Managing Your Hospital’s Chargemaster
October 10, 2013

Best Practice Chargemaster Management

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Practice Lead Compliance/Audit
Advisory Solutions - Revenue Cycle
Agenda

• Emerging Trends in Chargemaster Management
• Escalating Auditing and Monitoring
• CDM Utilization
• CDM Standardization
• Coding Approaches
• Chargemaster Management Planning
• Q&A
Emerging Trends in Chargemaster Management
Transparency

“The most comprehensive, consumer-friendly laws ensure ready access to information and data about a broad range of providers and services.”

*Health Care Incentives Improvement Institute*

*Report Cards on State Pricing Transparency Laws*

*March 2013*
Transparency

“Prices aren’t hidden from people buying a home or gas for their cars, and they shouldn’t be hidden from patients at hospitals either. Transparency helps Americans become smarter consumers,”

*Senator Finance Committee Chairman - Max Baucus*
Chargemaster Transparency

“By law, Medicare’s payments approximate a hospital’s cost of providing a service, including overhead, equipment and salaries.”

_Bitter Pill: Why Medical Bills Are Killing Us | TIME_
Chargemaster Transparency

“They were set in cement a long time ago and just keep going up almost automatically”

Bitter Pill: Why Medical Bills Are Killing Us | TIME
Chargemaster Transparency

• Correct codes
• Consistent application of mark-up formulas

• Protocols defining
  – Routine care and supplies
  – Room and board
  – Tiered/Bundled charges
    • Acuity based surgery levels
    • Labor, delivery and nursery levels
    • Clinic and E.R. levels
    • Ancillary tiered charges
Revenue Cycle Business Model

**Front-end**
- Patient access
  - Scheduling/registration
- IS support
- Medical records coding
- Charge capture/CDM coding
- Encounter services provided

**Back-end**
- Rejection processing
- Payment processing
- Appeals
- Contract management
- Third-party follow-up
- Claims submission
- Revenue generation
- Outpatient prospective payment system

Created by Fred J. Pane R. Ph.
CDM and the Revenue Cycle

• A current and accurate CDM is vital to any healthcare provider seeking proper reimbursement

• Without the CDM, the facility would not receive proper reimbursement

• Negative impact of an inaccurate CDM:
  – Overpayment
  – Underpayment
  – Undercharging for services
  – Claims rejections
  – Fines
  – Penalties
Packaged Services

• 2014 OPPS
• Release of bundled procedure codes
• Single physician/facility payment
2014 OPPS

The OPPS packages payment for multiple interrelated items and services into a single payment:

- to create incentives for hospitals to furnish services in the most efficient way by enabling hospitals to

- manage their resources with maximum flexibility, thereby encouraging long-term cost containment.
Trivia:
What does ‘APC’ stand for?
2014 OPPS

“adjunctive services”

integral, ancillary, supportive, dependent, and adjunctive services, hereinafter collectively referred to as “adjunctive services,” provided during the delivery of the comprehensive service
Adjunctive Services

This includes the

- diagnostic procedures,
- laboratory tests and other diagnostic tests, and treatments that assist in the delivery of the primary procedure;
- visits and evaluations performed in association with the procedure;
Adjunctive Services

• uncoded services and supplies used during the service;

• outpatient department services delivered by therapists as part of the comprehensive service;

• durable medical equipment as well as prosthetic and orthotic items and supplies when provided as part of the outpatient service;
Adjunctive Services

• and any other components reported by HCPCS codes that are provided during the comprehensive service,

• except for pass-through items, mammography services and ambulance services.
Comprehensive Services

• New Status Indicator J1 - Services paid through a comprehensive APC
• 29 comprehensive APCs to prospectively pay for device-dependent services associated with 136 HCPCS codes
• A single payment for the comprehensive service based on all charges on the claim
• A single beneficiary copayment, up to the cap set at the level of the inpatient hospital deductible
Existing Packaged Services

(1) Guidance services;
(2) Image processing services;
(3) Intraoperative services;
(4) Imaging supervision and interpretation services;
(5) diagnostic radiopharmaceuticals;
(6) contrast media; and
(7) Observation services.
New Packaged Services*

(1) Drugs, Biologicals, and Radiopharmaceuticals That Function as Supplies When Used in a Diagnostic Test or Procedure

(2) Drugs and Biologicals That Function as Supplies or Devices When Used in a Surgical Procedure

(3) Clinical Diagnostic Laboratory Tests

* Addendum P
New Packaged Services

(4) Procedures Described By Add-On Codes

(5) Ancillary Services (Status Indicator “X”)

(6) Diagnostic Tests on the Bypass List

(7) Device Removal Procedures
Health Systems

• Corporate CDM vs. Facility CDM
• Provider-Based Clinics
• Hospital Owned Physician Practices
  – Facility vs. pro fees
  – E&M services
Hospital Payment Methodologies – Coding Dependent

• **Prospective Payment Systems**
  – Hospital Inpatient
  – Hospital Outpatient

• **Fee-for-service**
  – Hospital outpatient ancillary
    • Lab
    • Therapy
    • Prosthetic and Orthotics (PO)
ESCALATING, AUDITING AND MONITORING
Trivia: Who is the S.C. Recovery Audit Contractor?
Who Is Watching?

- OIG (Office of Inspector General)
- DOJ (Dept. of Justice)
- FTC (Federal Trade Commission)
- CERT (Compliance Error Rate Testing)
- RAC (Recovery Audit Contractor)
- MIC (Medicaid Integrity Contractor)
- PSC (Program Safeguard Contractor)
- UPIC – combined ZPIC (Zone Program Integrity Contractor) and MAC (Medicare Administrative Contractor)
What Are They Watching?

• Drug Administration

• Service Units
  – Drugs
  – Timed vs. Untimed Codes
  – Frequency limitations

• Medical Necessity and Utilization

• Modifiers

• Overlapping Services

Connolly CMS Recovery Audit Contractor
What Are They Watching?

• Free or Discounted Devices
• Use of Observation
• Medical Necessity – multiple issues
• Off-Label Drug Use
• Herceptin and Multi-Dose Vials
• Outpatient drugs
  – Service units
  – Administration

• Ventilator management

OIG 2013 Work Plan
The 159 new boards and commissions created in the Obamacare bill.

Quagmire of New Unconstitutional Obamacare Agencies

Liberty Legal Foundation
Risks of a Poorly Maintained CDM

- Allegations of fraud or abuse
- Fines and penalties
- Take-backs
- Delayed A/R
- Negative publicity
- Increased scrutiny
- Loss of revenue
Additional Risk

• Denied Claims
  – Medical Necessity
  – Insurance Eligibility
  – Non-covered Codes (alternate codes)
  – Invalid Codes
  – Modifiers
  – Missing Records
  – Referrals/Authorizations
  – MUE
CDM UTILIZATION
CDM Utilization

“A recent trend has seen guidance from the Centers for Medicare & Medicaid Services (CMS) in which certain terms, phrases and/or directives are left open to interpretation. In releasing such guidance, CMS is moving the burden source of establishing compliance from precise definitions that can be revised over to policies and procedures that hospitals and other healthcare providers must formulate themselves.”

Addressing Ambiguous Guidance from CMS, Duane Abbey, PhD., CFP, RACMonitor, April 2011.
CDM UTILIZATION

• Observation
  – Medical Necessity
  – Active Monitoring

• Room and Board

• Physician Supervision
  – Direct vs. General
  – Nonsurgical Extended Duration Therapeutic Services

• E&M Mapping
Observation

**Observation Hour Calculation Form**

<table>
<thead>
<tr>
<th>Services requiring &quot;Active Monitoring&quot;</th>
<th>Actual Times</th>
<th># of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Administration</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>Cardiac Cath Lab</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>GI Endoscopy Lab</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>Unscheduled OP Dialysis</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>Other</td>
<td>Start Time</td>
<td>Stop Time</td>
</tr>
<tr>
<td>Drug Administration</td>
<td>IV Heparin</td>
<td>IV Cardizem</td>
</tr>
</tbody>
</table>

**Average Times**

- MRI 1 Hr
- CT 1 Hr
- Echo 1 Hr
- Ultrasound 1 Hr
- Nuc Med 1 Hr
- Nucl Stress Test 2 Hr
- PT Init Eval 1 Hr (PT Therapy will vary on # of modalities documented)
- OT Init Eval 1 Hr (OT Therapy will vary on # of modalities documented)
- ST Init Eval 1 Hr (Mod Ba Swallow 1 Hr) Other

**HOURS OF OBSERVATION TO CHARGE**

**DIRECT REFERRAL TO OBSERVATION**

**Drug Administration**

- **Infusion Therapy**
  - Chemo
  - Non-Chemo
  - Addl Hr
  - Concurrent Hr

- **IVP Injection**
  - Chemo
  - Non-Chemo
  - Addl New Drug IVP
  - Addl Same Drug IVP

- **Hydration Therapy**
  - Initial Hr
  - Addl Hr
  - (LCD: >500 ml infused)

- **SQ/IM Injection**
  - Chemo
  - Non-Chemo
  - # of SQ/IM

- **Vaccine Administration**
  - Influenza
  - Pneumo
  - Other

**Bedside Procedures**

- FSBS
- Fecal Occult
- Unscheduled OP Dialysis
- Paracentesis
- Thoracentesis
- Urine Catheter
- Straight Foley
- Complicated
- Specimen Collection

- Other
- Other

ACS, LLC

Created 1/2012
Room and Board

Outpatient costs associated with room, board, and nursing care

- Revenue Codes
  - 012X, 013x, 015X, 0160, 0169,
  - 0200 through 0204,
  - 0206 through 0209,
  - 0210 through 0212,
  - 0214, 0219,
  - 0230 through 0234,
  - 0239,
  - 0240 through 0243, and
  - 0249
E&M Visit Codes – New Rules

• Non-Medicare
  – Differentiating new vs. established
  – 5 levels of care
  – Criteria to map clinic resources consumed to 5 levels of care

• Medicare
  – No longer differentiate new vs. established
  – 1 level of care
  – Requirement for internal criteria suspended
CDM UTILIZATION

• Off Label Use of Drugs
• Self-Administered Drugs
• Drugs Integral to a Procedure
• Limited Use HCPCS Codes
• Drug Service Units
• Bundled Procedure Codes
Drug Charges

Approved Off-Label Use

Off-label, medically accepted indications are supported in either one or more of the compendia or in peer-reviewed medical literature.

J3490
J3590
J8999
J9999
Drug Charges

**ICD-9**

- 196.2 Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
- 196.5 Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
- 196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
- 196.8 Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites

**ICD-10**

- C61 Malignant neoplasm of prostate (for on-label or off-label indications)
- D075 Carcinoma in situ of prostate (for off-label indications only)
- C77.1 Secondary and unspecified malignant
- C77.2 neoplasm of intrathoracic lymph nodes Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
Trivia:
What is the definition of a SAD?
Drug Charges

Self-administered Drugs

Current Challenges

- Identification of SADs
- Application of A9270 and GY modifier, when required
- Use of revenue code 637 vs. 250
- Assignment to patient

• New Challenge

- Identification of comprehensive service
- Identification of SADs mapped to 637
- Revise to revenue code 250 or bill to MAC for reassignment?
Drug Charges

• **Drugs Integral to a Procedure**
  – Use of revenue code 250 instead of 637
  – Remove HCPCS code

• **Examples**
  – Nebulizer inhalation solutions
  – Eye drops
  – Irrigation solutions
Drug Charges

• Limited Use HCPCS Codes
  – Q0162 - Ondansetron 1 mg, oral. . .
    “FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.”
  – G9020 - Rimantadine hydrochloride, oral
    “per 100 mg (for use in a Medicare-approved demonstration project)”
  – Q4101 - Apligraf, per square centimeter
    When billing for biologicals skin substitute where the HCPCS code describes a product that may either be used as an implant OR applied as a skin substitute, hospitals should not separately report the HCPCS code when it is being used as an implantable device.
Drug Charges

Pharmaceutical Service Units

– CDM vs. Pharmacy Module vs. Claim Dictionary
– Fractions vs. Whole Numbers
### Drug Charges

#### Example:

**J3370 - Injection, vancomycin HCl, 500 mg**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS</th>
<th>REVENUE CODE</th>
<th>BILLING UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancomycin 250mg INJ</td>
<td>J3370</td>
<td>636</td>
<td>1</td>
</tr>
</tbody>
</table>

*Vancomycin 250mg dispensed = J3370 x 1*

*Vancomycin 500mg dispensed = J3370 x 2*

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS</th>
<th>REVENUE CODE</th>
<th>BILLING UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancomycin 250mg INJ</td>
<td>J3370</td>
<td>636</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*Vancomycin 250mg dispensed = J3370 x 1*

*Vancomycin 500mg dispensed = J3370 x 1*
Drug Charges

Auditing Service Units

“Partners HealthCare in Boston is focusing on 16 drugs, including Rituximab, Herceptin and Lupron. They set a range of billable units for each drug. Claims for billable units within that range are probably compliant, which allows Partners to focus its audits on claims for billable units outside that range.”

AISHealth, Report on Medicare Compliance, Nina Youngston, September 30 2013
Drug Charges

**J9217 - Leuprolide acetate**
(for depot suspension), 7.5 mg

- Indicated for palliative and adjuvant treatment of prostate cancer
- Injectable suspension that may be administered subcutaneously, or as a long-acting depot formulation. Depot given:
  - Monthly: 7.5mg = 1 service unit
  - Every three months: 22.5 = 3 service units
  - Every four months: 30 mg = 4 service units
  - Every 6 months: 45mg = 6 services units
- For the 22.5, 30 or 45 mg doses of leuprolide, bill J9217 three, four or six units respectively.
- Reimbursed = $202.84/7.5mg

**J1950 - Injection, leuprolide acetate**
(for depot suspension), per 3.75 mg

- Indicated for uterine leiomyomas only when it is given “concomitantly with iron therapy for the preoperative hematologic improvement of patients with anemia caused by uterine leiomyomata.”
- Recommended duration of therapy with Lupron Depot 3.75 mg is monthly up to three months. (Package Insert)
- Reimbursed = $747.92/3.5mg
Bundled Procedure Codes

• Cath Lab
• EMG
• Endoscopy
• Breast Biopsy
Bundled Procedure Codes

Diagnostic Carotid Angiography Arch Angiography

• 2012 Guidelines
  – Catheterization 36200
  – Imaging 75650

• 2013 Guidelines
  – Bundled service 36221 - For reporting purposes, remember that 36221 includes a non-selective aortic catheterization

• Simultaneous aortic arch and abdominal aortography is reported:
  – In 2012: 75650, 75625, and 36200
  – In 2013: 36221, 75625 (no additional 36200)
Bundled Procedure Codes

• Infusion Services
  – If performed to facilitate the infusion or injection, the following services are included and are not reported separately:
    a. Use of local anesthesia
    b. IV start
    c. Access to indwelling IV, subcutaneous catheter or port
    d. Flush at conclusion of infusion
    e. Standard tubing, syringes, and supplies
Bundled Procedure Codes

Endoscopy

2013

43268 - Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct

2014

43274 - Long Description: Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent
CDM STANDARDIZATION
CDM Standardization

• Corporate Standard
• System Standards
  - Shared Charges
  - Definitions
  - Abbreviations
  - HCPCS Code Use
  - Revenue Code Use
  - Pricing
Standardized Descriptions

• **Format**
  – General
  – Department Specific
    • Lab, Pharmacy, Supply

• **Abbreviations**

• **Conventions**
  – Character length
  – Special characters
  – Punctuation
Standardized Descriptions

Morphine 10mg/ml 20ml SYR

Syrup or Syringe?

Self-administered or Separately Billable?
Standardized Descriptions

Pharmacy

- Route of administration abbreviations:
  - TAB = tablet/capsule
  - SUPP = suppository
  - INJ = injection
  - IV = intravenous
  - SUSP = suspension
  - TOP = topical
  - PO = oral
Standardized Descriptions

• **Special Characters**
  - Send Out Lab Tests
  - Exploding Charges
  - Payer Identification
  - Productivity/Statistics
  - Old Charges
  - Special Order Supplies
Trivia:
Is a CPT code a HCPCS code OR
Is a HCPCS code a CPT?
Anatomy of a HCPCS Code

1. J2505 - ^2^Injection, ^1^pegfilgrastim, ^3^6 mg.

2. 97804 - ^1^Medical nutrition therapy; ^2^group (2 or more individual(s)), ^3^each 30 minutes.

3. 97150 - ^1^Therapeutic procedure(s), ^2^group (2 or more individuals).

4. 97116 - ^1^Therapeutic procedure, 1 or more areas, ^3^each 15 minutes; ^2^gait training (includes stair climbing).

- ^1^Description
- ^2^Limitations/Qualifiers
- ^3^Measurement – units of service
STANDARDIZED DESCRIPTIONS

Neulasta®

J2505 - Injection, pegfilgrastim, 6 mg

Neulasta is supplied in 0.6 mL prefilled syringes for subcutaneous injection. Each syringe contains 6 mg pegfilgrastim. The recommended dosage of Neulasta is a single subcutaneous injection of 6 mg administered once per chemotherapy cycle.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS</th>
<th>REVENUE</th>
<th>BILLING UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEGFILGRASTIM 6MG INJ</td>
<td>J2505</td>
<td>0636</td>
<td>1</td>
</tr>
</tbody>
</table>
# STANDARDIZED DESCRIPTIONS

## Untimed Codes

### Risk

<table>
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<tr>
<th>DESCRIPTION</th>
<th>HCPCS</th>
<th>BILLING UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAIT TRAINING</td>
<td>97116 (timed)</td>
<td></td>
</tr>
<tr>
<td>PT GROUP EX 1HR</td>
<td>97150 (untimed)</td>
<td>4</td>
</tr>
<tr>
<td>SPEECH THERAPY PED 2HR</td>
<td>92507 (untimed)</td>
<td>8</td>
</tr>
</tbody>
</table>

### Best Practice

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS</th>
<th>BILLING UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAIT TRAINING EA 15 MIN</td>
<td>97116 (timed)</td>
<td>1</td>
</tr>
<tr>
<td>PT GROUP EX</td>
<td>97150 (untimed)</td>
<td>1</td>
</tr>
<tr>
<td>SPEECH THERAPY PED</td>
<td>92507 (untimed)</td>
<td>1</td>
</tr>
</tbody>
</table>
STANDARDIZED DESCRIPTIONS

• Infusion and Injection Services

• Initial Service = Quantity of 1
  
  – 96360 - Intravenous infusion, hydration; initial, 31 minutes to 1 hour
  
  – 96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
  
  – 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
## STANDARDIZED DESCRIPTIONS

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS CODE</th>
<th>REVENUE CODE</th>
<th>BILLING UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>THERAP HYDRATION INITIAL 31-90MIN IV</td>
<td>96360</td>
<td>0260</td>
<td>1</td>
</tr>
<tr>
<td>THERAP INF INITIAL 16-90MIN IV</td>
<td>96365</td>
<td>0260</td>
<td>1</td>
</tr>
<tr>
<td>THERAP IVP 1&lt;sup&gt;ST&lt;/sup&gt; DRUG INITIAL</td>
<td>96374</td>
<td>0260</td>
<td>1</td>
</tr>
<tr>
<td>THERAP IVP SAME DRUG &gt;30MIN EA</td>
<td>96376</td>
<td>0260</td>
<td></td>
</tr>
<tr>
<td>THERAP IVP NEW DRUG EA ADDNL</td>
<td>96375</td>
<td>0260</td>
<td></td>
</tr>
<tr>
<td>THERAP IM/SC EA INJ</td>
<td>96372</td>
<td>0260</td>
<td></td>
</tr>
</tbody>
</table>
STANDARDIZED DESCRIPTIONS

• **Pediatric codes exceeding age parameters**
  
  – 36555 - Insertion of non-tunneled centrally inserted central venous catheter; *younger than 5 years* of age
  
  – 36556 - Insertion of non-tunneled centrally inserted central venous catheter; *age 5 years or older*
  
  – 99143 - Moderate sedation ..... *younger than 5 years of age*, first 30 minutes intra-service time
  
  – 99144 - Moderate sedation services ..... *age 5 years or older*, first 30 minutes intra-service time
### STANDARDIZED DESCRIPTIONS

**Supply Descriptions**

- **Noun/Adjective Format**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1874</td>
<td>N</td>
<td>Stent, coated/covered, with delivery system</td>
</tr>
<tr>
<td>C1875</td>
<td>N</td>
<td>Stent, coated/covered, without delivery system</td>
</tr>
<tr>
<td>C1876</td>
<td>N</td>
<td>Stent, non-coated/non-covered, with delivery system</td>
</tr>
<tr>
<td>C1877</td>
<td>N</td>
<td>Stent, non-coated/non-covered, without delivery system</td>
</tr>
<tr>
<td>C2617</td>
<td>N</td>
<td>Stent, non-coronary, temporary, without delivery system</td>
</tr>
</tbody>
</table>
STANDARDIZED DESCRIPTIONS

Laboratory Descriptions

• Test/Method/Specimen/Result Format

<table>
<thead>
<tr>
<th>Code</th>
<th>Modality</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82340</td>
<td>A</td>
<td>Calcium; urine quantitative, timed specimen</td>
</tr>
<tr>
<td>82310</td>
<td>A</td>
<td>Calcium; total</td>
</tr>
</tbody>
</table>

Radiology Descriptions

• Test/Modality/Anatomy/Views

<table>
<thead>
<tr>
<th>Code</th>
<th>Modality</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76700</td>
<td>Q3</td>
<td>Ultrasound, abdominal, real time with image documentation; complete</td>
</tr>
<tr>
<td>76705</td>
<td>Q3</td>
<td>Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)</td>
</tr>
</tbody>
</table>
Soft Coding
VS.
Hard Coding
Hybrid – Hard and Soft Coding Combined

• Tiered Charges
  – O.R., Anesthesia, PACU
  – Cath Lab and Interventional Radiolog
  – Labor, Delivery, Nursery
  – Blood Transfusion
  – Therapy Evaluations
  – Emergency Department
Tiered Charges

- Reduce Burden on Clinical Staff
- Reduce Errors
- Capture Acuity Related Costs
- Bundle Routine Supplies
- Enhance Transparency
- Reduces CDM Size
## Tiered Charges

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Normal labor no co-morbidities</th>
<th>Normal delivery</th>
<th>normal recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Normal delivery with 1st or 2nd degree laceration</td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>care of patient off unit</td>
<td>3rd or 4th degree laceration</td>
<td>Drips-insulin, magnesium</td>
</tr>
<tr>
<td></td>
<td>diabetic</td>
<td>cervical or sulcus tear</td>
<td>Diabetic</td>
</tr>
<tr>
<td></td>
<td>drug/alcohol abuse</td>
<td>operative vaginal delivery</td>
<td>Restraints</td>
</tr>
<tr>
<td></td>
<td>fetal demise</td>
<td>multiple gestation</td>
<td>Cardiac</td>
</tr>
<tr>
<td></td>
<td>Intrauterine growth restriction</td>
<td>double set up</td>
<td>HELLP</td>
</tr>
<tr>
<td></td>
<td>meconium</td>
<td>precipitous delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prolonged rupture of membranes</td>
<td>cardiac patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>induction/augmentation</td>
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<tr>
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<td>labor patient for cesarean section</td>
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<tr>
<td></td>
<td>active infection</td>
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<td>Level 3</td>
<td>abruption</td>
<td>hemorrhage</td>
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<tr>
<td></td>
<td>abnormal bleeding</td>
<td>amniotic fluid embolus</td>
<td>Seizure</td>
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<tr>
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<td>psychiatric/psychological issues</td>
<td>cervical laceration</td>
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<td></td>
<td>fetal distress</td>
<td>shoulder dystocia</td>
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<td>malpresentation</td>
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<td></td>
<td>multiple gestation</td>
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<tr>
<td></td>
<td>preterm labor</td>
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<td>trial of labor after cesarean</td>
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<tr>
<td></td>
<td>auto immune disorder</td>
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<tr>
<td></td>
<td>sickle cell</td>
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<td>fetal herpes</td>
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<td>idiopathic thrombocytopenia</td>
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<td>epileptic</td>
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<td>cardiac patient</td>
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<td>HELLP</td>
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<tr>
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</table>
Tiered Charges

Like Service

- PT Clinic A
  - Equipment
    - Overhead
    - Staff
  - Routine Supplies

- PT Clinic B
  - Equipment
    - Overhead
    - Staff
  - Routine Supplies
Tiered Charges

Un-Like Service

- PT Evaluation Simple
  - Single system assessment, evaluation for postop ambulation or crutch training.
  - Overhead: [Box]
  - Staff: [Box]

- PT Evaluation Complex
  - Multiple system assessment, neuro or cognitive evaluation, evaluation of adaptive equipment needs, multiple physical measurements such as muscle strength, ROM, etc.
  - Overhead: [Box] – additional test equipment required.
  - Mult Staff: [Box] may be necessary.
MODIFIERS

• Used with CPT and HCPCS codes when a service requires more definition or explanation
  – Services have been increased or reduced
  – An evaluation and management service was performed on the same date as a procedure
  – Bilateral procedure was performed
  – Repeat testing occurred
  – Identify the professional rendering the service

• Impacts reimbursement
  – The modifier that affects pricing should be placed in the primary position
  – Modifiers may result in additional or reduced reimbursement
MODIFIERS

Modifier 50

• **Bilateral procedures**
  - Diagnostic, radiology and surgical procedures
  - Performed on both sides during the same operative session or on the same day
  - Code description does not include “bilateral” or “unilateral”
  - Procedures that are bilateral by definition

• **Billing notes**
  - When using modifier 50, bill for one unit on the claim
  - Modifier 50 should follow the procedure code
  - Be aware of payer specific guidelines, some may prefer LT and RT to 50
MODIFIERS

Left and right procedures

• Left and right are only used when a procedure is performed on one side of the body and is a paired organ
• Bilateral modifier (50) is not valid
• Code description includes the word “unilateral,” use LT and RT even if performed on both sides

When not to use LT and RT

• E&M codes
• Pathology and lab codes
• Immunization, vaccine/toxoid codes
• Medicine codes that specify LT or RT in description
• Allergy and clinical immunology codes
• Osteopathic and chiropractic manipulation codes
MODIFIERS

Modifier LT, RT and 50 examples:

- **76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation**
- **73120 Radiologic examination, hand; 2 views**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HCPCS CODE</th>
<th>REVENUE</th>
<th>MODIFIER</th>
</tr>
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<tbody>
<tr>
<td>US BREAST UNIL RT</td>
<td>76645</td>
<td>402</td>
<td>RT</td>
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<tr>
<td>US BREAST UNIL LT</td>
<td>76645</td>
<td>402</td>
<td>LT</td>
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<tr>
<td>US BREAST BIL</td>
<td>76645</td>
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<tr>
<td>XR HAND 2V RT</td>
<td>73120</td>
<td>320</td>
<td>RT</td>
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<tr>
<td>XR HAND 2V LT</td>
<td>73120</td>
<td>320</td>
<td>LT</td>
</tr>
<tr>
<td>XR HAND 2V BILAT</td>
<td>73120</td>
<td>320</td>
<td>50</td>
</tr>
</tbody>
</table>
Trivia:
Modifier 59 is used to report that a clinic visit is distinct from a procedure?
MODIFIERS

Modifier 59

• Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

• Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

• Different diagnosis is not sufficient to justify the use of modifier 59.

• Only hard-code when it is true every single time it is billed

• DO NOT USE AS A MEANS OF BYPASSING NCCI EDITS!
MODIFIERS

Modifier 59 during diagnostic and interventional procedures

- Diagnostic angiography performed at the time of an interventional procedure is separately reportable if:
  - No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR
  - A prior study is available, but as documented in the medical record:
    - The patient’s condition with respect to the clinical indication has changed since the prior study, OR
    - There is inadequate visualization of the anatomy and/or pathology, OR
    - There is a clinical change during the procedure that requires new evaluation outside the target area of intervention.
  - Diagnostic angiography performed at a separate setting from an interventional procedure is separately reported.

- Diagnostic angiography performed at the time of an interventional procedure is NOT separately reportable if it is specifically included in the interventional code descriptor.
MODIFIERS

Services inherent to cardiovascular procedures:

– Routine vascular access
– EKG and cardiac monitoring
– Infusions and injections including drugs such as Angiomax and Sodium Bicarb, Nitrates
– Placement of occlusive device at puncture site (G0269)
MODIFIERS

Modifier 25

• Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.

• The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
CMS’ “Medicare Carriers Manual,” Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS’s “Medicare Claims Processing Manual,” Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to provide beneficiaries with advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills that they are responsible for paying.
MODIFIERS

Modifier 91

• In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.

• May not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.

• This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
MODIFIERS

Frequently Repeated Lab Tests:

- 82550 - Creatine Kinase (ck), (cpk); Total
- 82553 - Creatine Kinase (ck), (cpk); Mb Fraction Only
- 82657 - Enzyme Activity In Blood Cells, Cultured Cells, Or Tissue, Not Elsewhere Specified; Nonradioactive Substrate, Each Specimen
- 82947 - Glucose; Quantitative, Blood (except Reagent Strip)
- 82978 - Glutathione
- 84087 - Phosphohexose Isomerase
- 84132 - Potassium; Serum
- 84484 - Troponin, Quantitative
- 85027 - Blood Count; Complete (cbc), Automated (hgb, Hct, Rbc, Wbc And Platelet Count)
# MODIFIERS

<table>
<thead>
<tr>
<th>Description</th>
<th>HCPCS</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium Serum</td>
<td>84132-Potassium; Serum, plasma, whole blood</td>
<td></td>
</tr>
<tr>
<td>Potassium Serum Repeat Same Day</td>
<td>84132-Potassium; Serum, plasma, whole blood</td>
<td>91</td>
</tr>
</tbody>
</table>
MODIFIERS

No Cost Devices

Modifier FB - Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples).

Outpatient hospitals billing "no cost" devices must report a token charge of less than $1.01 for the item in the covered charge field append the -FB modifier to the procedure code for implanting the "no cost" device, along with the appropriate condition code. The modifier will identify the procedure code line for the "no cost" device, while the condition code will explain the reason why the device was provided free of cost.

When a hospital replaces a device with a more expensive device and receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier -FB to the procedure code (not the device code) that reports the service provided to replace the device. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charge field.

* See Claims Manual and CMS FAQ for additional instructions and scenarios.

CMS Claims Processing Manual, 100.04, Section 32, Paragraph 67.2.1. Chapter 4, 20.6.9 and 61.3.1.
## MODIFIERS

<table>
<thead>
<tr>
<th>Description</th>
<th>Charge</th>
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<tbody>
<tr>
<td>No Cost Device</td>
<td>$1.00</td>
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</table>
MODIFIERS

End Stage Renal Disease Services

- Modifier AY
  - E.R. Lab Work – No Longer Needed
  - Drugs Unrelated to ESRD
- Modifier JE
  - Drugs Related to ESRD
- Modifier JA
  - ESA IV Route of Administration
- Modifier JB
  - ESA SC Route of Administration
Revenue Codes

Revenue Code Detail

• Detailed vs. General
• Pharmaceuticals
• Implants/Supplies
### Revenue Codes

#### Fourth Digit Specificity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>030X</td>
<td>Laboratory</td>
</tr>
<tr>
<td>0300</td>
<td>Laboratory—General</td>
</tr>
<tr>
<td>0301</td>
<td>Laboratory—Chemistry</td>
</tr>
<tr>
<td>0302</td>
<td>Laboratory—Immunology</td>
</tr>
<tr>
<td>0303</td>
<td>Laboratory—Renal Patient (Home)</td>
</tr>
<tr>
<td>0304</td>
<td>Laboratory—Nonroutine Dialysis</td>
</tr>
<tr>
<td>0305</td>
<td>Laboratory—Hematology</td>
</tr>
<tr>
<td>0306</td>
<td>Laboratory—Bacteriology and Microbiology</td>
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<tr>
<td>0307</td>
<td>Laboratory—Urology</td>
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<tr>
<td>0309</td>
<td>Laboratory—Other Laboratory</td>
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<tr>
<td>031X</td>
<td>Laboratory Pathology</td>
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<td>0310</td>
<td>Laboratory Pathology—General</td>
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<tr>
<td>0311</td>
<td>Laboratory Pathology—Cytology</td>
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<tr>
<td>0312</td>
<td>Laboratory Pathology—Histology</td>
</tr>
</tbody>
</table>
Revenue Codes

Pharmaceuticals

• IV Solutions
  – With and Without HCPCS
• Radiopharmaceuticals
• Contrasts
• Self-administered Drugs
Revenue Codes

Implanted Devices

2009 IPPS Final Rule

– Medical Supplies Charged to Patients
– Implanted Devices Charged to Patients

“Capturing the costs and charges billed with the following UB-04 revenue codes: 0275 (Pacemaker), 0276 (Intraocular lens), 0278 (Other implants), and 0624 (FDA investigational devices).”
Revenue Codes

National Uniform Billing Committee (NUBC) definition

The following two steps should be utilized when determining if an item meets the implantable device definition:

First: CMS states what is not a device – A device is not a material or supply furnished incident to a service (for example, a surgical staple, a suture, customized surgical kit, or clip, other than a radiologic site marker). If the item passes the first step then review the second step.
Revenue Codes

Second: Utilize the NUBC definition of an implantable device to determine if the item meets the definition: “That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in area traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.”
Revenue Codes

Supplies may be billed separately only if they are:

Direct identifiable services to individual patients, and

Not generally furnished to most patients, and one of the following:

- Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;
- Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing.
Revenue Codes

The following items are always considered routine:

– Items which are furnished routinely and relatively uniformly to all patients, e.g., patient gowns, paper tissues, water pitchers, basins, bed pans, deodorants, mouthwashes.

– Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, band aids, antacid, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories, tongue depressors.

– Items which are utilized by individual patients but which are reusable and expected to be available in an institution . . . e.g., ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, other durable medical equipment (DME) which does not meet the criteria for ancillary services . . . under §2203.2 and the requirements for recognition of ancillary charges under §2203.
Revenue Codes

Non-Routine

• The criteria in §2203.2 explicitly state that items and services may be considered ancillary if they are identifiable items and services tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, and are either not reusable or represent a cost for each preparation. Accordingly, those items of DME which do not meet both the criteria of §2203.2 and the requirements of §2203 for recognition of ancillary charges must be classified as routine.
Trivia:
What does CDM stand for?
CHARGEMASTER MANAGEMENT & PLANNING
CDM Management Plan

• Key Elements
  – Guiding Principles
  – Charge Protocol & Billing Guidelines
  – Rate Setting
  – Hospital Wide CDM Management
  – Departmental Responsibilities
  – Charge Reconciliation
  – Auditing and Monitoring
CDM Management Plan

• Guiding Principles
  – to define criteria and,
  – to standardize policies and procedures for
    • CDM maintenance,
    • CDM structure and
    • Charge capture.
Guiding Principles

- Adherence to procedures for adding new items.
- CDM Coordinator to distribute coding updates.
- Department managers responsible to see that CDM contains all supplies and procedures available; and that all updates are processed, including meeting with Revenue Cycle committee.
- All required changes to the CDM will be implemented within 14 days of notification.
- Corresponding charges to be setup within 10 days.
- An audit will be conducted after 30 days to ensure new charges are setup and capturing correctly.
Guiding Principles

• Periodic review by external vendor.

• Utilization of CDM management tools for real-time updates and maintenance.

• Regular review by the CDM Committee.

• Annual price updates will be included in annual budget preparation activities.

• All pricing changes require administrative approval.
Guiding Principles

• Utilize CDM for charge capture, not for productivity or statistical tracking.

• Request CDM when an item is used more than five times per year.

• Service unit multiplier to be maintained in BAR.

• Utilize standardized descriptions for all charge items
  – Utilize list of standardized abbreviations and keywords that would otherwise change the CPT® code (e.g., specimen source, number of views, S&I, unit of measure/time increment, etc.).
  – Noun/adjective (e.g., Catheter Guiding 5F, Morphine 10mg/ml 10ml INJ, etc.).
Guiding Principles

• Utilize the most specific detailed revenue code available.

• Define use and set-up of panel/explosion charges (e.g., zero price, no CPT® code).

• Minimize use of miscellaneous CPT® codes.
  – Identify specific description of service/item when miscellaneous code is applied

• Inactivate all items with no volume after 12 months.

• Adhere to minimum cost threshold and definition to determine routine supplies.
Guiding Principles

• Departments using tiered charges will maintain protocols describing use and selection of charges
  – E&M
    • ER
    • Clinics
  – Acuity levels
    • OB
    • Nursery
    • Surgery
    • Anesthesia
  – Different Service but Same CPT
Guiding Principles

• Education and training:
  – General overview of findings and recommendations to RCC.
  – Breakout sessions to review billing rules and guidelines, policies and procedures, and new workflow to departments.

• Enforce daily charge reconciliation.

• Require audit and monitoring process.

• Implementation of technology.
  – Knowledge Source
  – CDM Management and Request tool
CDM Management Plan

• Create CDM Management Plan
  – Review and implement coding changes
    • New codes
    • Deleted codes
    • Revised codes
    • SI changes
      – Payment changes
      – Inpatient only issues
  – Changes in billing and regulatory guidance
  – Rate setting and pricing review
CDM Management Protocol

- **Internal Control System:**
  - Compliance
  - Operational needs
  - Managing risks
  - Continuous improvement
CDM Management Protocol

“This policy is established to maintain the charge master accurately, to keep pricing competitive and consistent, to comply with all pertinent billing and coding regulations, to comply with state rate-filing regulations and to maintain integrity in system-generated reports. Our objective is to optimize reimbursement through effective charge master maintenance in all revenue producing departments.”
CDM Management Protocol

- Access to the CDM
- Reviewing, approving and entering edits to the CDM
- Rate setting, mark-ups and discounts
- Standardized nomenclature for CDM descriptions
- Standards for application of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes
- Application of modifiers
- Revenue code assignments
- Chargeable versus non-chargeable items including routine items
- Mapping protocols for tiered or packaged services
- Supportive Billing Guidelines
- Plan for charge capture and compliance audits
- Schedule for hospital-wide and departmental CDM reviews
- Corrective action and compliance reporting
- I.T. coordination and support
CDM Management Plan

Rate Setting

• Periodic Rate Reviews

• Pricing
  – Mark-up
  – Increases

• Packaging

• Discounting

• Transparency
  – Upfront Pricing
  – Publication
CDM Management Program

• **Hospital Wide - CDM Coordinator Role**
  
  – Ensure departmental reviews are completed
  – All deleted and replaced codes are identified and replaced
  – Revenue codes assigned consistently across departments
  – Review of alternate codes for HCPCS not recognized by CMS
  – Missing companion or add-on codes
  – Service items with zero activity
  – Changes in status indicators and facility impact
  – Device dependent claim errors
  – Modifiers
CDM Management Program

• **Hospital Wide – CDM Coordinator**
  - Same service, same HCPCS code, same price across departments
  - Review of rates for services reimbursed based on cost
  - Rates below fee schedule or APC rate
  - Rates against internal policies
  - Changes in APC assignment and facility impact, including rates
  - Identification of routine items
  - Dictionary containing multipliers for service units
  - Review of revised HCPCS descriptions against current services
  - Descriptions consistent with CDM protocol policy
CDM Management Program

• Departmental Responsibilities
  – All services in CDM are still provided
  – New services have been added included related supplies
  – Comparison of new codes to current services
  – CDM descriptions match services and assigned HCPCS
  – Accuracy and update of order entry links, charge sheets, etc.
  – Technology changes
CDM Management Program

• **Departmental Responsibilities**
  – Review quarterly and annual HCPCS code changes
  – Ensure charges are available for all reportable services
  – Ensure charges are linked to charge capture and reporting tools
  – Coordinate pricing with other departments with like services
  – Evaluate pricing to ensure costs are accurately reflected
  – Maintain billing policies and protocols
  – Educate staff
CDM Management Program

• Recognize that the only “constant” is “change”
• Identify best practices; adopt and adapt
• Learn from and with others; collaborate
CDM Changes- Additions and Changes

• Department Responsibility
  – Procedure Dictionary
  – Item Masters
  – Formulary
  – Order Entry Links

• CDM Coordinator Responsibility
  – Creation of Charge Codes
  – Validation and Assignment of HCPCS Codes
  – Approval of Hard Coded Modifiers
  – Assignment of Revenue Code
  – Assignment of Service Unit Multiplier
  – Assistance with Pricing
CDM Management Program

• **Schedule Audits**
  – Departmental
  – Hospital Wide

• **Identify Problem Prone Areas**
  – Self-analysis from audits and risk assessments
  – OIG work plan
  – FI/MAC publications and education
  – RAC targets
  – Denials
  – Billing edits
  – Forums, list serves, newsletters
Daily Charge Reconciliation

• **Timely audits – Department Responsibility**
  – All services documented are billed
  – Correct charge code and CPT/HCPCS for service
  – Modifiers used properly
  – Correct units of service
Questions?
Best Practice Chargemaster Management

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