Finding Revenue Through your Chargemaster

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REVENUE INTEGRITY MANAGEMENT RESOURCES

Agenda

- Hospital Chargemaster
- Identifying Services Provided but Not Set Up
- Steps to completing a CDM Review
- Summary

Goals of this Education

- Understand efficient Chargemaster Management
- Identify Revenue Opportunities
- Steps to Completing a CDM Review

tal Chargemaster

Hospital Chargemaster

What Is a "Chargemaster"?

- A hospital-specific computer file that includes all procedures, services, supplies, and drugs provided by the organization.
  - Billable services
  - Drugs
  - Supplies
- Most hospital chargemasters include many thousands of line items and their information varies widely.

Hospital Chargemaster

- Without accurate HCPCS and/or the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT) codes and revenue codes, hospitals will not receive *proper reimbursement* for services rendered. Claim rejections, underpayments, overpayments, fines, and penalties may result."
- Largest file is your hospital that can "make or break" financial bottom line.

Hospital Chargemaster

The chargemaster maintains one of the most important functions in a hospital but often it is one of the last areas of focus because of its extensive amount of detail and the time required to maintain it.

Hospital Chargemaster

Benefits of an accurate Chargemaster:

- Correct services are captured for billing
- Decrease in claim rejections and denials
- Decrease in lost charges
- Fewer appeals or corrections
- Accurate information for decision support
- Increased reimbursement

Hospital Chargemaster

How a hospital uses its chargemaster varies:

- **Hard coding** (Coded from the chargemaster)

versus

- **Soft coding** (Coder is flagged that a surgery occurred from the chargemaster ("OR Level II," for example); then the coder identifies the actual CPT codes for the surgery)
- **Order entry** (Radiology)

Hospital Chargemaster

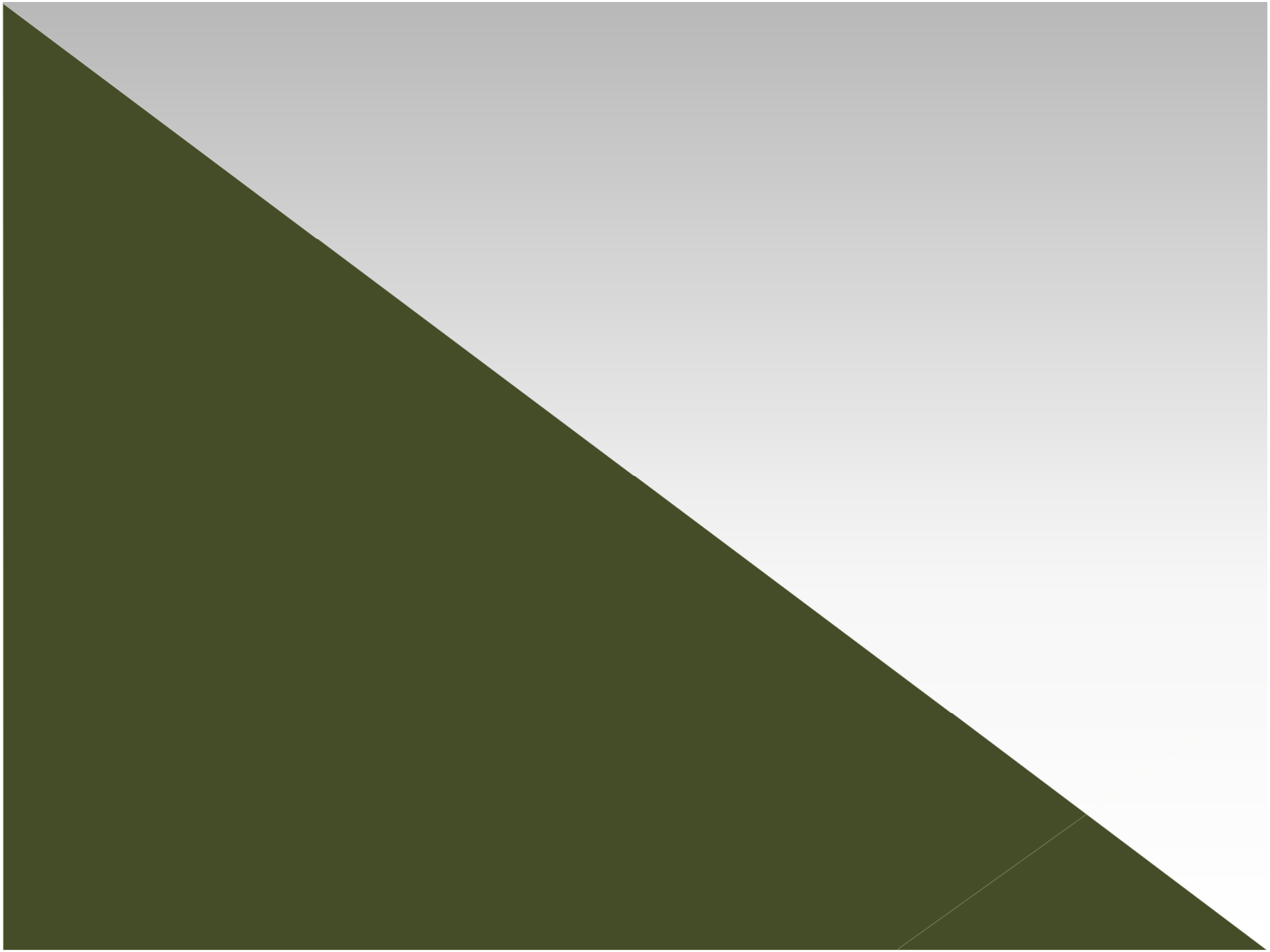
The Health Information Management (HIM) department (e.g., coders) usually codes major surgery (CPT 10000-69999), but the chargemaster has to be set up appropriately for this to be effective. These are often called "price buckets".

CDM Number	Billing Description	G/L Key	CPT	R.C.
43000107	I&D SUBCUT ABSC SIMP	430	10060	450
43000205	I&D SUBCUT ABSC COMP	430	10061	450
43000302	I&D PILONIDAL ABSC	430	10080	450
70210033	OR SURG LEVEL 1 1ST HR	403	-	360
70220031	OR SURG LEVEL 1 EA ADDL 15 MIN	403	-	360
70230035	OR SURG LEVEL II 1ST HR	403	-	360
70240036	OR SURG LEVEL II EA ADDL 15 MIN	403	-	360
70250044	OR SURG LEVEL III 1ST HR	403	-	360
70260018	OR SURG LEVEL III EA ADDL 15 MIN	403	-	360

elling Question #1

Q: How often should we review the OPPS (Outpatient Perspective Payment System) Code Updates?

1. Once per year
2. Twice per year
3. Three times per year
4. Four times per year



OPPS

Review the OPPS (Outpatient Perspective Payment System) Code Updates four times per year. While the majority of coding updates occur on January 1st of each year, the OPPS provide quarterly updates that should be reviewed on the Medicare Learning Matters Network. (January, April, July, October)

- April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS):

MM12175 (cms.gov)

- Annual Updates:

Addendum A and Addendum B Updates | CMS

dentifying Services Provided ut Not Set Up – Find the Money!

Find the Money

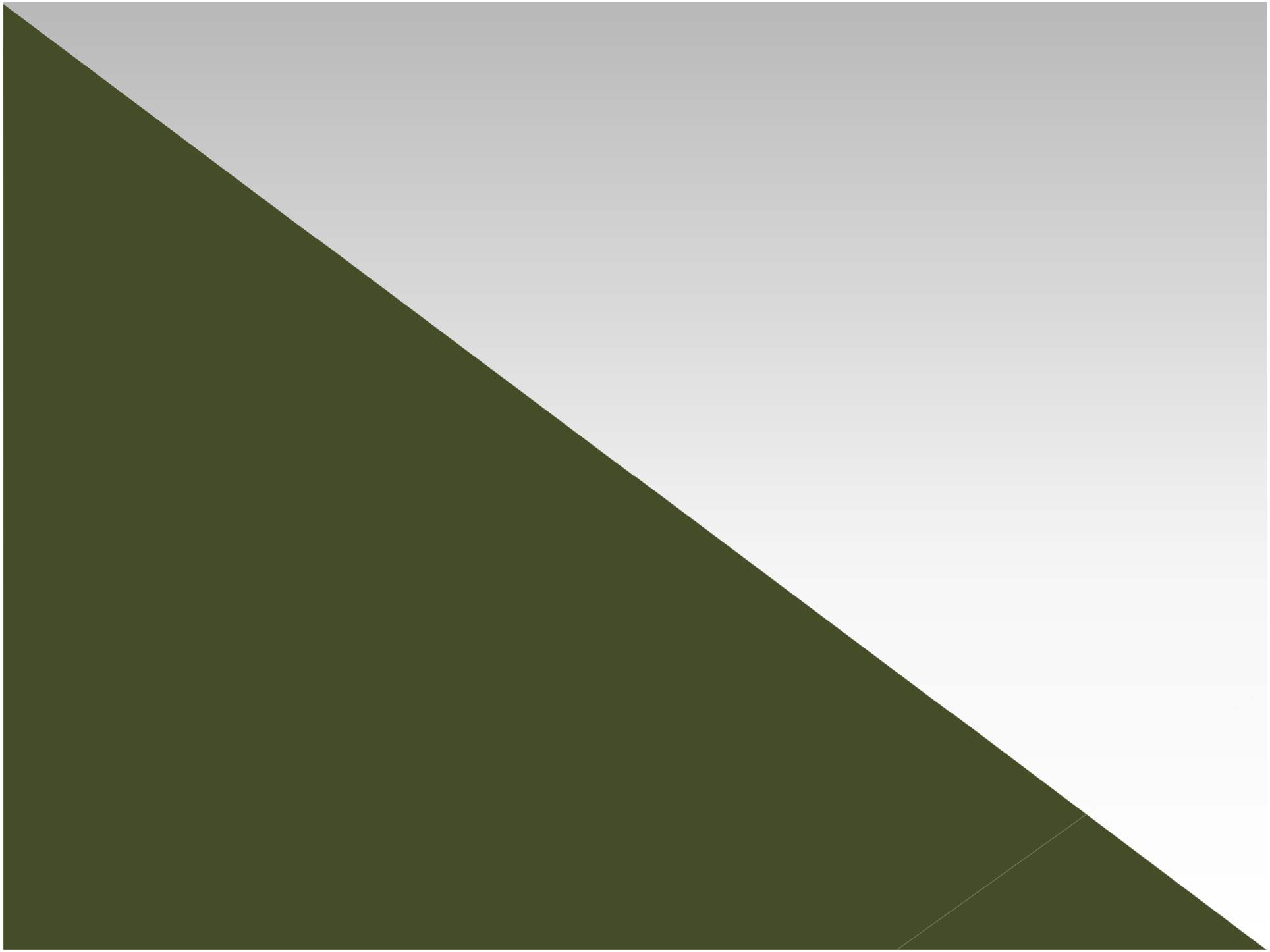
Target large revenue-producing areas of the facility or departments with complex coding of outpatient services

- Facility Evaluation & Management Clinic Codes
- Blood Transfusions, infusions & injections, CPR and Bedside Procedures in Med/Surg
- Emergency Room Facility and Professional Procedures
- Operating Room Anesthesia and Recovery
- Post-operative Pain Blocks

lling Question #2

Q: Facility Evaluation & Management coding may be based on Physician time and criteria.

1. Yes
2. No
3. Unsure
4. N/A



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CMS provided clarification regarding these principles as follows:

- Hospital-specific guidelines should not be based on physician resources. However, this does not preclude a hospital from using or adapting the physician guidelines if the hospital believes that such guidelines adequately describe hospital resources.

- Hospitals with multiple clinics may have different coding guidelines for each clinic, but the guidelines must be applied uniformly within each separate clinic.

ind the Money

Evaluation and Management (E/M) – A Commonly Confused Category: Verify E&M codes set up

- Can apply to many **FACILITY** outpatient settings: OB/GYN, Wound Care, General Surgery Clinic, Provider-based Clinic, Cancelled Cases in Pre-op area or Radiology: 99202-99215/HCPCS G0463
- Verify that they have a FACILITY E&M methodology: Medicare E&M requirements templates for OP Clinic, L&D, Wound Care and Cancelled Cases
  - AHA/AHIMA's Draft E/M Guidelines for Hospital Outpatient Care (cms.gov)

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CMS E&M GUIDELINE PRINCIPLES

CMS has identified 11 principles that hospitals' internal coding guidelines for visit coding are expected to follow. (See CY 2008 Outpatient Prospective Payment System (OPPS) final rule, published in the Federal Register on November 27, 2007). The first six principles have been reaffirmed, while the next five have been newly added for CY 2008.

In January 2014, under the OPPS changes, Medicare collapsed the E&M CPT 99201-99215 for all New & Established codes to one HCPCS Code G0463. (In 2021, CPT Code 99201 is no longer valid per the American Medical Association.)
Therefore, the guidelines listed below may be used for non-Medicare facility E&M carriers that utilize CPT codes listed above:

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CMS E&M GUIDELINE PRINCIPLES

1. Guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code;
2. Guidelines should be based on hospital facility resources, not physician resources;
3. Guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits;
4. Guidelines should meet the Health Insurance Portability and Accountability Act (HIPAA) requirements;

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CMS E&M GUIDELINE PRINCIPLES

5. Guidelines should only require documentation that is clinically necessary for patient care;
6. Guidelines should not facilitate upcoding or gaming.
7. Guidelines should be written or recorded, well-documented and provide the basis for selection of a specific code;
8. Guidelines should be applied consistently across patients in the clinic or ED to which they apply;

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CMS E&M GUIDELINE PRINCIPLES

Guidelines should not change with great frequency;
10. Guidelines should be readily available for fiscal intermediary (or, if applicable, Medicare administrative contractor) review; and,
11. Guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

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Per AAPC:

- "The **facility charge** represents the hospital's cost associated with caring for the patient's face-to-face visit. This can include nursing salaries, benefits, supplies, equipment, and/or indirect and direct costs for operating the clinic. Face-to-face nursing care tasks are not separately chargeable. For example: taking a patient's vitals, pain assessment, patient education, discharge instructions, specimen collection, and additional nursing assistance
- The **physician's charge** represents the E/M service, and the physician chooses the appropriate CPT® code based on several components like patient history, examination, medical decision-making, counseling, etc." In 2021, this changed to time and or criteria.

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- E&M levels may be set up with nursing interventions and/or time
- An E/M code should only be reported when the medical record documentation supports that a distinct evaluation and management service was provided as defined in the decision making tool. The existence of nursing services, such as doppler measurement or extremity pulses, that are not considered inherent in a performed procedure do not by themselves constitute a distinct evaluation and management service.

ind the Money

Emergency Room: Missing surgeries: Surgical procedure facility fee should be charged in addition to the ER level facility charge

- This is separate from the physician billing for the professional component of the surgical procedure. Example:
  - Patient presents to the ER

    CPT 99283 facility E/M charge
  - Surgical procedure also performed

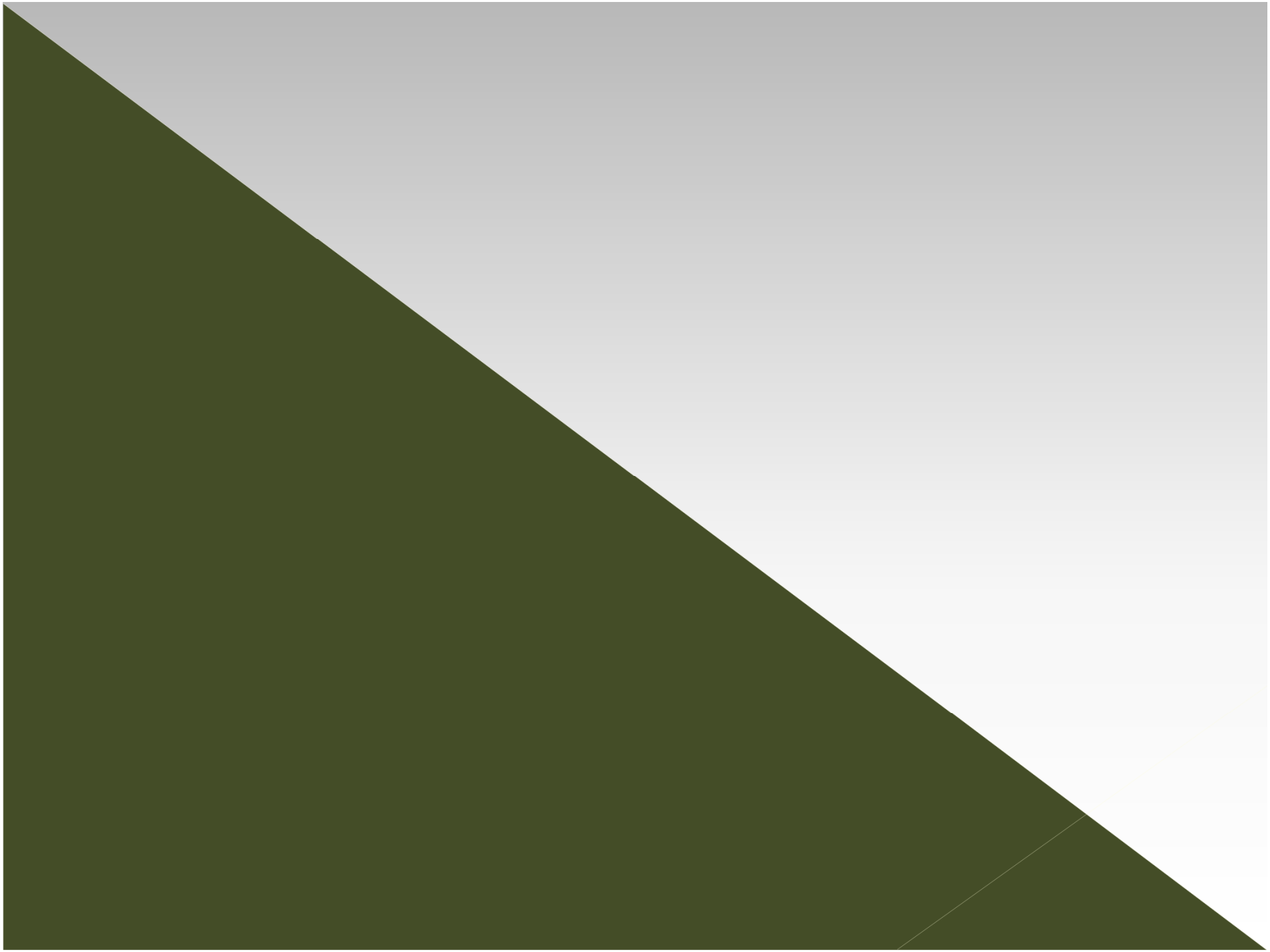
    Facility charge: CPT 12001 repair superficial wound

    Professional charge: CPT 12001 (if CAH bills physician services)

lling Question #3

Q: Is it appropriate to bill for Observation per Hour in addition to the Direct Referral for Observation Services?

1. No
2. Yes
3. Unsure
4. N/A



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- A: Yes. Patients Placed Directly for Observation. Report HCPCS G0379 in addition to G0378:
- Report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure), on the day of initiation of observation services.
- Bill just one unit of HCPCS G0379
- Patients presenting to the Emergency Room would not have G0379 on the claim

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- Are you billing for bedside procedures performed by nurses?
  - Infusions
  - Injection
  - Transfusions
  - Insertion of catheter
  - Bladder irrigation
  - Gastric intubation
  - Arterial puncture
- Facilities should charge for these procedures when the status is outpatient

ind the Money

- Bill one line item of G0378 with the total hours listed as units– do NOT bill more than one line item of G0378!
- Direct Admission to observation (G0379) should be billed in addition to G0378 for total hours.
- Direct Admission can occur anywhere EXCEPT the ER.

Find the Money - Compliance

Pulmonary: Bill Airway Inhalation Treatment (CPT 94640) "once per encounter" (outpatient only)

- Q: In the outpatient setting, is it appropriate to bill for more than one Airway Inhalation Treatment (CPT 94640) in a single "encounter"? Yes or No.

- A: No, not in the outpatient setting such as ER and/or Observation. While non-Medicare payors may have distinct billing rules, NCCI defined an "encounter" as the time that a patient presents to the time the patient is discharged.

Find the Money - Compliance

Per Ch. 11 of NCCI: 8. CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) shall not be reported separately.

Find the Money - Compliance

It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.

NCCI Chapter11_CPTCodes90000-99999_Final_11.12.19.pdf

National Correct Coding Initiative Edits | CMS

ind the Money

Infusions and Injections:

- Remember to charge for each drug infused/injected as well as the administration code in the ER and Nursing Floors

- Example: 100 mg Testosterone is injected, IM
  - **Drug**: J3150 Testosterone, up to 100 mg is charged
  - **Injection**: 96372, therapeutic or diagnostic injection, subQ or IM

Find the Money

Pharmacy:

- Do NOT bill units based on the way the drug is administered, stocked, or packaged
- Audit all drug descriptions against CMS for accurate billing units
- Review any dosage to billing unit system calculator or crosswalk
    - This will create a cleaner claim with a faster turn around time in payment and less staff rework

Find the Money

Accurate Billing of Drug Units (Drug Undercharged)

- Example, Ondansetron to prevent nausea and vomiting: HCPCS **J2405, per 1 MG**
- Typically ordered and administered 4 MG units. Therefore, billed units on UB04 should be 4.
- Many claim reviewed identify just one unit billed. Under-bill by 3 units.

Find the Money

Large dollar devices are missed; they should be charged separately

- Example:
  - OR procedure 57288 – Sling Operation for Stress Incontinence
  - Implantable Mesh (**C1781**) with Revenue Code **278** (Implantable Supply)

Steps to Reviewing a Chargemaster

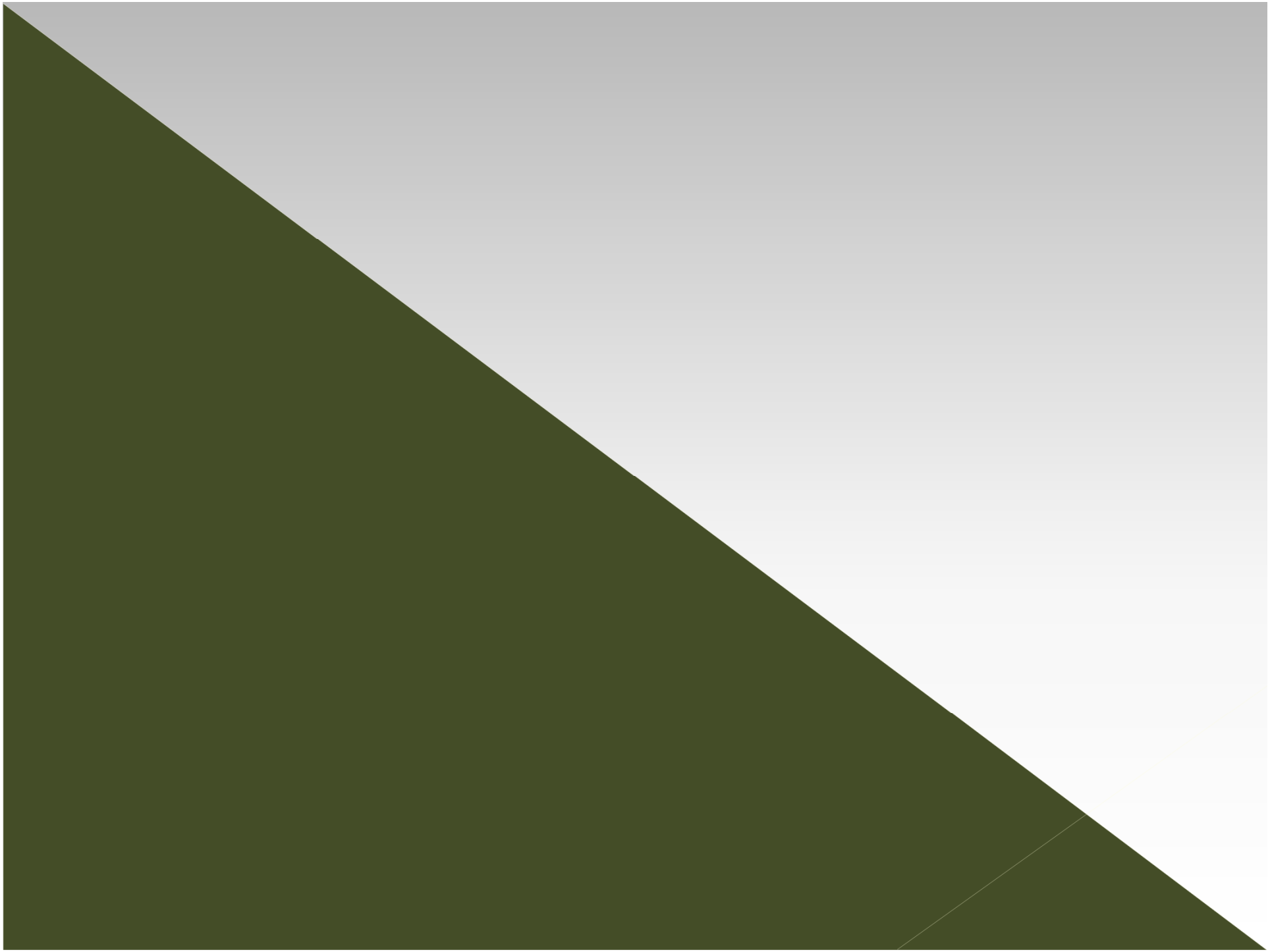
CDM Review

- Review the Chargemaster at least twice per year with each department manager providing outpatient services.
- Request each manager to look at their Revenue & Usage monthly to verify accurate use of services, supplies and drugs.
- Run chargemaster by CPT/HCPCS to look for price discrepancies of “like” codes (except for Laboratory, Pharmacy and Supply departments).
- Clean up the Chargemaster: Review line items with zero Revenue & Usage for 12-18 months for possible inactivation if no future use planned.
- Post a “read-only” copy of entire Chargemaster on hospital Intranet

lling Question #4

Q: Are CAH required to report the waste of single-dose vial drugs with Status Indicator G or K?

1. Yes
2. No
3. Unsure
4. N/A



CDM Review

- A: Yes, CAH facilities are required to report the waste for applicable drugs in the outpatient setting. This does not apply to inpatient billing.

- Per Medicare FAQ: "This policy applies to providers and suppliers who buy and bill drugs and is intended to track discarded amounts of drugs that occur as a result of the preparation of a drug dose for administration to a beneficiary. We anticipate that the JW modifier will be used mostly in the physician's office and hospital outpatient settings for beneficiaries who receive drugs incident to physicians' services. The JW modifier requirement also applies to Critical Access Hospitals (CAHs) since drugs are separately payable in the CAH setting.

DM Review

The JW modifier requirement applies to all separately payable drugs with status indicators G (Pass-Through Drugs and Biologicals) or K (Nonpass-Through Drugs and Non-implantable Biologicals, Including Therapeutic Radiopharmaceuticals) under the OPPS for which there is an unused or discarded amount."

The OPPS payment status indicators (SI) can be found in Column C of Addendum B.

JW Modifier: Drug/Biological Amount Discarded/Not Administered To Any Patient Frequently Asked Questions (cms.gov)

Addendum A and Addendum B Updates | CMS

Addendum D1 (cms.gov)

DM Review

Pharmacy

- Audit drug multipliers against the HCPCS dosage unit of measurement
- NDC-to-HCPCS: Use Palmetto file
- PDAC - 2020 NDC/HCPCS Crosswalk (dmepdac.com)
- Look for Self-Administration Rev Code 637: Are they billing SAD? Per a 2015 OIG (Office of Inspector General) Memo, this is an "all or nothing" game

- OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings (hhs.gov)

CDM Review

- Verify that CPR is set up (CPT 92950) in Med/Surg
- Look for facility Anesthesia (Rev Code 370) and Rev code 710 for Recovery in Surgery Department/PACU
- Post-Operative Pain Blocks (CPT 64450, example) for Orthopedic Procedures
- Wound Care, Clinics and L&D should have facility E&M (CPT 99211-99215) set up
- The ER must have 99281-99292 CPT codes

CDM Review

Look at Revenue & Usage by department.

- Look for HCPCS G0257 in ER. Ask if they provide unscheduled or emergent ESRD in the ER (G0257)
- Is there volume for Observation (G0378 and G0379)? There should be ☺
- Volume in bedside services on nursing floors?
- CPR set up and volume? CPT 92950
- Blood Transfusion set up and volumed? CPT 36430 typically 1/3 – ½ of total blood unit volume (example, P9016 Red Blood Cells). Audit revenue codes 390 and 391

CDM Review

- **Radiology**: look for contrast materials Q9967 if any "CT with Contrast" procedures set up. Bill per 1 ML unit
- **Respiratory Therapy:** look for "Unlisted Pulmonary Procedure" CPT 94799 set up with unbillable services such as Incentive Spirometry, Trach Care, Consultation. Review to inactivate.
- **Cardiac Cath and Endoscopy**: Conscious Sedation CPT codes 99152-99157.
- **Emergency Room**: Sort facility and professional surgical procedures (10XXX – 69XXX) by CPT codes. They should be an exact 1:1 match. Build procedures missing from either department.

DM Review

Verify bedside services are set up:

- Infusion & Injections
- Observation, per hour
- Cardioversion,
- Elective Gastric Intubation & Aspir
- Blood Transfusion
- Removal of devitalized tissue
- Neg pressure wound therapy
- Neg pressure wound therapy
- Paracentesis

DM Review

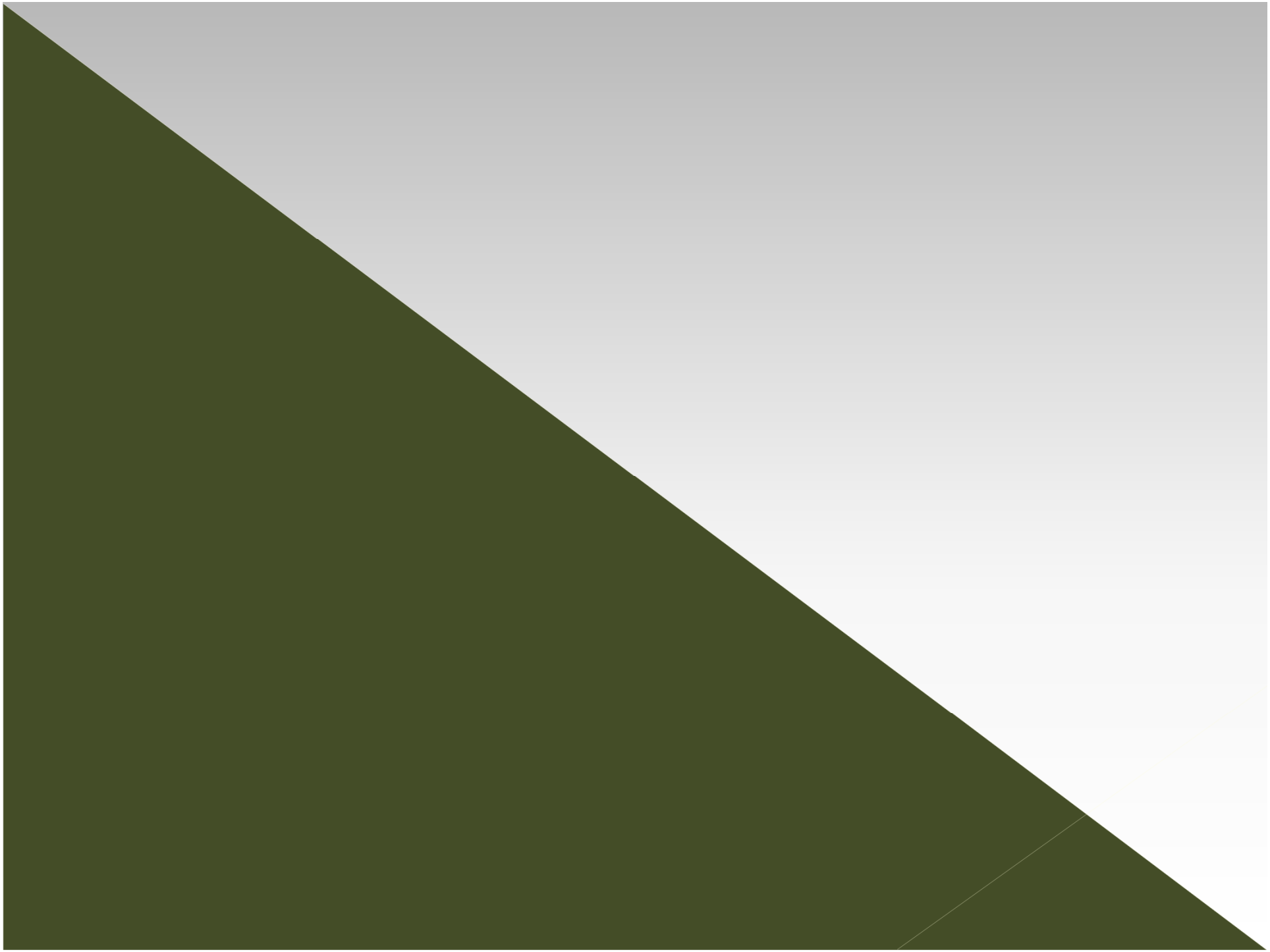
OB/GYN and L&D

- Bladder irrigation, simple
- Measurement of postvoiding by ultrasound Ther/proph/diag inj, sc/im
- Ther/proph/diag inj, ia
- Therproph/diag inj, iv push
- Observation G0378 & G0379
- Clinical E&M 99211-99215 (Triage Levels)

lling Question #5

Q: Does your hospital carve out total procedure time (CPR, Intubation) from the Critical Care time in the Emergency Room?

1. Yes
2. No
3. Unsure
4. N/A



CDM Review

- A: Per CMS, the procedure time should be deducted from Critical Care time. This is typically a manual process and if you are unsure of the answer, check with your outpatient coders, case management and ER Manager.
- The Critical Care Clock "stops" when performing non bundled, separately billable procedures. The time spent performing these procedures should not be included in the total Critical Care time:

CDM Review

Critical Care:

- The time that can be reported as critical care is the time spent by the hospital staff engaged in active face-to-face critical care related to the individual patient's care.

- Time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments.
  - Exp: 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date.

CDM Review

Separately billable procedures during Critical Care:

- CPR (92950) (while being performed)
- Endotracheal intubation (31500)
- Central line placement (36555, 36556)
- Intraosseous placement (36680)
- Tube thoracostomy (32551)
- Temporary transvenous pacemaker (33210)
- Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only (93010)
- Elective electrical cardioversion (92960)

- Exp: 60 minutes of total critical care time in which CPR required 10 minutes, intubation required 5 minutes, and the insertion of a central line required 5 minutes, would equal only 40 minutes of billable critical care time.

DM Review

Common Procedures BUNDLED into Critical Care Time Billing:

- Interpretation of cardiac output, chest x-rays, pulse oximetry, blood gases, information/data stored in computers
- Gastric intubation (e.g. nasogastric tubes)
- Temporary transcutaneous pacing
- Ventilatory management
- Blood draws for specimen
- Peripheral vascular access

CDM Review

The CPT critical care codes are 99291 and 99292

99291

- can only be billed with one unit on a given calendar date of service
- used to report first 30 – 74 minutes of critical care services

99292

- add-on code (cannot be billed without reporting 99291)
- used to report additional block(s) of time in 30 minute increments beyond the first 74 minutes of critical care services

CDM Review

Do not bill critical care time of less than 30 minutes:

- Exp: a patient with an active MI who is expedited from the ED to a cardiac catheterization lab within 25 minutes of arrival does not qualify as a critical care service, even though such care was provided. This should be reported using another appropriate E/M level code.

CDM Review

ER Trauma activation: Verify revenue code 68X as the level of trauma designated by the state.

- **G0390**: Trauma Activation with Critical Care
- Trauma Activation < 30 Minutes (Revenue code 68X and no associated HCPCS)

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No hospital or facility wants to miss an opportunity for improving their cash flow:

- Review the chargemaster for accuracy and completeness.
- Provide high-dollar department audits to ensure all charges are getting on the bill.
- Look for the low-hanging fruit—items being provided but not captured.
- Run the Chargemaster by CPT/HCPCS code: if you have both pro & facility fees set up, make sure there are corresponding CPTs for both!

ummary

Additional means of ensuring correct charge capture:

- Implement a daily reconciliation process of auditing charge tickets to patient census.
- Monitor revenue and usage reports.
- Perform Charge Capture Audit of the medical documentation to the UB-04 and Explanation of Benefits (EOBs) from insurance company.
- Review CMS Quarterly Changes for CPT and HCPCS updates.

ummary

- Provide an overview of the Hospital Chargemaster as a "CDM Kick-off". Ensure every employee understands they affect the charge capture process and the detail of what happens to their charge as it goes through the billing system.
- Teach employees that accurate charging is a part of everyone's job, whether they are in a clinical or financial position.
- Educate staff on the proper use of HCPCS descriptions.

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Assist in providing policies and procedures to standardize services and techniques:

- Standardize charge ticket formats.
- Create one online chargemaster change form for ease of use and to provide a tracking tool.
- Appoint one staff person as CDM Coordinator.
- Use a standard supply mark-up method.
- Develop a Routine Supply Policy of supplies bundled into procedure and a Non-routine Supply Policy for those to be charged separately.

ummary

Recommend a Chargemaster Compliance Committee:

- Include Finance, Compliance, Billing, Coding, Case Management, and "Chargemaster Coordinator."
- Review CMS updates quarterly to ensure changes are immediate and disseminated appropriately within departments, and updates occur to maintain compliance with government regulations and the Office of General Inspector (OIG).

ummary

Recommend that Materials Management create a process for physician ordering of large dollar, non-stock supplies:

- All devices ordered through Materials Management
- All sales associates work through Materials Management
- Ensures best price through preferred vendor contracts

ummary

Recommend the addition of billable, large dollar supplies to departmental charge tickets/order entry screens:

- Ensures supplies are billed
- Simplifies charging for staff
- Allows for supply tracking

tions?

Thank You!

69

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70

Resources

- All CPT/HCPCS codes, description and dosage unit recommendations provided by PPS were based on 201 9CMS guidelines found in the Hospital Outpatient PPS Addendum A&B found in the following website: www.cms.gov/HospitalOutpatientPPS/AU/list.asp

- Observation recommendations are based on the following Medicare guidelines found on the CMS website: www.cms/gov/manuals
  - a. Transmittal 1745
  - b. Transmittal 1445
  - c. Transmittal 1760
  - d. Medicare Claims Processing Manual, Ch 4, 290.4.1 and 290.2.2

71

Resources

- Medicare Benefit Policy Manual, CMS IOM Publication 100-02, Chapters 1, 6, 8, 10, and 13
- Medicare Claims Processing Manual, CMS IOM Publication 100-04, Chapters 1, 3, 4, 9, and 15
- HFMA "Missed Opportunities: Your Strategy for Correct and Complete Charge Capture"

72

Resources

CMS Manual System IOM, Pub 100-4, Medicare Processing Manual:

- Chapter 1, Section 50
- Chapter 3, Section 30
- Chapter 4, Section 250

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