Charge Capture & The Chargemaster

Chargemaster
- Charge number
- Descriptor
- Revenue Code
- CPT/HCPCS
- Multiplier
- Modifier(s)
- Charge amount

Order Completion
- Manual Charge Entry
- Preference List
- OR Time
- Bar Scanner
- Pharmacy

HIM
Scrubber

Charge Reconciliation
### Impact of Deficient Charge Capture

<table>
<thead>
<tr>
<th>Reimbursement</th>
<th>Regulatory Compliance</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
</table>
| • Missed revenue  
  • Delayed payments and back-end re-work  
  • Increased days in accounts receivable  
  • Incorrect data for decision support | • Inaccurate billing  
  • Denials  
  • Penalties and inquiries | • Rebilling  
  • Coinsurance |

**Common barriers to effective charge capture:**
- Perceived as a lower priority administrative function.
- Care providers and charge entry staff do not understand the risks associated and potential consequences for not capturing charges timely, accurately, and completely.
- Lack of formal policies and consistency standards.
- There is little to no training for those responsible for charge capture activities.
- Inadequate monitoring and feedback departmental charge posting and reconciling responsibilities.
Charge Capture Compliance

- Recovery Audit Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Medicare Administrative Contractor (MAC)
- Office of Inspector General (OIG)
- Program Integrity Contractors (ZPIC)
- Several others

Claims Payment Reviews
CERT Medicare 2017, Improper Payments

The fiscal year (FY) 2017 Medicare FFS program improper payment rate is 9.51 percent, representing $36.21 billion in improper payments.

<table>
<thead>
<tr>
<th>Error Category</th>
<th>Percent of 2017 National Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Documentation</td>
<td>1.7%</td>
</tr>
<tr>
<td>Insufficient Documentation</td>
<td>64.1%</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>17.5%</td>
</tr>
<tr>
<td>Incorrect Coding</td>
<td>13.1%</td>
</tr>
<tr>
<td>Other</td>
<td>3.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Recovery Auditors

Photo credit: https://racinfo.hms.com/home.aspx
Recovery Auditors

THIS LIST INCLUDES ALL CMS-APPROVED AUDIT ISSUES. Cotiviti RAC Approved Issues as of 08-10-2018 (PDF Version)

Cotiviti RAC Approved Issues as of 08-10-2018 (Excel Version)

Search within issue name

<table>
<thead>
<tr>
<th>Issue Number - Name</th>
<th>Review Type</th>
<th>Claim Type</th>
<th>Region and States</th>
<th>Date Approved</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>0001 - Complex Inpatient Hospital MS-DRG Coding Validation</td>
<td>Complex</td>
<td>Inpatient Hospital</td>
<td>all applicable states</td>
<td>01/23/2017</td>
<td>Details</td>
</tr>
<tr>
<td>0003 - Complex Medical Necessity Sacral Neurostimulation</td>
<td>Complex</td>
<td>Inpatient; Outpatient; ASC; Physician</td>
<td>all applicable states</td>
<td>01/23/2017</td>
<td>Details</td>
</tr>
<tr>
<td>0008 - Complex Medical Necessity Bariatric Surgery</td>
<td>Complex</td>
<td>Outpatient Hospital; Inpatient Hospital</td>
<td>all applicable states</td>
<td>01/23/2017</td>
<td>Details</td>
</tr>
</tbody>
</table>

https://www.cotiviti.com/healthcare/who-we-serve/cms-approved-issues

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Recovery Auditors

0036 - TRASTUZUMAB (HERCEPTIN), J9355 - MULTI-DOSE VIAL WASTAGE, DOSE VS. UNITS BILLED

<table>
<thead>
<tr>
<th>ISSUE NUMBER - NAME</th>
<th>PROVIDER TYPE AFFECTED</th>
<th>DATE OF SERVICE</th>
<th>STATES AFFECTED</th>
<th>ADDITIONAL INFORMATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0036 - Trastuzumab (Herceptin), J9355 - Multi-Dose Vial Wastage, Dose vs. Units Billed</td>
<td>Physician; Outpatient Hospital; Professional Services</td>
<td>3 years prior to the ADR Letter date</td>
<td>all applicable states</td>
<td>Social Security Act, Section 1833, [42 U.S.C. 1395l (e)]: Medicare Claims Processing Manual, 100-04, Chapter 17, Section 405; CDC: Questions about Multi-dose vials; Package label (manufacturer website): Herceptin</td>
<td>Documentation will be reviewed to determine if the billed amount of trastuzumab (Herceptin) meets Medicare coverage criteria and applicable coding guidelines.</td>
</tr>
</tbody>
</table>
**Anatomy of an LCD**

- Coverage indications, limitations, and/or medical necessity
- Coding guidelines
- ICD-10 codes that support medical necessity
- Documentation requirements
- Utilization guidelines
- Supplemental articles and instructions
Novitas Probe Reviews

JH Targeted Probe & Educate 
Denosumab (Prolia/Xgeva) Round One Results

Findings by State

Checklist: Denosumab (Prolia) Injections Documentation

This checklist is intended to provide Healthcare providers with a reference for use when responding to Medical Documentation Requests for Denosumab Injection services. Healthcare Providers retain responsibility to submit complete and accurate documentation.

<table>
<thead>
<tr>
<th>Check</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please submit a Mandatory Advanced Beneficiary Notice (ABN) if issued</td>
</tr>
<tr>
<td></td>
<td>Physician Orders</td>
</tr>
<tr>
<td></td>
<td>Documentation must contain pertinent history and progress notes to validate the diagnosis (bone metastasis/high risk of fracture) submitted on the claim</td>
</tr>
<tr>
<td></td>
<td>Documentation to support the medical necessity for the administration of Denosumab (T-Score, FRAX Score, Bone Density Scan)</td>
</tr>
<tr>
<td></td>
<td>Beneficiaries who are participating in a clinical trial must include the clinical trial name, sponsor of the clinical trial, and the sponsor-assigned protocol number</td>
</tr>
<tr>
<td></td>
<td>Treatment/medication record must include the patient’s name, date, dosage, time, route and site of Denosumab injection, and signature of individual who administered the drug</td>
</tr>
</tbody>
</table>
Outpatient Coding Resources

- CPT 2018
  - CPT Assistant
  - Clinical Examples in Radiology
  - Errata & Technical Corrections (ama-assn.org)
- HCPCS Level II
- Medicare Online Manuals
- National Correct Coding Initiative (NCCI)
- Medically Unlikely Edits (MUEs)
- Local Coverage Determinations & Articles
- Medicare Guides and Resources Center (website)
- Other

National Correct Coding Initiative (NCCI)

- The CMS developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payments.

- NCCI policies based on CPT coding conventions, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

- Over 1 million PTP (procedure to procedure) edits.
3. Casting/splinting/strapping shall not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Several examples follow: (1) If a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider shall not report CPT codes such as 19515, 19540, or 20550 for that anatomic area; (2) A provider shall not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20545); (3) Debridement CPT codes (e.g., 11442-11449, 17557) and grafting CPT codes (e.g., 19040-19776) shall not be reported with a casting/splinting/strapping CPT code (e.g., 20440, 29580, 29581) for the same anatomic area. This subsection was moved from Section 6 (Fractures, Dislocations, and Casting/Splinting/Strapping), Subsection 2.
Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers shall not report CPT codes 96360-96377 for these services.

5. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately. Similarly, the fluid utilized to administer drug(s)/substance(s) is incidental hydration and shall not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410) which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity) before or after transfusion or chemotherapy, it may be reported separately.

6. Hydration concurrent with other drug administration services is not separately reportable.
Charge Capture Considerations

**Are charge capture expectations clearly understood?**
- Writing guidelines?
- Role of the CDM end-users?
- Process to identify and implement regulatory updates?
- Monitoring and oversight?

**Are CDM end-users poised for success?**
- Education and training? Back-up personnel?
- Revenue Cycle Team; representation and support?
- Charge sheets?
- Charge definitions or instructions?
- Daily charge reconciliations?
- Periodic charge capture audits?

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**Charge Capture Considerations**

**Charge Sheets**
- Include all billable procedures and supplies, with supplemental instructions for charging where needed.
- Review completed sheets prior to posting.
- Ensure annual sheets are completed, updated, and reconciled to the CDM.

**Charge Posting**
- Verify patient account number prior to entering charges.
- Post charges on the day the service is rendered.
- Exceptions?
- Supplies and drugs
- Miscellaneous charges

**Daily Reconciliation**
- Next day activity
- Reconcile charge sheets to a schedule, logbook, or other mechanism to ensure charges are captured for all patients treated.
- Reconcile charges posted in system (e.g., Departmental Charge Report) to charge sheets to ensure accurate and complete entry of all charges.
Charge Capture Considerations

- Test new charges & updates to CDM
- Review compliance with coding & documentation requirements (CPT, NCCI, LCDs, etc.)
- Centralized or decentralized process
- Perform periodically
- Verify payments received
- Communicate results to Revenue Cycle Team

Charge Capture Documentation Reviews

Charge Capture & The Chargemaster

- Chargemaster
  - Charge number
  - Descriptor
  - Revenue Code
  - CPT/HCPCS
  - Multiplier
  - Modifier(s)
  - Charge amount

Order Completion
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- Pharmacy

HIM
Scrubber

Charge Reconciliation
CDM Considerations

- 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.

Clinical departments are responsible. Do not isolate them from the process.

CDM Considerations

**CDM Maintenance Policy**

- Access
- New requests – charge capture testing
- Rate setting and review
- Same service, same price?
- Charge description format
- Statistical charges
- Modifiers
- Hard code vs. soft code (HIM)
- Tiered charges
- Patient chargeable supplies
- Annual reviews
CDM Considerations

<table>
<thead>
<tr>
<th>Dept #</th>
<th>Charge #</th>
<th>Descriptor</th>
<th>RC</th>
<th>CPT</th>
<th>Mod</th>
<th>Charge</th>
<th>I/P Usage</th>
<th>O/P Usage</th>
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<tbody>
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<td>3170</td>
<td>4401559</td>
<td>Flowcytometry/ tc 1 marker</td>
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</tr>
</tbody>
</table>

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CDM Considerations - Supplies

- Separately billable if:
  - Medically necessary,
  - Exceeds cost threshold,
  - Not reusable or equipment,
  - Provided as direction of a physician/provider,
  - Supporting documentation, and
  - Not floor stock.
- Suggest written guidelines with examples.
- Review guidelines from top payers.
CDM Considerations - Supplies

Advantages to Bundling

- Improve charge capture
- Reduce cost/operational efficiency
- Decrease payer audit recoupment
- Patient satisfaction

Other Considerations

- Revenue neutrality
- Pricing transparency
- Data and decision support
- Auditing and monitoring

CDM Considerations - Resource Based Charges

- Operating Room, Recovery, Anesthesia
  - Procedures mapped to charge levels include:
    - Equipment
    - Reusable instrumentation
    - Routine supplies
    - Staffing
    - Room turn-over
  - Review annually
  - Market comparison
CDM Considerations - Resource Based Charges

- Emergency Department
  - Distribution of ED visit levels
    - Facility component
  - CAH
  - OPPS
  - CMS Outpatient Standard Analytical File
- PEPPER reports (OPPS)
- CMS OPPS FINAL RULE 2018 - 11 guiding principles

**MEDICARE OUTPATIENT – ED LEVELS**

- National Average
CDM Considerations - Benchmarking

- Emergency Department
  - Total ED visit levels (99281-99285)
  - Initial infusions (96360, 96365)
  - IV pushes (96374, 96375, 96376)
  - Surgical procedures (10000-69999)
  - Critical care (99291)

CDM Revenue Cycle - Infrastructure

- Administrative support (executive sponsor)
- Representation (Finance, CDM coordinator, Coding, Clinical department leaders, motivated individuals only)
- Other representation, as needed
- Meet periodically

Revenue Cycle Team
### CDM Revenue Cycle - Infrastructure

#### Team Objectives
1. Facilitate accurate billing in compliance with Federal guidelines
2. Improve consistency and accuracy of charge capture processes
3. Reduce number of claims requiring manual intervention
4. Identify opportunities for operational improvements (best practices)

#### Team Responsibilities
- Oversight and monitoring
- Establish procedures and controls for CDM and charge capture operations – monitor effectiveness to maintain best practice operations.
- Monitor Hospital and departmental activities
  - Annual CDM reviews
  - Periodic charge capture, documentation reviews
  - Compliance with charge capture standards (daily charge posting, daily reconciliations, late charges, etc.)
- Denial prevention
- Data analytics and benchmarking
- Oversee implementation of new regulations
- Maintain action plan
CDM Revenue Cycle - Infrastructure

- Regulations
  - Merely distributing regulations, coding/billing information to affected clinical areas RARELY achieves accurate and compliant reporting
  - CDM end-users are responsible
  - Follow-up and action plans
  - Maintain key regulations (e.g., paper binder)
  - Part A vs. Part B

Future Regulatory Updates

- Designated individual compiles updates
- Send to Revenue Cycle Team prior to meeting
- Invite affected departments, as needed
- Discuss and implement controls
- Action plan with follow-up
- Testing of change, where appropriate
Scott Treida, MT (ASCP), CPC

Mr. Treida is a Director with Blue & Co., LLC on the Indianapolis Revenue Cycle team. Scott started consulting with Blue & Co. 20 years ago. He is responsible for coordinating and performing detailed work related to Blue & Co.’s revenue cycle management services; concentrating on chargemaster (CDM) and coding quality reviews, regulatory compliance, and revenue cycle team development. Scott is a frequent presenter at local and national professional associations.

Scott is a graduate of Indiana University with degrees in Biology and Medical Technology. He is a certified professional coder (CPC), and Medical Technologist with board certification by the American Society for Clinical Pathology (ASCP).

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