

*CPAs / ADVISORS*



# Chargemaster Compliance & Revenue Capture

ICAHN Annual Conference | November 14, 2019

Scott Treida, MT (ASCP), CPC  
Blue & Co., LLC | Director

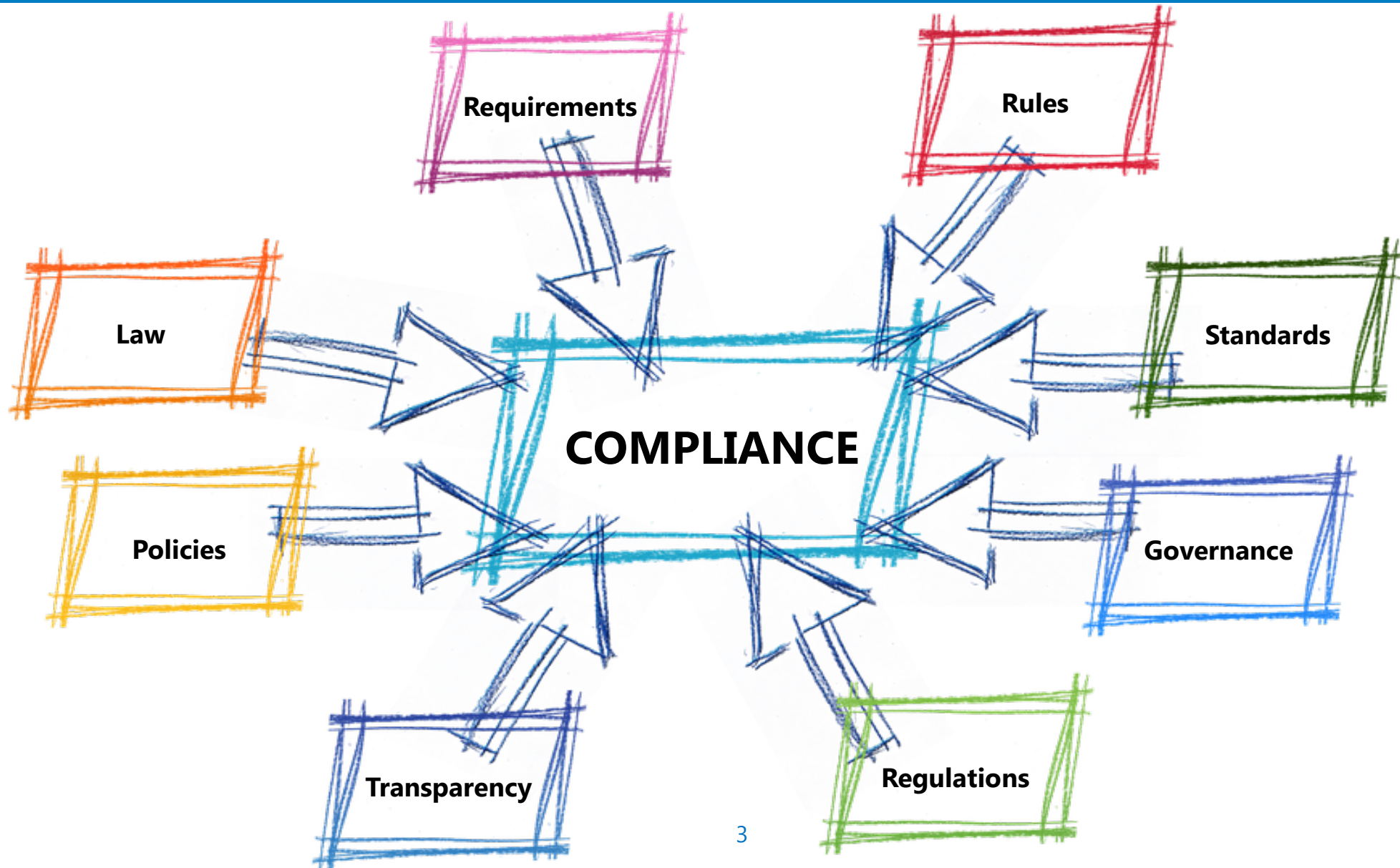
# CDM Considerations

- 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.



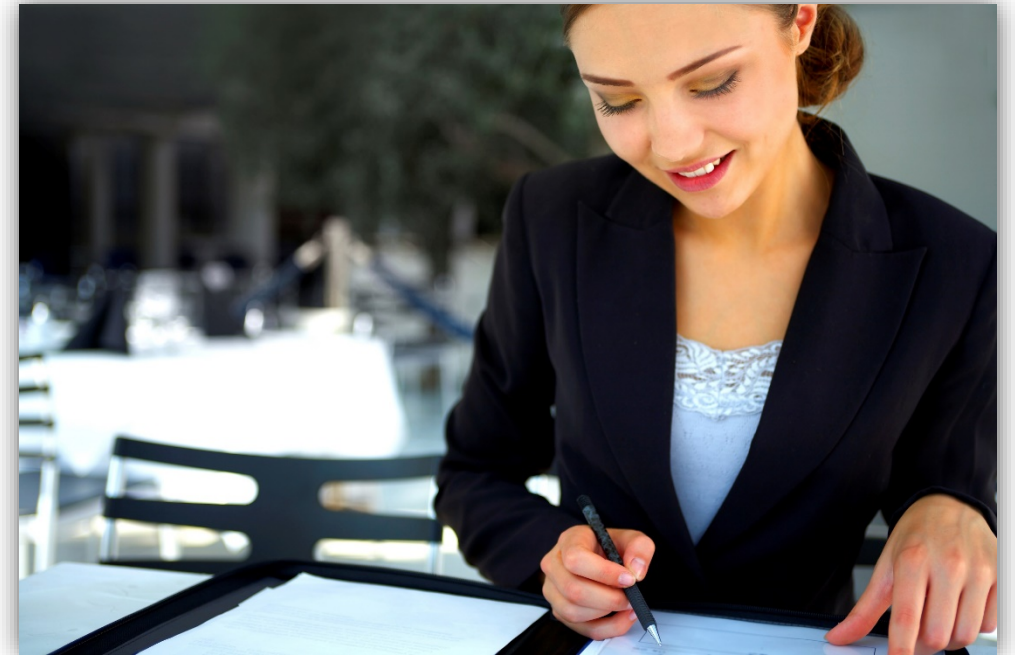
Clinical departments are responsible.  
Do not isolate them from the process.

# Coding and Charge Capture



# Claims Payment Reviews

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

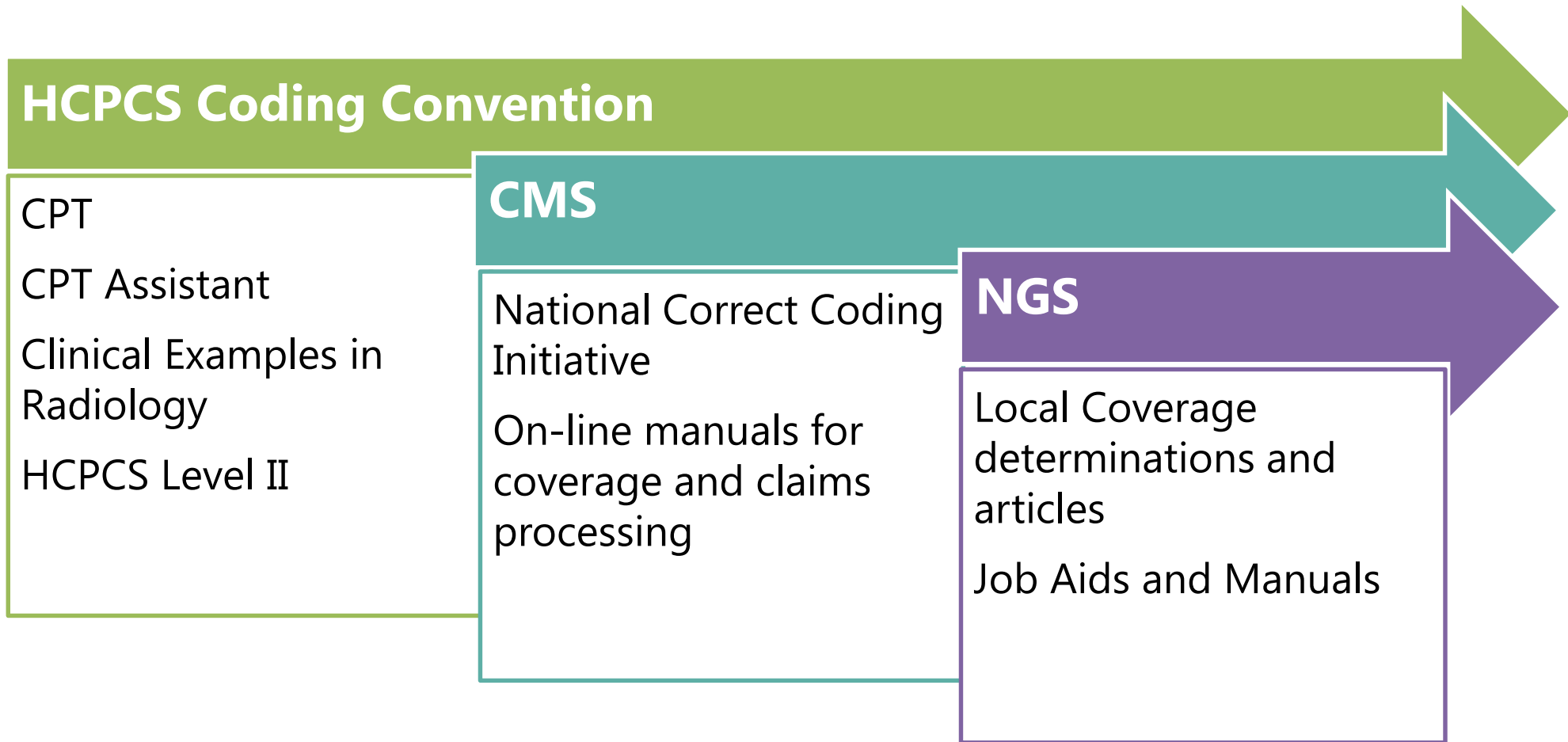


# CERT Medicare 2018, Part B

- Comprehensive Error Rate Testing (CERT) program
- FY 2018 Medicare FFS program improper payment rate was \$31.6B

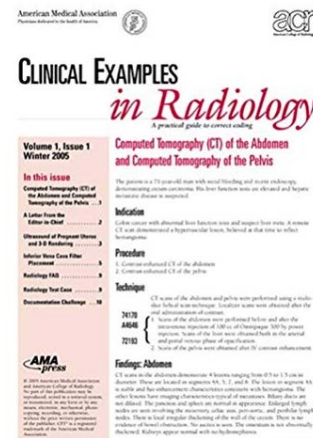
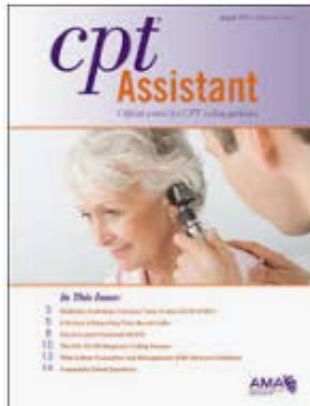
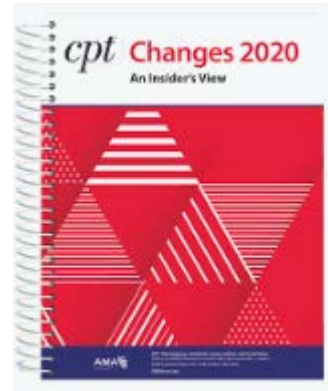
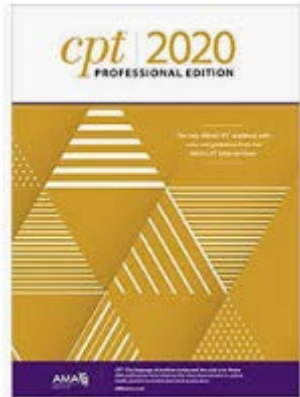
Category	Percent of Improper Payment Rate
No Documentation	2.6%
Insufficient Documentation	58.0%
Medical Necessity	21.3%
Incorrect Coding	11.9%
Other	6.3%
Total	100.0%

# Coding - References and Hierarchy





# CPT

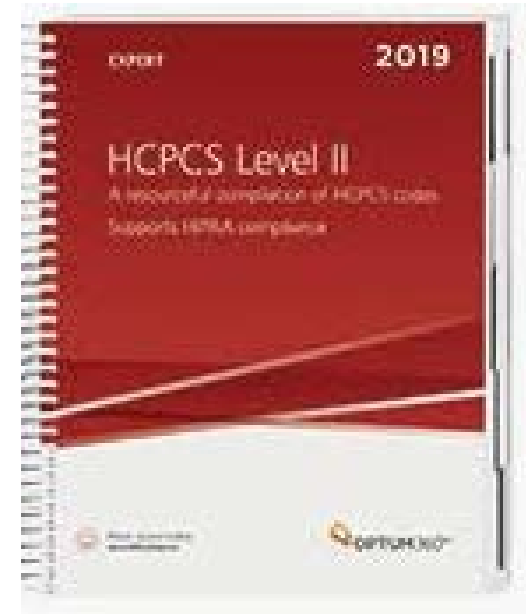


- E/M – 99XXX
- Anesthesia – 0XXXX
- Surgery – 10XXX-69XXX
- Imaging – 7XXXX
- Laboratory – 8XXXX
- Medicine – 9XXXX
- Cat. III – 0XXXT
- Modifiers - 25, 50, 59, etc.

# HCPCS Level II

## Alpha Numeric

- Supplies – AXXXX, CXXXX, LXXXX
- Orthotics/Prosthetics – LXXXX
- DME – EXXXX
- Drugs – CXXXX, JXXXX, QXXXX
- Procedures - GXXXX
- Modifiers – RT, LT, JW, etc.



Quarterly Updates – CMS Transmittals



# National Correct Coding Initiative

- Promotes national correct coding methodologies and to control improper coding leading to inappropriate payment in outpatient claims.
- Coding policies based on:
  - Coding conventions (CPT)
  - National and local policies and edits
  - Coding guidelines developed by national societies
  - Analysis of standard medical/surgical practices

# National Correct Coding Initiative

- 1,000s NCCI Procedure-to-Procedure edits
  - Physician
  - Hospital
- Edits are applied to same day services by the same provider to the same beneficiary.

CPT	Descriptor	Reason	Modifier	Status
74160	Computed tomography, abdomen; with contrast material(s)	Standards of medical / surgical practice	Allowed	Primary
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	Standards of medical / surgical practice	Allowed	Secondary

# National Correct Coding Initiative

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**USE OF MODIFIER 59 TO BYPASS  
MEDICARE'S NATIONAL  
CORRECT CODING INITIATIVE  
EDITS**


















Daniel R. Levinson  
Inspector General

November 2006  
OEI-08-02-00771

**Table 1. Code Pairs That Did Not Meet Program Requirements**

Type of Error	Projected	
	Percentage of Code Pairs	Allowed Amount (Millions)
Services not distinct	15%	\$31
Services not adequately documented	25%	\$28
- Primary, secondary, or both services not documented	12%	\$16 <sup>1</sup>
- Different code should have been billed	7%	N/A <sup>2</sup>
- Documentation insufficient to make a determination	5%	\$9
- Documentation not provided	1%	\$3
<b>Total</b>	<b>40%</b>	<b>\$59</b>

# National Correct Coding Initiative

 CHAP1-gencorrectcodingpolicies_final121218.pdf
 CHAP2-CPTcodes00000-01999_final103118.pdf
 CHAP3-CPTcodes10000-19999_final103118.pdf
 CHAP4-CPTcodes20000-29999_final103118.pdf
 CHAP5-CPTcodes30000-39999_final103118.pdf
 CHAP6-CPTcodes40000-49999_final103118.pdf
 CHAP7-CPTcodes50000-59999_final103118.pdf
 CHAP8-CPTcodes60000-69999_final103118.pdf
 CHAP9-CPTcodes70000-79999_final103118.pdf
 CHAP10-CPTcodes80000-89999_final121218.pdf
 CHAP11-CPTcodes90000-99999_final103118.pdf
 CHAP12-HCPCScodesA0000-V9999_final103118.pdf
 CHAP13-CPTcodes 0001T-0999T_final103118.pdf
 INTRODUCTION_final103118.pdf
 TableofContents_FINAL110618.pdf

## Compliance Considerations

- Know the edits and instructions for your services
- Understand when to apply PAYMENT DRIVEN modifiers, 59, RT/LT, etc.
- Differences between NCCI and CPT Assistant

# National Correct Coding Initiative

CHAP4-CPTcodes20000-29999\_final10312017.doc

Revision Date: 1/1/2018

CHAPTER IV  
SURGERY: MUSCULOSKELETAL SYSTEM  
CPT CODES 20000-29999  
FOR  
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES

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 29515, 29540, or 29580 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 20526-20615); (3) Debridement CPT codes (e.g., 11042-11047, 97597) and grafting CPT codes (e.g., 15040-15776) shall not be reported with a casting/splinting/strapping CPT code (e.g., 29445, 29580, 29581) for the same anatomic area. This subsection was moved from Section G (Fractures, Dislocations, and Casting/Splinting/Strapping), Subsection #2.

# National Correct Coding Initiative

CHAP5-CPTcodes30000-39999\_final10312017.doc

Revision Date: 1/1/2018

CHAPTER V  
SURGERY: RESPIRATORY, CARDIOVASCULAR,  
HEMIC AND LYMPHATIC SYSTEMS  
CPT CODES 30000-39999  
FOR  
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES

*6. CPT code 36415 describes collection of venous blood by venipuncture. Each unit of service (UOS) of this code includes all collections of venous blood by venipuncture during a single episode of care regardless of the number of times venipuncture is performed to collect venous blood specimens. Two or more collections of venous blood by venipuncture during the same episode of care are not reportable as additional UOS.*

*An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.*



# National Correct Coding Initiative

CHAPTER XI  
MEDICINE  
EVALUATION AND MANAGEMENT SERVICES  
CPT CODES 90000 - 99999  
FOR  
*NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES*

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.

# Local Coverage Determinations

Final LCDs for Contractor Results

[71 Records]

Selection Criteria:

Contractor(s):

States: Illinois

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Last

View Items Per Page:

25

ID	TITLE	EFFECTIVE DATE	REVISION EFFECTIVE DATE	END DATE	LAST UPDATED	STATUS	SELECT ALL
							<input type="checkbox"/>
<a href="#">L33646</a>	Botulinum Toxins	10/01/2015	10/31/2019	N/A	10/25/2019	Active	<input type="checkbox"/>
<a href="#">L33396</a>	Posterior Tibial Nerve Stimulation for Voiding Dysfunction	10/01/2015	10/24/2019	N/A	10/18/2019	Active	<input type="checkbox"/>
<a href="#">L35076</a>	Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	10/01/2015	10/24/2019	N/A	10/18/2019	Active	<input type="checkbox"/>
<a href="#">L36406</a>	Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	04/01/2016	10/10/2019	N/A	10/18/2019	Active	<input type="checkbox"/>
<a href="#">L33398</a>	Transcranial Magnetic Stimulation	10/01/2015	10/24/2019	N/A	10/18/2019	Active	<input type="checkbox"/>
<a href="#">L33585</a>	Breast Imaging: Breast Echography (Sonography)/Breast MRI/Ductography	10/01/2015	10/24/2019	N/A	10/18/2019	Active	<input type="checkbox"/>
<a href="#">L33576</a>	Urodynamics	10/01/2015	10/24/2019	N/A	10/17/2019	Active	<input type="checkbox"/>

# Local Coverage Determinations

- LCDs
  - Indications, Limitations, and/or Medical Necessity
- Local Coverage Articles
  - ICD-10 Codes that Support Medical Necessity
  - Coding Information
  - Documentation Requirements
  - Utilization Guidelines

# Barriers to Effective Charge Capture

- Perceived as a lower priority administrative function.
- Little to no training for those responsible for charge capture activities.
- Lack of formal policies and standards.
- Care providers and charge entry staff do not understand the risks associated and potential consequences for not capturing charges timely, accurately, and completely.
- Inadequate monitoring and feedback.



# 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?

# 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.



# CDM Considerations

- Limit access to the CDM with add/change forms
- Implementation of Regulatory Updates
  - RCT oversight
  - Process for identification and distribution
  - Billing, Coding, and Clinic perspective
  - Action Plan
  - Testing
- Annual review of the CDM by the clinical departments – including revenue and usage statistics



# CDM Considerations

Dept #	Charge #	Descriptor	RC	CPT	Mod	Charge	I/P Usage	O/P Usage
3170	4401559	Flowcytometry/ tc 1 marker	312	88184		\$ 128.00	6	30
3170	4400588	Flowcytometry/tc add-on	312	88185		\$ 29.00	6	30
3170	4400437	Flowcytometry/read 9-15	312	88189		\$ 81.00	6	30
3170	4401401	Decalcify tissue	312	88311		\$ 47.00	82	212
3170	4401427	Special stains group 1	312	88312		\$ 89.00	61	120
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	3	37

*CPT codes and descriptions only are copyright American Medical Association. All Rights Reserved.*

# CDM Considerations – Operating Room

- OR charge levels (example):
  - OR Level A – First 30 min
  - OR Level A – Add 15 min
  - OR Level B – First 30 min
  - OR Level B – Add 15 min
  - OR Level C – First 30 min
  - OR Level C – Add 15 min

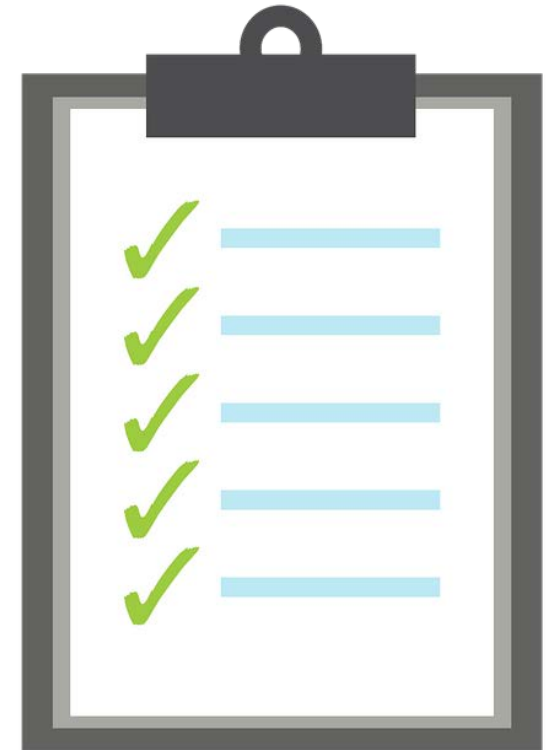


# CDM Considerations – Operating Room

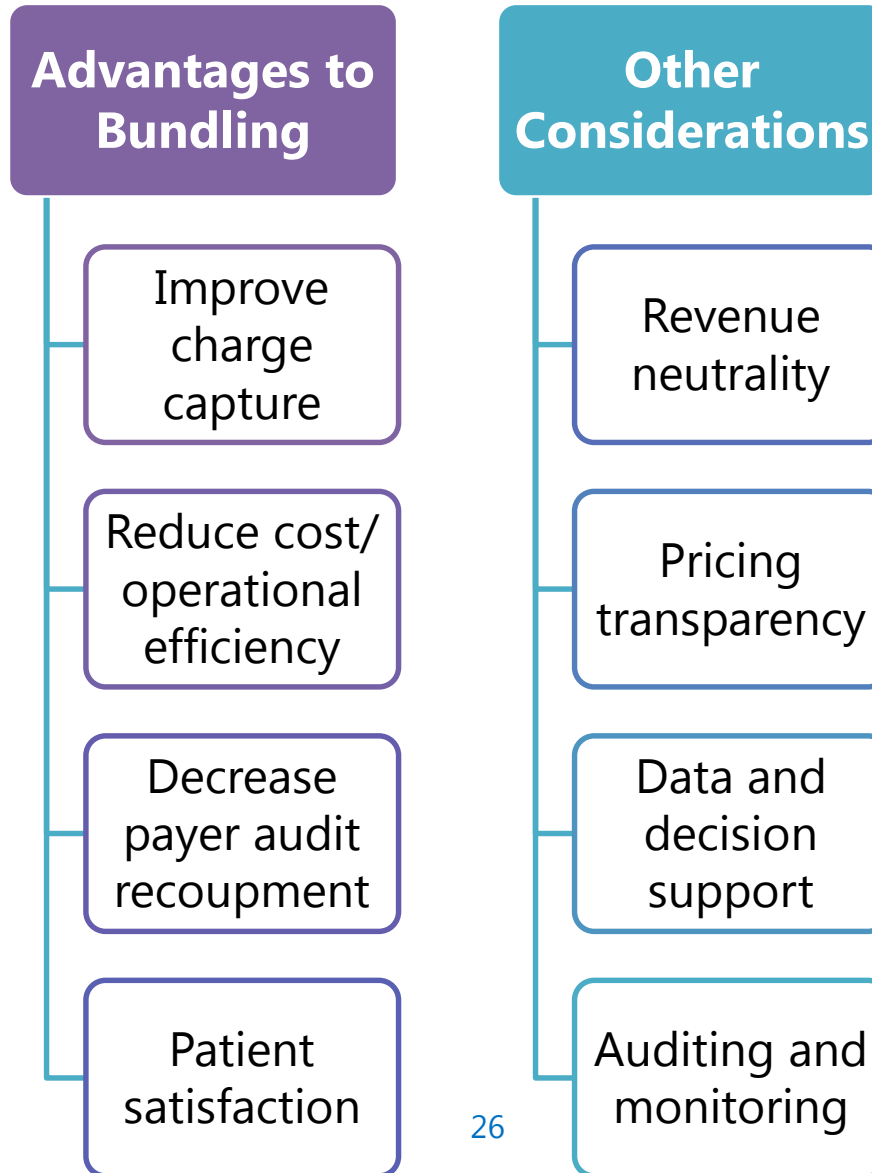
- Procedures mapped to charge levels based upon relative expenses (which are not charged for separately)
  - Equipment
  - Reusable instrumentation
  - Routine supplies
  - Staffing
  - Room turn-over
- Review annually
- Market comparison

# CDM Considerations - Supplies

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



# CDM Considerations - Supplies





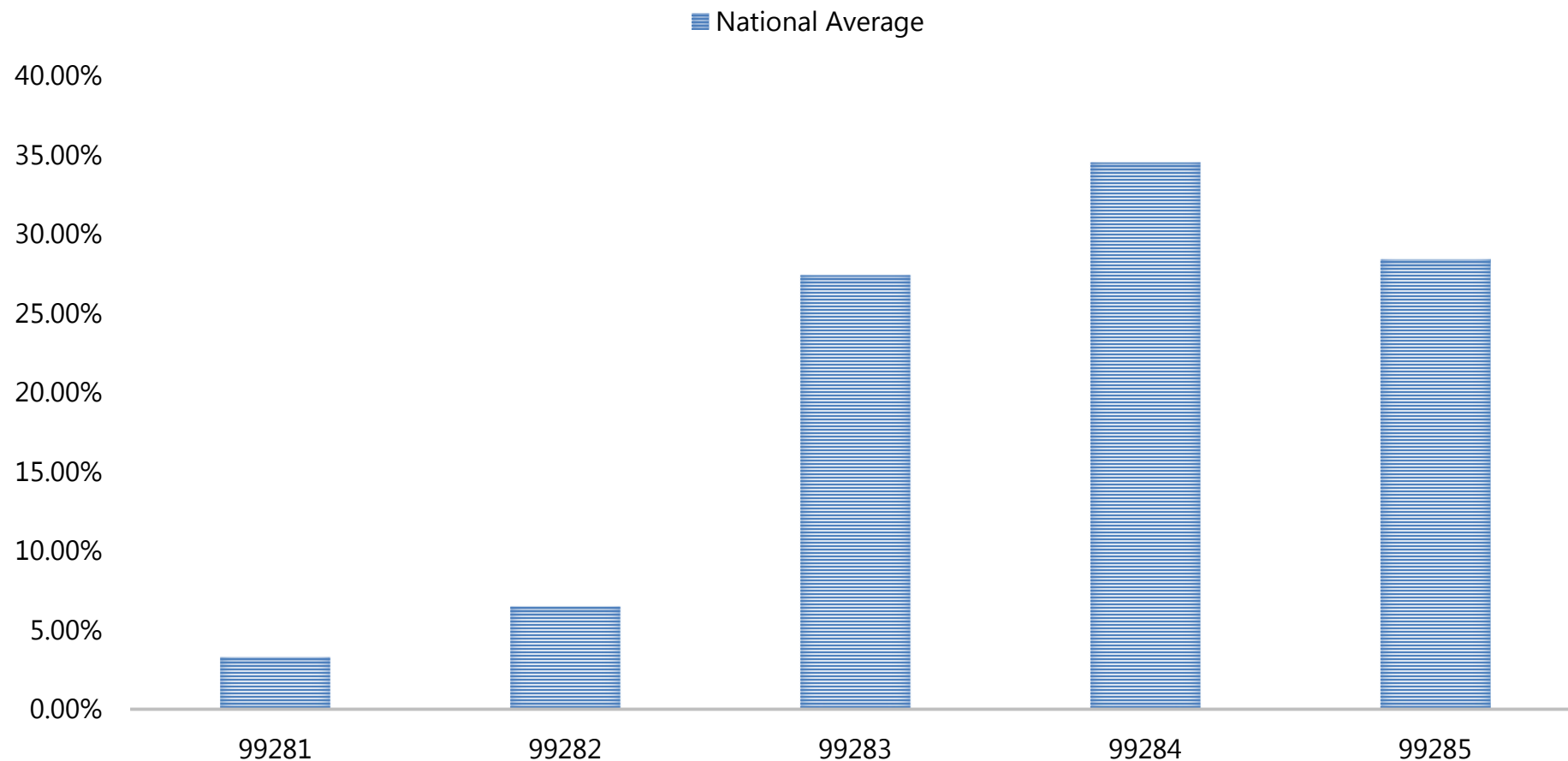
# CDM Considerations – Emergency Department

- CMS OPPS Final Rule 2018 - 11 guiding principles
- Distribution of ED visit levels
  - Facility
  - Medicare
  - Outpatient



# CDM Considerations – Emergency Department

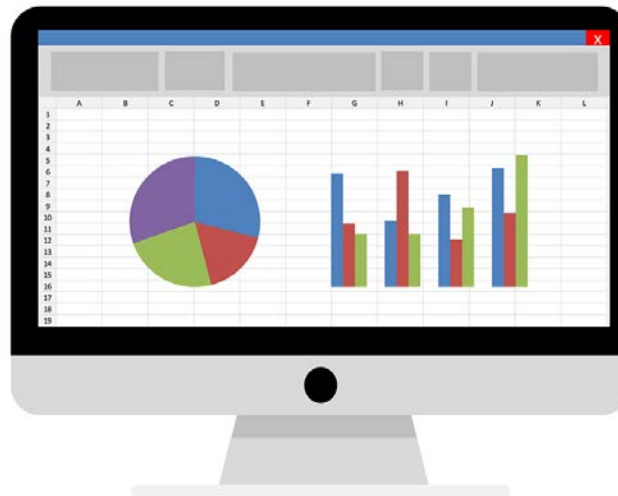
## MEDICARE OUTPATIENT – ED LEVELS



CMS Outpatient Standard Analytical File

# CDM Considerations – Emergency Department

- Benchmark common ED procedures to total ED visits - Outpatient
  - Initial infusions (96360, 96365)
  - IV pushes (96374, 96375, 96376)
  - Surgical procedures (10000-69999)
  - Critical care (99291)



# CDM Considerations – Charge Amounts

- Pricing Transparency
- Marking up formulas
  - Beware when using Medicare OPPS payment rates for surgical (or other) procedures that include significant packing. Device intensive procedures, comprehensive APCs, etc.
- Payer mix considerations
- Market analysis

# Questions



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Scott is a Director with Blue & Co., LLC on the Indianapolis Revenue Cycle team. Scott started consulting with Blue & Co. over 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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