

Critical Access Hospital Chargemaster: What you don't know can hurt you!



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CPAs & BUSINESS ADVISORS

Objectives

- Discuss the reimbursement issues related to the chargemaster
- Discuss the compliance issues related to the chargemaster
- Discuss appropriate CPT and revenue code matching
- Discuss the processes for establishing a new charge in the chargemaster



Background

- Chargemaster is often ignored due to cost reimbursement
- Used for patient billing and accounting
- Sometimes hospitals attempt to use the chargemaster as a mechanism to measure workload



Accurate Chargemaster

- Correct services are captured for billing
- Decrease in claim rejections and denials
- Decrease in lost charges
- Fewer appeals or corrections
- Accurate info for decision support
- Increased reimbursement
- Keeps the RACs away!



Outside Forces Affecting the Chargemaster

- Annual updates of CPT/HCPC codes
- New line items need to be added along with charges for new services
- Pricing changes
- Changes in the payer rules
- Productivity/workload statistic changes



Who is Responsible for the Chargemaster?

- Business Office
- Health Information Management
- IT/Data entry
- Compliance Officer
- Clinical staff
- Chargemaster Coordinator
- Finance



How are You Getting Paid from Medicare?

Service	Interim Payment	Final Payment
Inpatient Routine/Ancillaries	Per Diem	101% of cost
Swing Bed Routine	Per Diem	101% of average routine cost per day
Swing Bed Ancillaries	Per Diem	101% of cost
Outpatient Therapies	% of charges	101% of cost
Lab	% of charges	101% of cost
Non-patient lab	Fee Schedule	Fee Schedule
Radiology and other Dx	% of charges	101% of cost
Emergency Dept	% of charges	101% of cost
Observation	% of charges	101% of cost
Supplies and Drugs	% of charges	101% of cost
Provider Based RHC (Under 50 beds)	Per visit	Cost per visit
Provider Based RHC (Over 50 beds)	Per visit	Lower of cost per visit or per visit limit



Reimbursement Methodologies

- Retrospective Methodologies
 - Cost Based (Medicare)
- Charge Based Methodologies
 - Billed Charges
 - Percentage of Charges (Other Commercial Contracts)
 - Fee schedules



Fee Schedules

- Fixed payment based on CPT code assignment
- Multiple payments possible per episode of care
- Not all CPT codes provide additional payment



Cost Based

- Interim payments based on interim rates
 - Per diem
 - % of charge
- Final payments based on cost report (Medicare) or other similar format



Billed Charges

- Total charges = total payments
- Charges impact payments
- Number of individual charges do not impact payment



Percentage of Charges

- % Total charges = total payments
- Charges impact payment
- Number of individual charges do not impact payment



Cost Report - Medicare

- Determines final reimbursement for inpatient, swingbed, outpatient and rural health clinic services.
- Understand that as a critical access hospital, for Medicare, you are paid the hospital's allowable cost.
- Allowable cost isn't total cost, excludes such things as advertising, total bad debt expense, among many other expenses.



Cost Report - Medicare

- Understand you are paid cost for Medicare.
 - Example – assume 50% of patients are Medicare

	All Patients	Ratio of Cost-to-Charge	Medicare Charges	Medicare Pays
A	<u>\$10 of Cost</u> \$20 of Charge	.5	\$10	\$5
B	<u>\$10 of Cost</u> \$40 of Charge	.25	\$20	\$5
C	<u>\$10 of Cost</u> \$10 of Charge	1.0	\$5	\$5

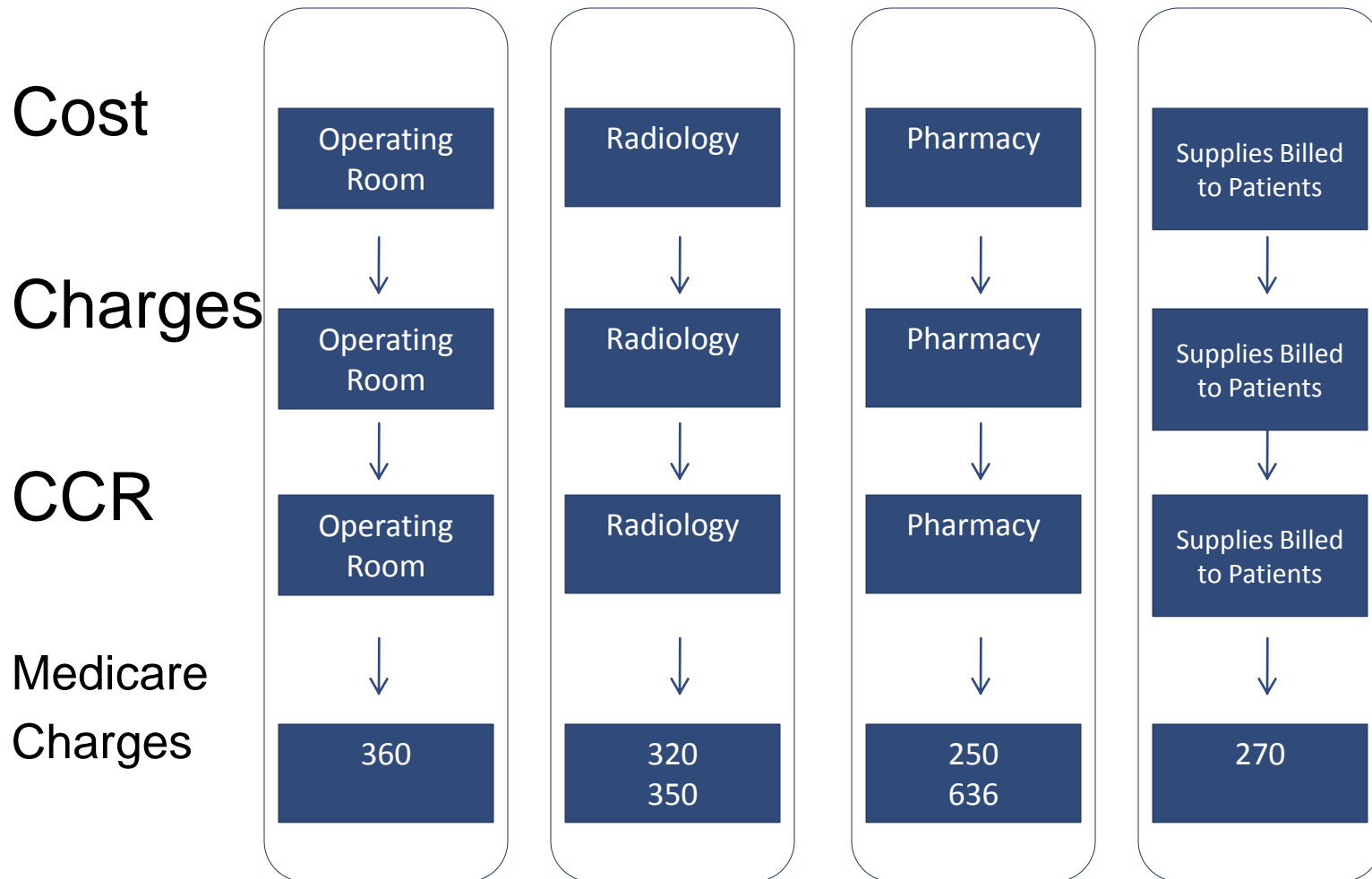


Cost Report - Medicare

- Key is the matching principle
 - Costs are in the same department as revenues and revenue code assignments
- Personnel involved in the chargemaster should understand how revenue codes are “cross walked” to the cost report.



Cost Report – Matching Principle



Cost Report

- Common revenue codes matching problems
 - IV Administration
 - Blood Administration
 - Supply Charges
 - Chemo Administration



Outpatient Med/Surg Services

- What are Outpatient Med/Surg Services and why are they a chargemaster concern?
 - Observation
 - Recovery (Phase II)
 - Chemotherapy
 - IV Therapy
 - Injections
 - Medical Visits
 - Treatment Rooms
 - Sleep Studies



Outpatient Med/Surg Services cont.

- Often revenue department does not match expense department
- Cost report calculations do not automatically allow for proper allocation of costs or for proper reimbursement



Observation

- Front Loading of charges
- Tracking of hours for cost report
- Different levels of service
- Proper billing of hours of service
- Observation versus Phase II recovery



Observation

Front Loading of Charges

- 50 to 75 percent of facility resources expended in first 2 – 3 hours
- Charges usually equal 15% - 40% of daily room charge in first 2 – 3 hours
- Prevents inappropriately low charges for short observation stays



Observation

Front Loading of Charges

- Problems often a result of system limitations
- Need to develop methodology
 - Appropriate pricing
 - System limitations
 - Efficient billing



Observation

Front Loading of Charges

Duration of Stay	Charge
1 hour	\$240
2 hours	\$480
3 hours	\$600
4 hours	\$622
5 hours	\$644
6 hours	\$666
7 hours	\$688
8 hours	\$710
9 hours	\$732
10 hours	\$754
11 hours	\$776
12 – 24 hours	\$800



Observation

Front Loading of Charges

- May have to adjust methodology to allow automatic reporting of hours on UB-04
- Revenue code 762 – No CPT code required
- Annual revenue and usage reports provide Observation hours for cost report



Observation

Different Levels of Service

- Different levels of service provided in Observation
 - Regular
 - With Telemetry/Monitoring
 - Don't report CPT code 93012
 - Isolation



Observation

Different Levels of Service

- Expect separate room charges for various levels
- Recommend separate Observation room charges matching the inpatient room levels



Observation Billable Hours of Service

- Billed hours must meet requirements
 - Start – When patient is admitted to observation
 - End – The time the patient is discharged
 - Assumes the patient is receiving medically necessary observations services up to time of discharge
 - Does not include time in observation after treatment is finished



Observation Billable Hours of Service

- Automated Systems
 - Discharge times do not always properly reflect the time medically necessary services are discontinued
- Manual
 - More accurate
 - Manual process



Observation

Billable Hours of Service

- Medicare Cost Report Audit
 - Expect review
 - Could include review of medical records



Observation

Observation versus Phase II Recovery

- Outpatient services provided after outpatient surgery are not considered observation unless:
 - Normal recovery has ended
 - Complication has occurred
 - Attending physician has admitted patient to observation status
- Services not meeting this criteria are more appropriately considered Phase II

Recovery



Observation

Observation versus Phase II Recovery

- Phase II Recovery services create billing problems
 - Revenue and expense matching
 - Failure to report revenues



Observation

Observation versus Phase II Recovery

- Recommendations
 - Establish separate general ledger revenue account for “outpatient Med/Surg services
 - Generate hourly rates for Phase II Recovery
 - Recovery per hour
 - Recovery 1 hour, Recovery 2 hours



Chemotherapy

- Various locations of service
 - Separate, distinct department
 - Emergency Room
 - Med/Surg
 - Treatment Room



Chemotherapy

- Recommendations for revenue vary based on location
 - Separate GL revenue account
 - Emergency Room
 - Outpatient Med/Surg Services



Chemotherapy

- Meets billing requirements
- Provides hours for cost report if performed in Med/Surg
- Rev codes 331, 335



IV Therapy

- Various locations of service
 - Separate, distinct department
 - Emergency Room
 - Med/Surg
 - Treatment Room



IV Therapy

- Recommendations for revenue vary based on location
 - Separate GL revenue account
 - Emergency Room
 - Outpatient Med/Surg Services



IV Therapy

- Commonly missed charge identified during review of revenue cycle
 - Failure to update charge slips
 - Failure to train staff
 - Rev Codes 260, 450, 510, 760, 761



IV Therapy

- May require two sets of charges in Emergency Room
 - Emergency
 - Scheduled



Injections

- Various locations of service
 - Emergency Room
 - Operating Room
 - Separate, distinct department
 - Med/Surg
 - Treatment Room



Injections

- Recommendations for revenue vary based on location
 - Emergency Room
 - Operating Room
 - Separate, distinct department
 - Outpatient Med/Surg Services
 - Treatment Room



Injections

- Commonly missed charge identified during review of revenue cycle
 - Inadequate charge slips
 - Lack of training



Injections

- Final revenue codes assignment based on facility strategy to limit variation of revenue codes in each department for cost reporting purposes
- Rev codes 260, 450, 510, 760, 761



Injections

- May require two sets of charges in Emergency Room
 - Emergency
 - Scheduled



Sleep Studies

- Various locations of service
 - Separate, distinct department
 - Med/Surg



Sleep Studies

- Recommendations for revenue vary based on location
 - Separate GL revenue account
 - Outpatient Med/Surg Services
 - Rev codes 519, 74x, 920



Self-Administrable Drugs

- Two separate issues
 - Compliance
 - Billing Efficiency
- Compliance
 - Self-Administrable drugs are non-covered unless otherwise indicated by fiscal intermediary
 - Rev code 637 for outpatients



Self-Administrable Drugs

- Billing Efficiency
 - Why do we bill for all these little drugs?
 - Low dollar
 - Over the counter
 - High cost of maintaining billing system



Self-Administrable Drugs

- Billing Efficiency
 - Model into facility charges
 - Patient friendly billing
- Prescription Drug Benefit impact?



Supplies

- Routine vs non-routine
 - Routine supplies not billable to Medicare
 - Lack of comprehensive or consistent list
 - Negative impact of billing other payers



Supplies

- Impact on charges/billing efficiency
 - Minimal to no impact on charges and overall reimbursement
- Significant improvement in billing efficiencies
 - No stickers
 - No chargemaster
 - No lost stickers



Supplies

- Expense matching
 - Often overlooked in chargemaster review/redesign
- Non-billable supply expense must be reported in appropriate department



Emergency Room

- E&M definitions in the CPT book are for physicians
- Hospitals use E&M codes but create own definitions
- Should reflect resource utilization
- Separately identifiable procedures should not be included in the E&M selection
- Procedures are to be billed separately
- Bell curve---should not have huge swings



CPT/HCPCS Requirements

- Required or not?
 - OCE includes valid and invalid CPT/HCPCS
- Medicare Claims Processing Manual Chapter 4 Section 20.1
 - Indicates CAHs only required to report CPT/HCPCS for services not reimbursed based on reasonable cost



CPT/HCPCS Requirements

- Required or not? (continued)
 - CCI edits are applied by fiscal intermediary



CPT/HCPCS Requirements

- Considerations:
 - Other payers require reporting of CPT/HCPCS to determine coverage and payment
 - How does Medicare determine coverage for services when an ABN has been issued?



CPT/HCPCS Requirements

- CPT/HCPCS required:
 - Fee schedule services
 - Referenced clinical Lab services (TOB 141)
 - Services reported under Method II professional billing



CPT/HCPCS Requirements

- Recommendation
 - Report CPT/HCPCS unless otherwise indicated



Modifiers

- Not all modifiers are required by Medicare
 - Level I Modifiers
 - Reported as appropriate
 - Level II Modifiers
 - Not required
 - Majority are for Radiology modifiers



Modifiers

- Recommendation
 - Verify third party requirements
 - Discontinue unnecessary efforts



Ideas to Keep Chargemaster Current/Successful

- Organization needs to take ownership of the chargemaster, not any one individual.
- Involves various people & departments throughout the organization
 - Department Heads!!!
 - Coding (HIM)
 - Billing
 - Finance



Ideas to Keep Chargemaster Current/Successful

- Departmental responsibilities include:
 - Updates for any new services
 - Review for accuracy
 - Descriptions
 - CPT codes
 - Possible pricing
 - Review for any unused service codes and recommend they be inactivated



Ideas to Keep Chargemaster Current/Successful

- Recommend having written chargemaster policies that are applied on a consistent basis:
 - “Hard” or “Soft” coding of revenue codes & CPT codes
 - Bundling of items



Ideas to Keep Chargemaster Current/Successful

- Recommend annual update/review of chargemaster that covers all departments.
 - CPT code changes
 - Pricing
- Organized by the “Chargemaster Team”



Ideas to Keep Chargemaster Current/Successful

- Ongoing maintenance
 - Review of newsletters from payers
 - Local MAC updates
 - Transmittals
 - CPT changes
 - Who ensures that changes get made if something is applicable in a newsletter



Ideas to Keep Chargemaster Current/Successful

- “Change Form”
 - Form used to make changes (additions, deletions or changes) to the chargemaster.
 - Supporting information should accompany change form and be kept for future reference should questions arise
 - Must have approval from key personnel/departments
 - Department heads
 - HIM
 - Chargemaster team (Director)
 - Finance



Ideas to Keep Chargemaster Current/Successful

- Ensure that you have all of the current reference manuals
 - CPT and HCPCS books
 - Uniform Billing Editor
 - Specific department reference manuals
- Ordering of manuals should be consolidated
 - Kept current
 - Discount pricing
 - Appropriate number



Ideas to Keep Chargemaster Current/Successful

- Understand all of the other systems that interact with the chargemaster.
 - Ancillary department systems
 - Pharmacy, lab, etc.
 - Billing system edits
 - Order Entry & Charge Entry
 - Encoder
 - Claims scrubber



Ideas to Keep Chargemaster Current/Successful

- Everything may not be showing accurately on the claim form, even though correct on the chargemaster.
- Have periodic audits, review inpatient and outpatient claims.
 - Proper coding
 - Missed charges
 - Proper Units



Summary

- Remember – you are paid cost by Medicare.
- Important to match expenses with revenues on cost report.
- Proper overhead statistics are very important in determining Medicare reimbursement.



Summary

- Total number of chargeable items doesn't drive reimbursement.
 - Bundle items as long as they are not separately payable by a payer
 - Creates efficiencies in billing process
- An updated and effective chargemaster will streamline the billing process = Efficiency and \$\$\$\$



Questions?

