

CAH Chargemaster Strategies



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CPAs & BUSINESS ADVISORS



Background

- The chargemaster has one of the most important functions in a hospital but quite often it is one of the last areas of focus
 - Extensive amount of detail
 - Time required to maintain it.



Background

- Constant changes in the industry require ongoing attention
 - Changes in organizational structure and programs
 - Changes in payor rules
 - Changed in cost report opportunities

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

Inaccurate Chargemaster

- Errors in charge capture
- Increase in claim rejections and denials
- Increase in lost charges
- Greater appeals or corrections
- Inaccurate information for decision support
- Decreased reimbursement
- Decreased cashflow
- Increased cost in billing and collection process



Best Practices

- Best practices include active communication between:
 - CEO
 - CFO
 - CNO/DON
 - HIM
 - Business Office

➤➤➤ Medicare Cost Reimbursement

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

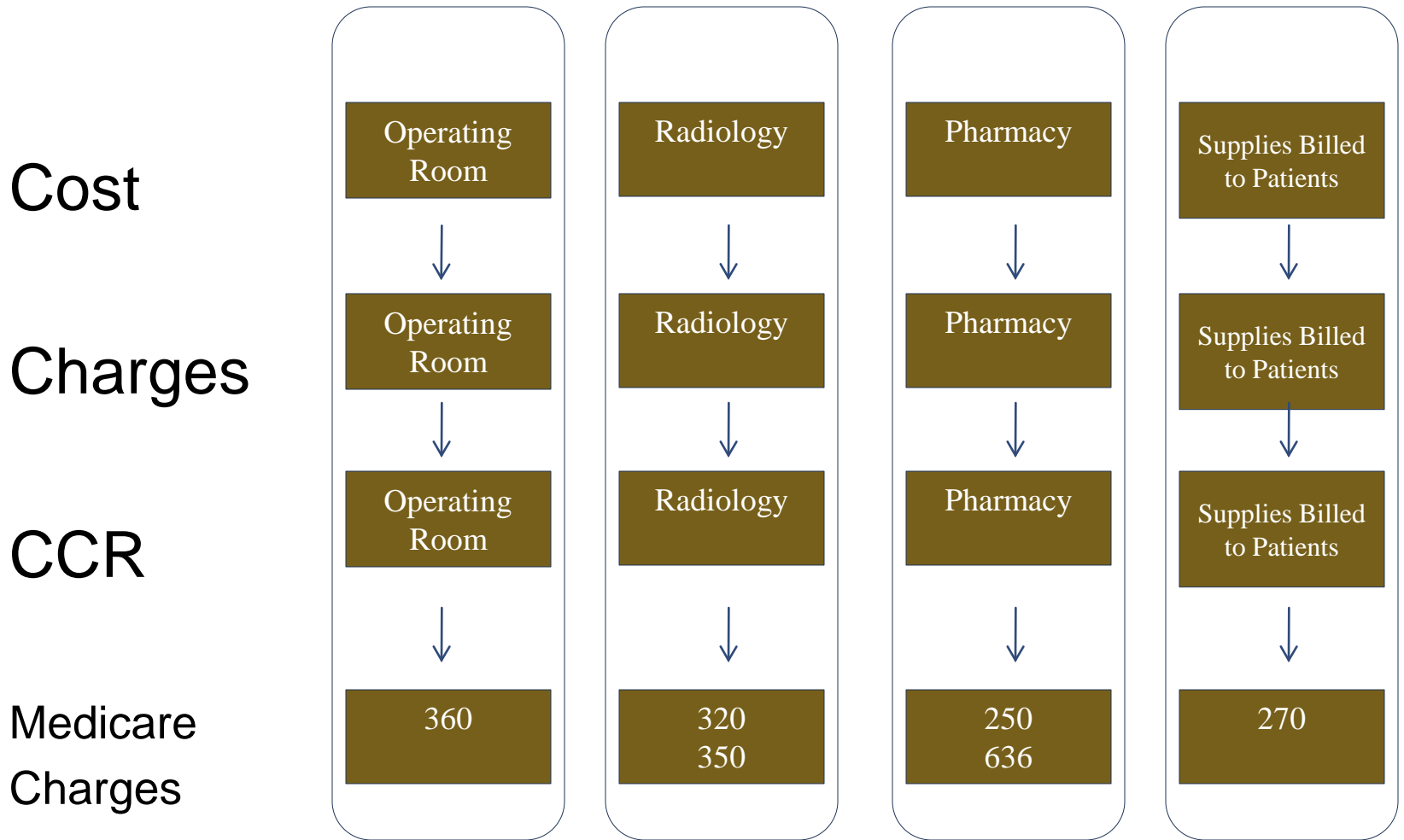
	All Patients	Ratio of Cost-to-Charge	Medicare Charges	Medicare Pays
A	<u>\$10 of Cost</u> \$20 of Charge	.5	\$10	\$5
B	<u>\$10 of Cost</u> \$40 of Charge	.25	\$20	\$5
C	<u>\$10 of Cost</u> \$10 of Charge	1.0	\$5	\$5



Medicare Cost Report

- Key is the matching principle
 - Costs are in the same department as revenues and revenue code assignments
 - Including overhead allocations
- 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
 - Observation
 - Recovery
 - Chemotherapy
 - IV Administration
 - Injections
 - Blood Administration
 - Treatment Rooms
 - Inpatient Bedside Procedures
 - Supply Charges

Outpatient Med/Surg Services

- What are Outpatient Med/Surg Services and why are they a chargemaster concern?
 - Observation
 - Recovery (Phase II)
 - Chemotherapy
 - IV Administration
 - Injections
 - Blood Administration
 - Treatment Rooms

Outpatient Med/Surg Services

- What are Outpatient Med/Surg Services and why are they a chargemaster concern?
 - Often revenue department does not match expense department
 - Revenue
 - Emergency Room
 - Same Day
 - Other Outpatient
 - Expense
 - Med/Surg
 - ??
 - Cost report calculations do not automatically allow for proper allocation of costs or for proper reimbursement
 - Only allows for automated “carve-out” of observation services from Med/Surg



Observation – Front Loading 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 Charges

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

»» Observation – Front Loading Charges

- Normal Methodology
 - Observation per hour = \$41.66
 - 24 hour max = \$1,000



Observation – Front Loading Charges

Duration of Stay	Charge
1 hour	\$300
2 hours	\$600
3 hours	\$750
4 hours	\$778
5 hours	\$806
6 hours	\$834
7 hours	\$862
8 hours	\$890
9 hours	\$918
10 hours	\$946
11 hours	\$974
12 – 24 hours	\$1,000



Observation – Front Loading Charges

- May have to adjust methodology to allow automatic reporting of hours on UB-04
- Revenue code 762
 - G0378 or G0379
 - Do not report 99218-99220
- 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
 - 30 day service period
 - 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

- 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

- Automated Systems
 - Discharge times do not always properly reflect the time medically necessary services are discontinued
 - Errors occur when there are non-billable hours during course of stay
- Manual
 - More accurate
 - Manual process



Observation – non-billable Hours

- Active nursing documentation expected
 - Hours of services not including proper documentation of observation are non-billable
 - Must be sure Medicare does not absorb cost of non-billable services.
 - Non-billable hours must be tracked for inclusion in Medicare cost report.
 - Gross up of Observation revenues
 - Inclusion in total observation days



Observation – non-billable Hours

- Procedures performed during observation
 - Medicare allows for separate reporting
 - Other payers may pay on a fee schedule
 - Must be medically necessary
 - Internal challenges for hospital systems
- Claims Processing Manual Chapter 4 §290.2.2
 - “Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).”
 - Infusion Therapy requiring drug titration

Observation – Other Areas

- If observation is performed in other departments (i.e. emergency room, same day surgery, etc.) separate revenues should be reported in these departments
 - Allows for proper revenue and expense matching
 - Direct expenses
 - Indirect expenses
 - Must provide cost report preparer with PSR revenue allocation for revenue code 762.



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 versus Phase II Recovery

- Phase II Recovery services create billing problems
 - Revenue and expense matching
 - Revenue in recovery
 - Expense in Med/Surg or Emergency Room
 - Failure to report revenues



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
 - Must provide cost report preparer with PSR revenue allocation for revenue code 710.



Chemotherapy

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



Chemotherapy

- Recommendations for revenue vary based on location
 - Separate infusion services 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
- Must provide cost report preparer with PSR revenue allocation for revenue codes 331 and 335.



Blood Administration

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



Blood Administration

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



Blood Administration

- Billing units must equal 1
 - Blood Administration – 1 hour
 - Blood Administration – 2 hours
 - Blood Administration – 3 hours
 - Etc.



Blood Administration

- Meets billing requirements
- Provides hours for cost report if performed in Med/Surg
- Rev code 391
- Must provide cost report preparer with PSR revenue allocation for revenue code 391.



IV Therapy/Injections

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



IV Therapy/Injections

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



IV Therapy/Injections

- 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
 - May need to provide cost report preparer with PSR revenue allocation.

IV Therapy/Injections

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



Treatment Rooms

- Various services
 - Minor procedures
 - Wound Care
 - Coumadin Clinics
 - Clinic Services



Treatment Rooms

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



Treatment Rooms

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



Treatment Rooms

- CPT Code Assignment
 - 99201 – 99205
 - 99211 – 99215
 - 10000 – 69999
 - Miscellaneous 99XXX



Treatment Rooms

- Revenue Code Assignment
 - 360
 - 361
 - 490
 - 510
 - 760
 - 761



Treatment Rooms

- Final revenue codes assignment based on facility strategy to limit variation of revenue codes in each department for cost reporting purposes



Outpatient Nursing Charge Capture

- Typically the single greatest revenue opportunity that can be solved by multidisciplinary communication and commitment
- *“Infusion Confusion”*----everyone has it
 - Size of organization does not matter
 - Chargemaster driven or assigned by coding staff?
 - If assigned by nursing staff they must be specifically trained



Outpatient Nursing Charge Capture

- Probably most accurate if assigned by coding staff **IF** documentation is present
 - Nursing must step up quality of documentation
 - May also initiate charge generation
- Multiple National Correct Coding Initiative (CCI) Edits are involved



Outpatient Nursing Charge Capture

- Billing office should not 'automatically' assign modifiers to get around CCI edits
- No start time, no stop time, no documentation of route equals no billing!
- Assessment of documentation by both nursing and physician to substantiate medical necessity
- **Education, education, education**

Inpatient Bedside Procedures

- To bill or not to bill?
 - Fully inclusive room rates by level
 - Separate billing for bedside procedures
- Traditionally most facilities considered bedside procedures provided to inpatient to be part of the fully inclusive room charge

Inpatient Bedside Procedures

- Implementation of charge based DRGs has brought this issue back up to the forefront.
 - Does not impact CAH reimbursement
 - Inpatient cost is determined based on total days and not on charges

Inpatient Bedside Procedures

- Implementation of charge based DRGs has brought this issue back up to the forefront.
 - Recommendations in IPPS final rule recommending providers separately bill for bedside procedures to allow for cost finding
 - No guidance on how CMS will use this information to determine cost
 - A cost to charge ratio is not calculated for inpatient cost centers
 - Transferring direct costs to ancillary departments does not allow for accurate cost finding

Inpatient Bedside Procedures

- Options
 - Develop levels of fully inclusive room rates
 - Based on overall level of care provided on a specific day
 - Recognizes use of additional resources
 - Recommend limited number of levels
 - Need to address ability to generate proper charges in current billing system

Inpatient Bedside Procedures

- Options
 - Develop separate charges for bedside procedures
 - Determine whether to report in current Nursing departments or in existing ancillary cost centers
 - Use of current ancillary cost centers requires allocation of nursing time
 - Does not allow for proper allocation of overhead costs
 - Use of current Nursing departments do not require allocation of nursing time

Inpatient Bedside Procedures

- Options
 - Current ancillary departments
 - Use applicable revenues for individual services
 - Current Nursing department
 - Use incremental nursing revenue codes (23x) for Medicare and Medicaid
 - Commercial payors
 - Use incremental nursing revenue codes if allowed by payor
 - Otherwise use applicable revenue codes for individual services

Inpatient Bedside Procedures

- Recommendations
 - Use current Nursing department
 - Easier implementation
 - Unless can prove alternative would significantly impact reimbursement
 - Determine best methodology for charge capture
- Most importantly – Educate the nursing staff as to the methodology being used and how each methodology impacts net reimbursement



Emergency Room

- 5 levels of services
- Facility and physician billing do not need to match
- AHIMA and AMA propose levels that split out procedures from levels. Based on nursing documentation.
 - Performance of separately billable procedures should not be included in determination of E/M level



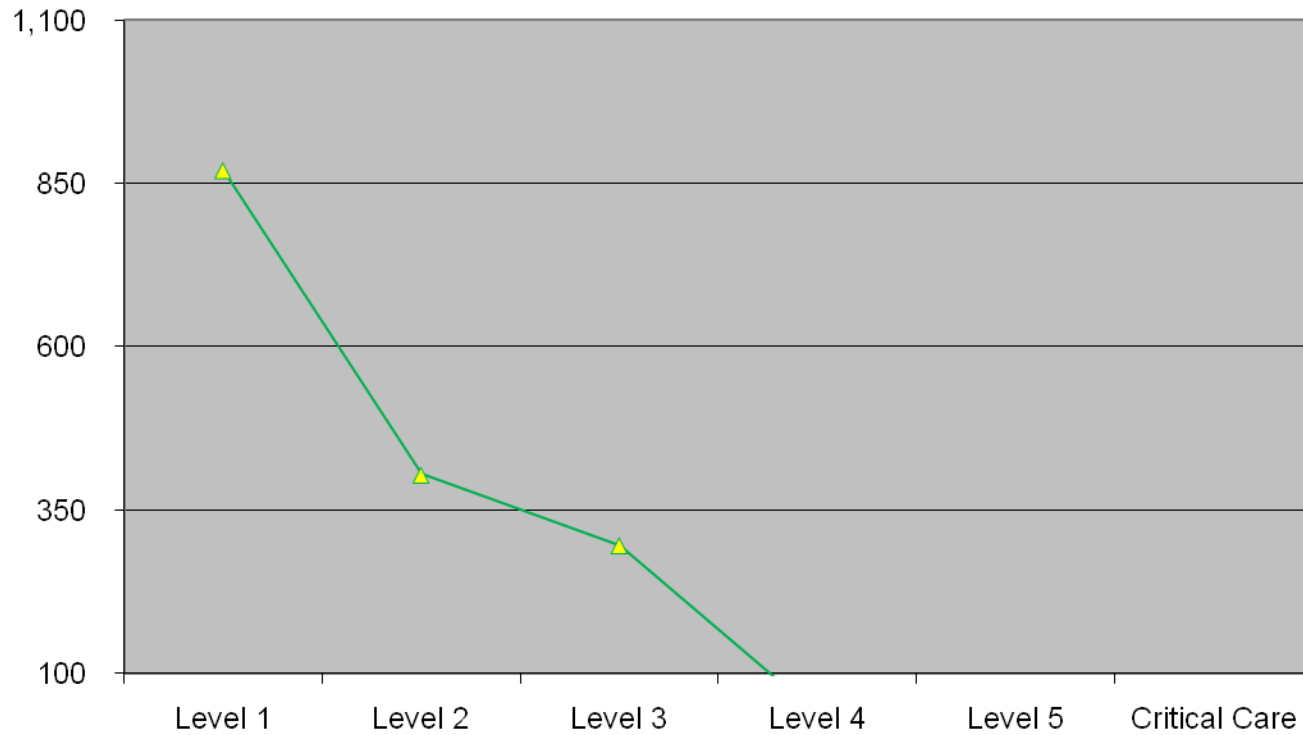
Emergency Room Billing

- Review ER E&M charges for a time period
- Plot on a graph
- Should result in a curve reflective of the level of services provided
 - If results don't prove appropriate curve, review acuity sheets with a clinical committee such as ER Charge Nurse



Emergency Room Billing

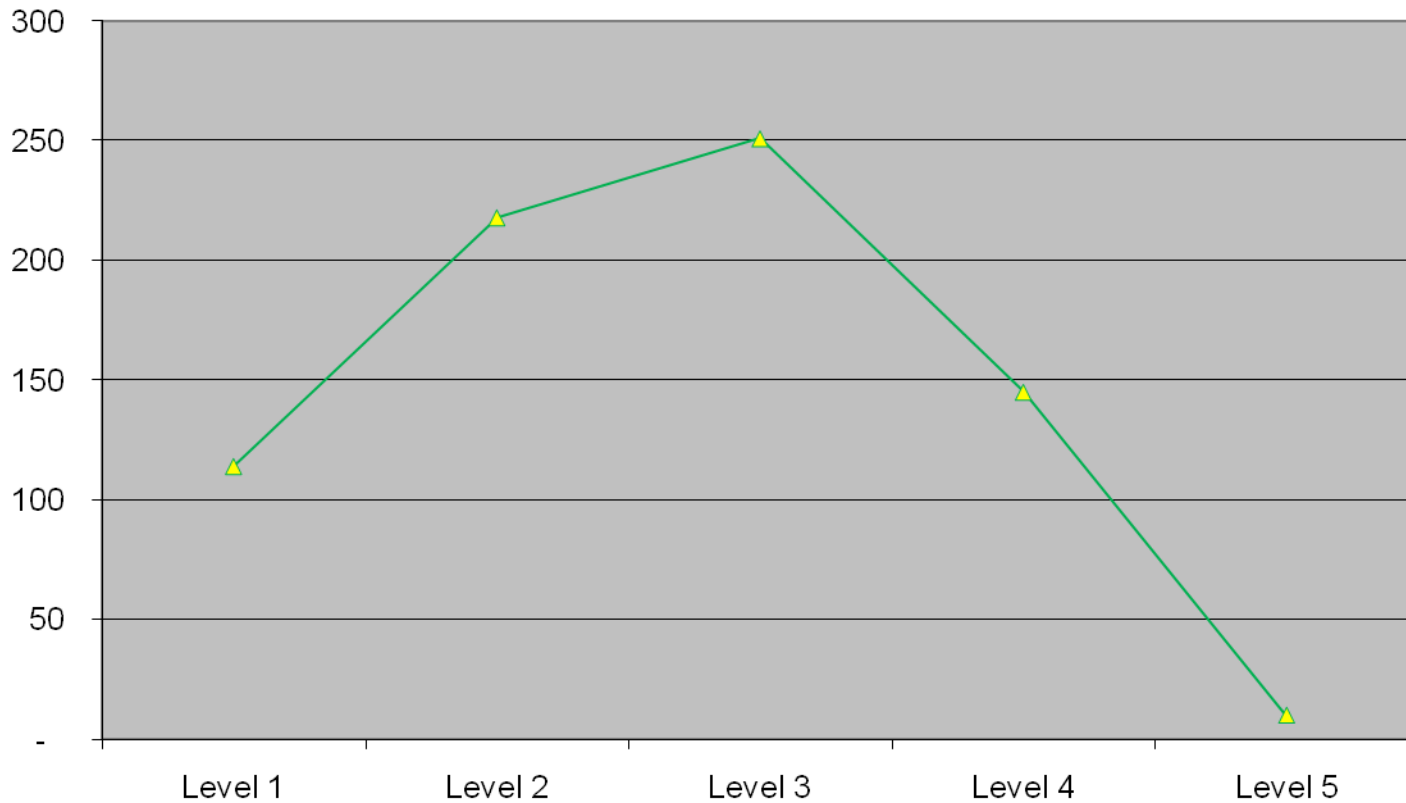
EXAMPLE - BEFORE





Emergency Room Billing

EXAMPLE - AFTER





Emergency Room Billing - Procedures

- Verify separate charges are generated for procedures in Emergency Room
 - Do not include procedures in E/M point assignments
 - Compliance
 - Reimbursement
 - Verify total charges exceed applicable fee schedules
 - Frequently occurs if separate charges are not generated



Emergency Room

- Procedures performed in Emergency Room
 - Need to **charge** for both the E&M and procedure when appropriate
 - Other payers may pay each component on a fee schedule
 - Revenue can be easily lost if single Emergency Room charge is generated and multiple CPT codes assigned to charges
 - Lower of charge or fee schedule
 - Percentage of charges contracts



Emergency Room

- Charge Capture
 - Chargemaster driven or assigned by coding staff?
 - If assigned by nursing staff they must be specifically trained
 - Probably most accurate if assigned by coding staff **IF** documentation is present
 - May also initiate charge capture



Supplies

- Many questions being raised about billing for routine supplies and equipment
 - Historically Medicare has indicated facilities are not to separately bill for routine supplies and equipment
 - Regulations do leave some room for interpretation
 - Many FIs/MACs have issued guidance indicating routine supplies and equipment are not separately billable
 - Some guidance from outside consultants recommending facilities separately bill for these items
 - Opportunity to improve reimbursement from third party payors



Supplies

- Issues to be addressed
 - Guidance from FI/MAC
 - Noridian – December 2009
 - Consistency in billing all payors
 - Revenue code 27x versus other revenue codes
 - Must address revenue and expense matching for cost report purposes



Supplies

- Recommendation
 - Continue to develop fully inclusive rates for services that reflect cost of supplies and equipment
 - Only payors that will reimburse these costs are those that reimburse based on charges or percentage of charge
 - Properly developed fully inclusive charges allows facilities to maintain streamlined billing process while receiving appropriate revenues from these charge based payors
 - Supports movement toward patient friendly billing



Supplies

- Currently most providers report all revenues and expenses for billable supplies in single cost center on cost report
 - Line 55 – Medical Supplies Charged to Patients



Supplies

- Results in charge compression
 - Occurs when charges for higher cost supplies are based on a lower mark-up methodology than for lower cost supplies
 - Medicare utilization for these high cost supplies is often higher than average supply utilization
 - Results in lower Medicare reimbursement



Supplies

- Example – single cost center
 - Direct costs = \$400,000
 - Overhead costs = \$400,000
 - Revenues = \$2,000,000
 - Medicare utilization = 50% (\$1,000,000)
 - Cost to charge ratio = 0.40
 - Medicare reimbursement
 - $\$1,000,000 * 0.40 = \$400,000$



Supplies

- Example – separate cost center
 - Direct costs
 - Low cost supplies = \$240,000
 - High cost supplies = \$160,000
 - Overhead costs
 - Low cost supplies = \$240,000
 - High cost supplies = \$160,000
 - Revenues
 - Low cost supplies = \$1,680,000
 - High cost supplies = \$320,000



Supplies

- Example – separate cost center
 - Medicare utilization
 - Low cost supplies = 45% (\$760,000)
 - High cost supplies = 75% (\$240,000)
 - Cost to charge ratios
 - Low cost supplies = 0.29
 - High cost supplies = 1.00
 - Medicare reimbursement
 - Low cost supplies = \$220,400
 - High cost supplies = \$240,000



Supplies

- Impact
 - Old Medicare reimbursement = \$400,000
 - New Medicare reimbursement = \$460,400
 - \$60,400 improvement
 - 15% improvement on supply reimbursement!



Supplies

- To correct this issue CMS has proposed to segregate billable supplies into two cost centers on updated cost report worksheets
 - Line 71 – Medical Supplies Charged to Patients
 - Line 72 – Implantable Devices Charges to Patients



Supplies

- Split to be based on revenue code assignment
 - The corresponding revenue codes for each cost center are as follows
 - “Implantable Devices Charged to Patients”
 - Revenue codes 275 (Pacemaker), 276 (Intraocular Lens), 278 (Other Implants) and 624 (Investigational Devices (IDEs))
 - “Medical Supplies Charged to Patients”
 - Revenue codes 270 (General classifications), 272 (Sterile Supply) and 273 (Take-home supplies), and all other supply codes not included in the “Implantable” cost center



Supplies

- Operational issues for consideration
 - The expenses and revenues coded to these cost centers on the Medicare Cost Report would be based upon the revenue codes for the supplies billed
 - Most likely will require new general ledger department on cost report
 - Will require use of line 14 for Central Supply if not currently used



Imaging Services

- In the past most smaller providers have reported all imaging services in a single department or cost center
 - Due to limited number of alternative cost centers available on cost report
 - Due to commingling of space and staff
- This methodology can lead to inappropriate cost based reimbursement
 - Variation in mark up between various service lines
 - Variation in Medicare utilization between various service lines

Imaging Services

- Updated Medicare cost report will continue to have current cost center options with new breakouts in for imaging services
 - Line 54 : Radiology – Diagnostic
 - Line 55 : Radiology – Therapeutic
 - Line 56 : Radioisotope
 - Line 57 : CT Scan
 - Line 58 : MRI
 - Line 59 : Cardiac Catheterization

Imaging Services

- These breakouts will afford providers with an opportunity to analyze the potential benefits of separate identification of costs
 - Recommend modeling impact before implementing any changes



Imaging Services

- Analysis will require the separate identification of all revenues and expenses by service area
 - Salaries
 - Direct expenses
 - Overhead allocations will need to separately identified for each service area based on facility's allocation statistics
 - Square footage
 - Equipment depreciation
 - Laundry pounds
 - Housekeeping time studies
 - Medical Records time studies
 - Etc.

Imaging Services

- Departmental Overhead such as departmental supervisor will need to be separately identified and allocated in manner similar to Nursing Administration
- Impact will vary by provider
- Will most likely require updates to current chargemaster



Other Opportunities

- Other opportunities similar to Supplies and Imaging
 - Chemotherapy
 - Cardiac Rehab



Closing

- The reimbursement opportunities and risks are significant for the critical access hospital.
- Ongoing monitoring and strong communication between departments and Management can allow facilities to protect and enhance overall revenue streams.



Questions??
