

Charge Description Master Reviews

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Today's Discussion Topics

- Full Chargemaster Reviews
- Annual Chargemaster Reviews
- Ongoing Chargemaster Maintenance
- Common Chargemaster/Billing Issues
- OPPS Chargemaster Findings
- CAH Chargemaster Findings

2

Importance of Chargemaster

- Determines 100% of patient revenue
- Sets prices for all services
- Key roll in financial reporting
- Key roll in Cost Report processing
- Cost accounting
- Inventory control

3

Full Chargemaster Review

- Every 3 to 5 years
- Benefits of using a reputable outside firm
 - Expertise
 - Knowledge of other facilities
 - Knowledge of industry standards
 - Third party factor
 - Time factor
 - Attorney client privilege

4

Chargemaster Review Firm

- Experience
 - Check references
- Knowledge
 - Medicare Cost Reporting
 - HCPCS coding
 - UB-04/1500 claims submission requirements
 - Third-party reimbursement methodologies

5

Proposal Elements

- Review of HCPCS codes, revenue codes, modifiers and annual usage
- Onsite visit
- Include Department Managers
- Cursory review of the Cost Report
- For PPS hospitals – an APC audit
- For CAHs – a more detailed Cost Report review

6

Full Internal Review

- Commit to the process – very time consuming
- Schedule a separate time for each department
- Send each department's section ahead of time
 - Include a usage report for the last year

7

Full Internal Review

- Include department managers and/or their designee
- Include representatives from the Business Office, Compliance, Finance and HIM in each session
- Do the session away from the manager's work area

8

Full Internal Review

- During the session – review
 - Each line item in the CM
 - Annual usage – is the line being used
 - Routine services – is it billable and/or should the facility bill for it
 - Revenue code assignment
 - HCPCS assignment
 - Modifier assignments
 - G/L or department assignment
 - Narrative description
 - Charge amount/pricing

9

Full Internal Review

- During the session – review
 - Exploding charges and Tier charging
 - The department's charging documents
 - Charge sheets – need to match what's in the chargemaster
 - Order entry screens
 - Charge entry process
 - Charging concerns from the B.O.
 - Late charges
 - Lost charges

10

Full Internal Review

- During the session – review
 - Any compliance concerns with the manager
 - ABN issues
 - Billing issues raised by the B.O.
 - Coding issues raised by HIM
 - CMS national concerns
 - MAC concerns
 - RAC concerns

11

Annual Chargemaster Review

- Send chargemaster section to department manager – include usage
- Department manager to review
 - Usage
 - Charge narratives
 - HCPCS codes
 - Modifiers
 - Charge amount/pricing
 - Exploding links/Tier specific codes

12

Annual Chargemaster Review

- The department manager should also review the charge sheets/order entry screens used by the department
- The department manager should note any changes, sign off on the chargemaster and return it
- Is the review part of the Managers annual performance review?

13

Ongoing Maintenance

- Most changes should be initiated by a department manager
- All changes should be documented on some sort of a form
- For new charges, packaging/bundling
 - Keep detailed notes on reasons for change

14

Ongoing Maintenance

- All changes should be reviewed by Finance, HIM and the Business Office
- Only one or two people should have authority to change the chargemaster
 - Should know how changes affect other areas
 - Should understand the cost report and the impact of revenue code and G/L assignments

15

Hard vs. Soft Coding - HCPCS

- Hard coded HCPCS codes are assigned through the chargemaster
 - The majority of HCPCS code assignments
 - If set up wrong – its wrong every time
- Soft coded HCPCS codes are assigned by HIM
 - There has been a general movement towards soft coding for some services
 - Problems with soft codes not on the UB-04

16

Hard vs. Soft Coding - HCPCS

- Departments typically hard coded – Lab, Radiology, EKG/EEG/Sleep Studies, Therapy (PT, OT, SLP, RT, CR, PR), Pharmacy, Devices
- Departments done both ways – Cath Lab, GI Lab, Treatment room, ER E/M, ER procedures, Observation, Clinics
- Departments typically soft coded - OR

17

HIM Charging (Hard-Soft Coding)

- HIM areas are starting to add charges rather than just assigning codes
- Alleviates some of the issues seen with soft coding
 - Soft codes overriding hard codes
 - Hard codes overriding soft codes
 - Soft codes dropped when no charges on the claim
 - Soft codes attached to wrong charges

18

Common Hard-Soft Coded Services

- More and more hospitals are having HIM charge for nursing services
 - Observation & related services
 - Drug Administration services
 - Blood Administration
 - ER Services (E/M & Procedures)
 - Clinic/Treatment room services

19

Revenue Codes

- The purpose of HCPCS codes is to define the service being provided
- The purpose of revenue codes is to define where (the cost center) the service is being provided
- The original purpose of revenue codes was to facilitate cost reporting

20

Revenue Codes

- The revenues and expenses of providing a service should be matched with the revenue code (cost center) used to bill Medicare
- One of the goals for a chargemaster is to have as few revenue codes in a department as possible – one would be best but is rarely obtainable

21

Revenue Codes

- Revenue and expense matching is critical in CAHs
- Revenue and expense matching is important for future payments and weight setting in PPS hospitals
- Has CMS relaxed its HCPCS/Revenue code edits?

22

Routine Supplies/Services

- The manual sections most often quoted relate to SNFs
- Most bulletins issued by the FI/MACs refer to these SNF manual sections
- Commercial payers are attempting to deny payments based on these sections
- The hospital manual is much less restrictive as to what can be billed

23

Routine Supplies/Services

- Industry Standard definitions (?)
 - Billable Items and Services
 - Services identifiable to individual patients
 - Items or services not generally furnished to most patients
 - Items that are not reusable
 - Items that represent a cost for each preparation

24

Routine Supplies/Services

- Non-Billable Supplies or Services
 - Equipment
 - Reusable items that are sterilized
 - Floor stock items
 - Routine nursing services
- Per-use rental items should be chargeable
- The facility has a choice in floor stock items

25

Routine Supplies/Services

- Each hospital should have a billable supply policy that addresses:
 - Patient convenience items
 - Equipment
 - Reusable supplies
 - Routine supplies
 - Low cost items

26

Routine Supplies/Services

- Need to carefully model the elimination of routine items
 - Identify the appropriate routine or procedure charges
 - Document the process
 - Monitor changes
- Typically, rates in other areas are increased to offset the reduction
- May reduce lost charges

27

Bundling Supplies

- Can reduce lost charges
- Can reduce overhead cost
- The price should reflect billable items
- Averaging may not be the best approach in a CAH
- Document all bundling decisions for future reference

28

Observation Services

- What is observation
 - Purpose
 - Physician order
- What is not observation
 - Routine post surgical services
 - Acute interventions
 - Prep or pre-op time
- Observation hours must be correctly tracked for billing and cost reporting

29

Observation Services

- The time starts when the patient is placed in the observation bed
- Observation end time or "Discharge"
"the clock time when all clinical or medical interventions have been completed, including any necessary followup care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient"

30

Observation Services

- Effective 1/1/08 – Observation hours should not include time when other services are being provided that require active monitoring by nurses
 - Colonoscopies
 - Blood Administration
 - Infusion Therapy
 - Chemotherapy
 - Other time absent from the room

31

Observation Services

- Front end loading of observation charges
- Two levels of observation if two room rates
- Don't use the ICU rate for observation services
- An ABN should be issued for non medically necessary observation

32

Recovery Services

- Recovery services typically last 4 to 6 hours post op – **not a hard definition**
- Recovery services provided in an inpatient bed
 - Do not bill as observation
 - Bill using revenue code 710
- Referred to as "Phase II" recovery or "Extended Recovery"

33

Recovery Services

- Pain management services are not billable during the normal recovery period
- Pain management is billable after the normal recovery period
- There should be a policy that defines the normal recovery period

34

OP Services in an IP Bed

- Represent outpatient services provided in an inpatient cost center
- Typical types of services
 - IV Therapy/Injections
 - Blood Administration
 - Chemotherapy
 - Phase II or Extended Recovery
 - Minor procedures or E/M services
- Match revenues and expenses

35

Pharmacy

- One of the hardest departments to maintain
- HCPCS code assignments ("J" codes) and unit assignments are critical for OPSS
 - A high area of missed reimbursement
- CAHs should be very cautious with the decision of whether or not to use the HCPCS codes

36

Self-Administrable Drugs

- These drugs are not covered by Medicare Part B and should not be billed as covered
- Bill as non covered using:
 - revenue code 637
 - HCPCS code A9270
 - Modifier GY
- Billing as covered is a compliance risk

37

Take Home Drugs

- These drugs are not covered by Medicare Part B and should not be billed as covered
- Different than self-administrable
- Billed as non covered on the UB-04
- Billed using revenue code 253
- Many facilities have a separate mark-up formula for these drugs

38

Part D Coverage

- Some self-administrable and take home drugs may be covered by Medicare Part D
 - The patient may ask for a statement indicating the NDC number

39

IP Bedside Procedures

- An extremely grey area
- Consultants are split on this issue
 - Coding/Revenue based consultants typically recommend charging
 - Cost Report/Reimbursement based consultants typically recommend not charging
- The issue has to do with the Cost Report

40

IP Bedside Procedures

- Medicare splits services provided to Inpatients into two categories
 - Routine – billed on a per day basis at midnight
 - Ancillary – billed on a per service basis
- Each of these categories has its own set of revenue codes
- There are no “routine” revenue codes that describe bedside procedures

41

IP Bedside Procedures

- Most hospitals bill bedside procedures using ancillary service revenue codes such as 360 (OR), 761 (treatment room) or 940 (other therapeutic)
- On the cost report it is not possible to match the revenue associated with these services to the routine cost center

42

IP Bedside Procedures

- Possible solutions
 - Move nursing costs to an ancillary department
 - Difficult to track and do
 - Bill services with the incremental nursing revenue code
 - 23X
 - Daily room charges will be greater than semi-private room rate

43

IP Bedside Procedures

- IHC's opinion is that hospitals should not charge for IP bedside procedures
- The difference in the costs of the care between a patient with a bedside procedure and one without is typically less than the difference in cost between patients admitted for the same service but different co-morbid conditions*

44

Pricing Issues

- Hospitals should have a pricing policy
- Medicare's requirement is that the charge for a service reasonably reflects the cost of providing that service
- Not many hospitals have developed or have access to the information that can provide accurate cost information

45

Common Pricing Methods

- The method used to set charges may/will differ by department/area
 - Based on cost
 - Based on regional comparisons
 - Based on fee schedules
 - Based on APC amounts
 - Services with packaging vs. services with little or no packaging
 - Competitive pressures

46

Pricing Issues – Supplies

- Typically based on cost
- Multi-tiered mark-up formula
 - Charge compression
- Updates
 - As costs change (increase or decrease)
 - Annual - can cause significant problems over time

47

Pricing Issues – Supplies

- New "Implantable Devices Charged to Patients" cost center
 - Revenue codes 275, 276, 278, 624
 - Not just "C" coded items
 - Not all items may be high cost items
 - Will we have separate chargemaster departments for these two categories?
 - There will be issues related to separating the costs of these two categories of supplies

48

Pricing Issues - Pharmacy

- Based on cost or other national indicator of cost – AWP, ASP, AAC
- Multi-tiered mark-up formula
- Updates
 - As costs change (increase or decrease)
 - Annually - can cause significant problems over time
- Will we need to charge separately for overhead costs

49

OPPS Findings

- Still many areas of missed revenues
 - Emergency Room services
 - Drug Administration services
 - Observation services
 - OP services in an IP bed
 - Treatment Room services
 - Pharmacy unit errors
 - Complicated coding areas
 - Provider-based clinical areas

50

OPPS Findings

- Many of the same services have been on the top 10 missed charges list for the last 8 years
- Beginning to see HIM or coding staff located in busy ERs
- Beginning to see HIM staff **code and charge** for services provided in nursing areas or by nurses

51

OPPS Findings

- Extended Assessment & Management composite APCs
 - ER & provider-based clinic mapping systems
 - Use of HCPCS code G0379
 - Tracking of observation hours

52

OPPS Findings

- "N" Status services
 - All "N" status HCPCS codes should be billed separately
 - If packaged revenue code items are not billed separately – the facility must make sure the costs of the services are in the correct cost center

53

CAH Findings

- Most CAH facilities have a high volume of Medicare patients
- A CAH chargemaster review should never be done without a concurrent review of the pertinent sections of the cost report
- Often, more reimbursement increases can be found through the cost report than through the CM

54

CAH Findings

- The issue of assigning correct revenue codes is much more critical in a CAH
 - Goal of not repeating revenue codes in more than one department
- Matching revenues and expenses
 - Move all supplies to one department
 - Important to move costs to appropriate areas

55

CAH Findings

- It is beneficial to make low dollar supplies and pharmacy items "floor stock"
 - Must allocate costs to the area using the supply
- It is beneficial to increase the use of skilled level swing beds

56

CAH Findings

- Medicare's manual indicates that CAH hospitals are not required to report HCPCS codes. But...
 - NCDs and LCDs still apply
 - Some HCPCS codes are still required by Medicare
 - Items paid under fee schedule amounts
 - Method II professional charges
 - Certain pharmacy items
 - There are still system edits in place

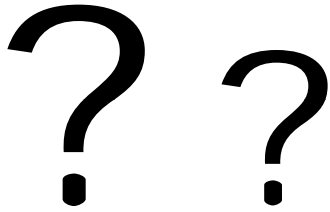
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CAH Findings

- IHC recommends using HCPCS codes in a CAH just as in an OPPS hospital
- The one exception may be the pharmacy "J" codes – **but only if there are no fee schedule based payers**
 - Certain "J" codes with specific coverage criteria are still required by Medicare
- C codes for devices are not needed

58

QUESTIONS



59
