should inactivate charges that are no longer needed
- Keeping obsolete items in the CDM:
 1. Leaves the possibility open for incorrect charges to be selected
 2. Makes the CDM larger, more cluttered, and more difficult to analyze
- Review all items with no volume for 12-18 months and consider for inactivation



Charge Explosions/Panels

- Charging for related services can be assisted with the use of charge explosions or panels
 - Charging a single line item which “explodes” out to multiple line items
- Commonly seen in radiology, lab
- Be very careful that explosions are only utilized when every component is performed
- Clearly identify which charges are explosions
- Be mindful of how annual code changes can impact existing explosion set-ups



Charge Master Reviews

- Best practice – complete review every 1-2 years
- Involve clinical departments!
 - Share findings
 - Review processes and procedures
- It is more than just confirming valid CPT/HCPCS codes
 - Volume analysis, identification of missing charges, pricing, etc.
- Don't forget to implement changes!
 - A comprehensive CDM review sitting on the shelf collecting dust helps nothing!



Does a Clean CDM Guarantee Revenue Maximization and Risk Reduction?

NO!



CDM is One Major Piece of the Puzzle

- The CDM is a major component of the middle revenue cycle and its importance cannot be understated
- However, the positives of a clean CDM can be negated due to poor charge capture
- A charge may be perfectly represented in the CDM file, but....
- If it isn't captured, it isn't paid!



What is Charge Capture?

- Ensuring that each patient encounter is charged completely and compliantly for all services, supplies, and pharmaceuticals used

- Very complex process
 - Multiple types of patient encounters
 - Many different departments and locations
 - Unique coverage and billing requirements
 - Variety of information systems



Who Captures Charges

- During a single patient encounter, many different hospital departments and associated personnel contribute to providing and charging for services and supplies

- Do all parties understand the complexities of charge capture?
 - Nurses?
 - Ancillary staff?
 - Coders?
 - Billers?

- One major reason for charge capture failures is that many personnel are not properly trained or provided with the necessary resources



Charge Capture Risks

- Missing charges
 - Not charging for all items/services being delivered
- Incorrect charges
 - Charging for items/services that were not the actual items/service being delivered
- Late charges
 - Delays in posting charges leading to held claims, rebills, write-offs
- Reduced productivity
 - Spending far too much time fixing charging issues on the back end



Methods of Charge Capture

- Order entry (ordered/resulted)
- Upon EHR documentation
- Manual entry by specified staff (and backup person if staff is out?)
- HIM/coding (are there backlogs/delays?)
- Patient accounts? (hopefully not!)



What Methods are Used at Your Facility?

- Does each clinical department head have a complete understanding of how they are charging for what is being done in their areas?
- What is the worst response that we often here when we ask a clinical department head “how do you charge for _____” ?

I DON'T KNOW

- How can you be sure that you are getting paid for everything that you are doing if you don't even know how you are charging for it?



Are You Charging for Everything You Can?

- Interview departmental staff to determine all services that are being performed
- Confirm that all chargeable items/services are identified in the CDM
- Review code ranges in CPT book
- Review new CPT codes
- Chart reviews/audits may identify services being performed that aren't being captured



Identifying Charge Capture Errors

- Daily charge reconciliation
 - Confirm that appropriate charges are being posted to every account
- Revenue and usage reports
 - Look for trends that might identify issues
- Late charge reports
 - Excessive late charges due to charge capture breakdowns
- Chart reviews
 - Identify deficiencies that might otherwise go unnoticed



Connecting the CDM to Charge Capture

- Regardless of how charges are being captured - where are the charges coming from?
- How are charge capture methods in clinical areas linked to the CDM?
 - Electronic procedure menus interfaced with CDM? Charge sheets?
- Do items/services being described in various charge capture methods link to matching items in the CDM?



Connecting the CDM to Charge Capture

- Verify that a 1:1 relationship exists between items on charge sheets and the CDM
 - Charge sheets get outdated! Is there a process for regular review? Revision date should be included on document.
- Review of “mapping” is just as important as review of CDM or charge capture processes



Ensuring Accurate Charge Capture

- Provide departments with the education and tools that they need to manage their charges
 - Written policies and procedures
 - Training regarding billing rules and guidelines
 - Paper or electronic resources (e.g., CPT books, online reference sites, CDM management tools)
 - CDM resource – information coordinator
- Require daily charge reconciliation
- Perform regular audits
 - Compare physician orders, to chart documentation, to itemized charges, to claim form – identify deficiencies or missing charges



Conclusion

- Clean and complete CDM and accurate charge capture are critical to the financial success of any hospital
- This cannot be a secondary responsibility, but rather must be an area of focused effort and attention
- Requires the right people with the right knowledge and the necessary resources needed to get the job done right
- There is more than one piece to the Middle-Revenue Integrity puzzle. Breakdowns in any area can lead to risks.
- One size does not fit all – every facility is different. Each hospital needs to develop processes that work depending on the size, the resources and the people at your facility.



Questions?

Jon.Menard@Bolderhealthcare.com