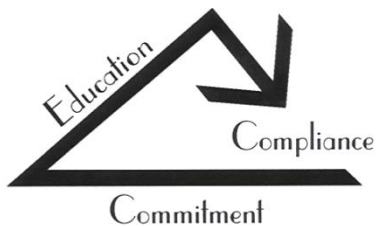


GETTING THE KINGDOM IN ORDER

CAH - Charge and Chart Audit for CASH

AR Systems, Inc.



THE BIG PICTURE

Focusing On Revenue
Capture

With Appropriate
Documentation =

Real, Sustainable Cash

UNDERSTANDING REVENUE

OWNERSHIP -THE SHORT

VERSION

- ⦿ Average daily revenue = charge tickets = revenue generating departments
- ⦿ Average daily cash = C A S H = HIM & PFS/business office
- ⦿ Average daily expenses = all employees
Gap between ADR and ADC = contractuels/absorb
Gap between ADC and expenses = profit (!)

LET'S START AT THE BEGINNING..

- Welcome to the charge master - **CDM**
 - It houses all charges that are billable
 - It houses all stats-only items
 - It houses all hard coded CPT codes
 - It houses all activity used for productivity
 - It requires at least yearly updating with changes in the CPT and HCPCS manuals
 - It houses all regulatory billing requirements

CREATING A FOCUS ...AND KEEPING IT

- ◉ Determine accountability for charge capture
- ◉ Determine an internal strategy for ensuring success thru ongoing education & audit
- ◉ Determine focus on aligning cost to charges
- ◉ Determine a commitment to completeness & accuracy of the bill

AND WHO IS THE OWNER OF THIS PROCESS-

Yep, Department Heads... Psst.... Do they know it??

- ◉ Let's review how to make the above goals attainable.

GOLDEN RULE FOR CHARGING

- Use Medicare Guidelines for all payers
- No care team/charge capture staff member can even tell who the payer is for the pt.
- **Question**: How are charges to be created?
- **Answer**: Cost plus a reasonable mark up



STANDING PROUD W/OUR PUBLIC

- What is patient loyalty?
- Commitment?
Responsiveness?
Great service?
- Yes, great components of patient loyalty, but it doesn't answer the question.
- In one word, loyalty is a feeling or an emotion.
- Pt loyalty is a feeling people have about you that inspires them to keep coming back.

"The pocket guide to patient loyalty" by Joe Heuer

Balance paid = Felt Empathy

Return = All aspects of care met

REVENUE OPPORTUNITIES W/IN THE CDM

- ◉ Key to success is department ownership
- ◉ Key to success is understandable charge descriptors. The MOM TEST!
- ◉ Key to success is ongoing CDM/Revenue Integrity Team work in identifying revenue opportunities, changing regulations and teaching to all effected individuals.
- ◉ Key to success is automation for research, etc—but only with the above elements!!

“



How involved is each department head in the ownership of the Charge Master?

Hot Spots to monitor and aggressively address:

Yearly CPT coding updates. Each department head has the responsibility to review all charge master codes, compare against the new codes, and make appropriate changes. (New codes Jan. yearly)

Conduct a yearly CPT code versus CDM versus the charge ticket. This will identify new CPT-4 ancillary codes; volume attached to charge numbers will identify which charge numbers are and are not being used; and ensure that the charge ticket accurately reflect chargeable items.

SAMPLE DEPARTMENT HEAD'S CHARGE MASTER WORK PLAN

GET STARTED: run CDM with Volumes

- Cry and curse a lot!
- Review all charge sheets used
- Get the CDM
- Get the current CPT manual
- Get Addendum B/Medicare's APC \$
- (CAH not paid by APC/free resource)

Begin to go through each chargeable item:

- Compare charges to Addendum B/CMS
- Learn about the co-insurance assignment
- Evaluate for new CPT codes
- Questions to the Revenue Integrity team

PATIENT FRIENDLY BILLING

RECOMMENDATION #13 -

UNDERSTANDABLE CDMS

- Billing & CDM should be understandable.
- Designed to promote understanding by patient and insured.
- Use standardized process for accuracy of each chg, description & code.
- **BEST PRACTICES:**
 - Reviewed periodically
 - Designed to promote pt understanding- key elements in the descriptor: w, w/o, bi, uni, views, ltd, complete - with a focus on the MOM TEST.
 - What will the patient understand? They are the audience.
 - Use standardized process- CDM Integrity team

WHO IS THE AUDIENCE FOR THE CDM?

- When the patient calls your BO, can they explain the itemized bill --which is the CDM? (Hint - use 2 descriptors-1 internal/techy; 2/patient friendly)
- If not, patient friendly, with key indicators in the descriptor.
- **Audience for the itemized bill:**
 - Auditors/payers
 - Patients
 - Business Office who has to attempt to answer the pt's call.
 - Internally -dept can create a techy descriptor separate from the itemized bill

- Patient Friendly Billing Project
- Maintain key elements in all descriptors:
with/without, views, bi, uni, limited, complete-but revise descriptor to tell patient what the charge is.
- Does it pass the Mom Test?
 - CXR2V??
 - OS Calcus 2V?
 - Otoacoustic Emissions testing?
 - Orbits without contrast?
 - DupAorta/IVC Iliacs/Graft com?



CDM GOLDEN RULES

Global Issues:

1. **Standardize pricing throughout the organization.** Each department head should know how pricing is established and incorporate same into all new items or new services. Standardize direct and indirect costs prior to the mark up process per department. This process should be understood by the department head and documented.
2. **Understand the difference between billable and payable.** Not all services are payable under Medicare, but if they are billable—they should be billed. Standardizing billing practices will ensure maximum revenue is collected from other payers.
3. **One code = one charge.** Many departments have **fee schedules** that are severely impacted by historical billing practices to the payers. Ensuring that payers only receive one charge for each HCPC code is important to protect future fee schedules. (CAH are not paid by fee schedules by Medicare; other payers? Historical data base integrity)
4. **Yearly update all CPT and HCPC codes.** The AMA publishes new CPT manuals yearly. Each department head should review all codes for deleted, new and revised codes. (NOTE: The codes are directed toward physician/AMA services. Some may be used differently in a hospital setting.)

GLOBAL ISSUES (CONTINUED):

5. Conduct yearly walk throughs of each department. With each new CPT manual, take the opportunity to look at each service, each charge and identify any new revenue in each department.
6. Patient friendly descriptions. Remember that the patients and the billing office are the primary customers for the charge descriptors. Keep them simple and easy for the audience to understand. Continue to tie the descriptor to the CPT narrative with an additional component of patient friendly. IT CAN BE DONE!
7. Eliminate "miscellaneous" and "charge editable/zero" charges. Both of these create dual problems: a) they cannot survive audit and b) assigning pass through codes would be impossible. Patients and auditors/payers also have problems with "miscellaneous" on the itemized charges. (NOTE: IF stats only, indicate same in descriptor.



AND THEN THERE WAS CHARGE CAPTURE-- IDENTIFY THE HOT SPOTS

- ◉ Lost Charges/Revenue
- ◉ Daily Charge Reconciliation
- ◉ Cost of Late Charges

- ◉ And easy chart/charge audit to identify documentation challenges and charge alignment

NOW BEGIN THE AUDITING PROCESS TO DETERMINE WHAT MIGHT BE BROKEN...

○ Department Benchmark UB04 audits:

- Compare 10 UB-04/billing documents against the itemized statement- Outpt areas 1st (Obs, ER, Surgery, Hospital based clinics/IV therapy/Chemo)
- Look for potential lost charges (ER: sutures but no procedure)
- Look for billing combinations that were missed: 250/pharmacy -how was it given? IV Infusion, injection
- Look for non-billable items present: Medicare outpt self administered medications/pt pays; routine supplies
- Look for descriptions that won't pass the 'Mom' test
- Look for charges that are not uniform across the facility

BRAINSTORM -LOST CHARGES

- ⦿ Not 'new revenue' but lost revenue
- ⦿ Question: "What services are we currently not billing for or costs that we are not covering?"
- ⦿ Brainstorm with department heads, compile a master list and start looking - primarily outpatient but limited inpt.



WHAT DOES A LOST CHARGE LOOK LIKE

- Focus on high stress/severity of illness areas
- Focus on labor intensive processes
- Ask all depts to look for potential lost revenue
 - Code Blue - how is nursing assuring charges made it to the bill? Drugs? Supplies? 92950/Cardiac Arrest? Procedures done?
 - “Sticky” for supplies - nursing has them on their clothing. Who do they belong to? How many go down on the sheets?
 - Patient complaints - once research, corrected claim -but is research done to determine who the charge really does belong to?

HOT SPOTS FOR LOST REVENUE

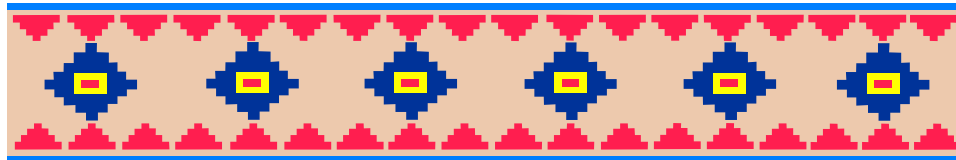
- ◉ Recovery - house wide - up to 4-6 hrs
- ◉ Nursing services in ancillary areas
- ◉ Drug Administration - Observation
- ◉ OB - from ER, scheduled visits, delivery rates
- ◉ Hospital based clinics - E&M visits
- ◉ Blood transfusion - house wide
- ◉ Scheduled procedures done in the ER
- ◉ OR - Implantables & invoice reconciliation

THE “COST” OF A LATE CHARGE

- Rework - to the individual dept, to PFS and the pt -as they get corrected bills/EOBs
- Reprocessing the claim, lost productivity
- Lost Revenue with limited accountability
- Decreased patient satisfaction
- Track and trend repeat late activity, dept specific
- Do dept heads know what a late charge is?

CREATE DAILY RECONCILIATION PROCESS

- **Daily Dept-Specific Audits:**
- Compare scheduled/resulted/completed patients against charges generated. (2 day lag)
 - Manual schedules or automated
 - Registrations with no charges. Why?
 - Ensure each patient activity is accounted for.



LOOK FOR CHARGE OWNERSHIP

- Nursing is not good at charge capture..so...
- Aggressively look for ways to move ownership with nursing still responsible for charting, not charging:
 - Lab - Blood Transfusions/36430. Auto have Blood products/P + 36430 bill together. (Safety net: billing edit to reject any claims without both 390 and 391 present.)
 - **Charge Capture Analyst** - identifies charges, completes charge ticket and logs all lost charges due to missing documentation. Nursing's partnership is to ensure the start and stop times of each bag are present. CCA 's partnership is charge capture. WORKS!

ATTACKING PROBLEMATIC CHARGE CAPTURE PROCESSES

- ◎ **Observation** - IV Infusion, Injections, Blood Transfusions, output procedures
 - IDEA: Identify an owner to charge capture on the unit or move to Charge Capture Analyst
 - IDEA: Drug Administration & bedside procedures = major lost revenue
 - IDEA: Create Observation Attack Team to audit daily for billable time, G code, and charge capture for nursing procedures, Condition Code 44 = 1 touch.

DRUG ADMINISTRATION

CHALLENGES

- ⦿ High area of lost revenue: ER to observation, direct obs, OR to obs
- ⦿ Co-mingling inpt and obs beds = highly problematic time charting for drug administration.
- ⦿ Focus nursing on charting start and stop times to capture every minute.
- ⦿ Charge capture is highly complex for nursing

WHAT IS A HOSPITAL BASED CLINIC?

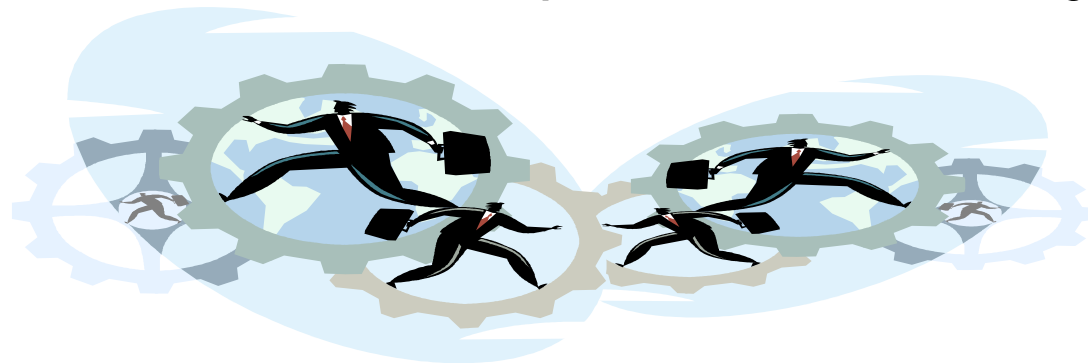
- Two kinds - a department of the hospital and a hospital-owned, physician directed clinic.
- Brainstorm the outpt services that could be a HBC: wound, transfusion, MNT, pain, nursing services done in imaging, cancer, IV outpt therapy, OB, ambulatory services done after the physician's office closes
- "Visits' (99211-15/510 or 761) are billed under incident to for both types of HBC.
- Individual leveling criteria, separate from physicians, must be documented and leveled.

NURSING REVENUE OPPORTUNITIES

- ◉ Drug adm - nursing floating outside the care area. Who is completing the charge ticket?
- ◉ OB - look at the aspects of outpt : ER to OB; scheduled visits; post inpt discharge/lactation HBC visit.
- ◉ Scheduled visits in the ER - bill as a HBC visit
- ◉ Drop in pts for after care as an outpt - bill as a HBC visit (suture removal, follow up care)
- ◉ All Drug Adm and Blood -outpt housewide
- ◉ Physician orders, medically necessary services, E&M leveling for all HBC visits, incident to the physician

RT DONE BY RN - OUTPATIENT OPPORTUNITY

- **RT** done by an RN - billable as an outpt only (OBS, ER, Hospital based clinic) ; part of the R&B inpt/Nonbillable (MIM Section RT 3101.10 B #2, #6)
- As this is an 'interp', confirm with your FI



AND MORE.....

- ◎ Pharmacy -triggers ripple revenue in outpatient areas
 - IDEA: Look at revenue codes: 250/IV, IM, sub and 636 and ask: How were these given? IV infusion and/or injection codes should be present.
 - IDEA: Both routing and dosage should be in all pharmacy narratives-drives other nursing revenue.
 - IDEA: Perform audits to ensure both the drug and how it was given/nursing's charges are present.
 - IDEA: Look for alternatives to do charge capture -like observation.-but also charge off the MAR.

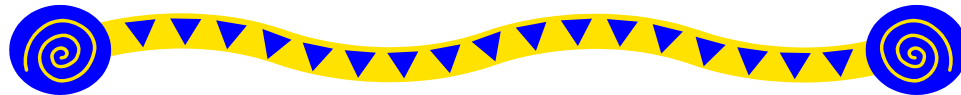
AND MORE.....

◎ Emergency Room

- Look for 3 'separately identifiable services" - nursing, surgical/interventional, E&M/visit
- Always bill the procedure 1st, then look to the ER visit.
- Closely watch the bell curve for outpt E&M levels = reasonably relate intensity of services to the 5 levels
- Ensure no 'double dipping' is occurring within the E&M leveling tool. (CPT code billed separately PLUS included in the E&M leveling)

FOCUSING ON THE HOT DEPARTMENTS

- **Blood and Blood Transfusion** - Partnership with nursing and blood bank/charge and charting
 - IDEA: Have blood bank/lab input charges for both the blood product/handling (P codes) and the transfusion (36430) Nursing charts.
 - IDEA: Build internal computer edit to reject any claims without 390 AND 391 present.



AND MORE...IN CASE YOU WERE BORED

- ◉ OR/Invasive procedure - Options: procedure based and time based.
- ◉ Explore creating time based service lines, add levels when significant costs regarding a) nursing and b) equipment
- ◉ Reduce pricing in multiple procedures in 1 encounter
- ◉ Aligns costs to charge - no 'averaging', actual time
- ◉ No hard coding of CPT codes. HIM codes from dictation
- ◉ Explore creating service line-specific categories
 - Options: OR with GYN 1st 15 minutes, OR with OB/GYN each additional minute
 - Options: OR with eyes, per minute (no front loading)
 - Options: Endo 1st 15 minutes, Endo each additional minute
 - Unscheduled = Emergent. Ortho unscheduled per minute.

...SIZZLIN' DEPARTMENT

◉ Recovery

- ◉ Moderate Sedation=2006 change; inc recovery
- ◉ Recovery must be clearly charted-PACU and handoff to nursing -up to 4-6 hrs /outpt
- ◉ Inpt = only PACU is billable; in-room recovery covered in the R&B rate
- ◉ Explore creating 'phases' to align costs to charges or anesthesia specific options.

Phase 1 (post procedure 1-to-1, high chg) + (in PACU)

Phase 2 (less than 1-1, lesser chg) up to 4-6 hrs (outside PACU/care areas)

Extended (after routine recovery of 4-6 hrs) Usually in care areas

STARRED* PROCEDURE -EXCEPTION

- ◉ Appendix G/CPT = list of included CPTs
- ◉ Conscious Sedation is used 99.9% so therefore inherent and not separately billable.
- ◉ Since C/S is used, see CPT 99148-50 for guidelines regarding recovery. Inherent and not separately billable,
- ◉ Ensure the procedure \$ includes all these.

MEDICARE GUIDANCE ON ROUTINE RECOVERY

Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)

MORE INPATIENT ISSUES

- Evaluate options to capture 'non-routine' services - remembering cost report impact
 - Bed side procedures as additional charge/761
---OR---
 - Create a 'high intensity R&B rate" when procedures are done in the room. Semi, Private and High intensity. Each patient will have to be "managed" and moved to the higher R&B daily, defaulting back to the primary room assignment.
 - EX) 1 day high intensity \$900 3 days semi \$800 = 4 LOS

INPATIENT POTENTIAL

- Most nursing services are covered in 'routine care' - usually defined as 6-8 hrs of direct patient care. To bill separately, must go beyond 'routine.'
- Develop pre-established criteria for charging a high intensity R&B when services exceed 'routine.'
 - Suicide watch, Restraints, Isolation, Skilled Sitter, 1on1, tele, specialty bed & /or bedside procedure. (Discuss Bedside separately)

ROUTINE VS NON-ROUTINE SUPPLIES—HELP



The Medicare Reimbursement Manual defines Routine Services in 2202.6 on page 22-7:

"Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the "room and board" charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

"In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. " (See § 2203.1 for further discussion of routine services in an SNF.)



ROUTINE SUPPLIES -ALWAYS A CHALLENGE

MEDICAL SUPPLIES ARE THOSE ITEMS THAT, DUE TO THEIR THERAPEUTIC OR DIAGNOSTIC CHARACTERISTICS, ARE ESSENTIAL TO THE CARE ORDERED BY THE PHYSICIAN TO TREAT OR DIAGNOSE THE PATIENT'S ILLNESS OR INJURY. THESE SUPPLY ITEMS FIT INTO TWO CATEGORIES:

- ROUTINE (NOT SEPARATELY BILLABLE) SUPPLIES ARE CUSTOMARILY USED DURING THE USUAL COURSE OF TREATMENT, ARE INCLUDED IN THE UNIT SUPPLIES AND ARE NOT DESIGNATED FOR SPECIFIC PATIENT.
- NON-ROUTINE (SEPARATELY BILLABLE) SUPPLIES ARE NECESSARY TO TREAT A SPECIFIC PATIENT'S ILLNESS OR INJURY BASED ON A PHYSICIAN'S ORDER AND A DOCUMENTED PLAN OF CARE.

CONDUCTING A CHARGE, CHART AUDIT

- At least quarterly, take a small sample and compare orders, against documentation of service, against actual billed service against the UB.
- Ensure they all match -consider:
 - Protocol vulnerabilities
 - LCD/NDC limitations
 - Physician orders present
 - Severity of illness /doctor w/intensity of services/nursing
 - Evaluate the impacts of the hybrid medical record
 - DEVELOP CORRECTIVE ACTION with compliance

MONITOR THE PROCESS

- ◉ For charge capture to work, each individual must understand their role in the process.
- ◉ Explore observing each area, 24 hr shift
- ◉ Develop charge capture internal manual - addressing manual process, order entry, and other, more unique processes - pods, HIM, etc.
- ◉ Develop feedback process for Dept-specific auditing

CELEBRATE THE BABY STEPS...

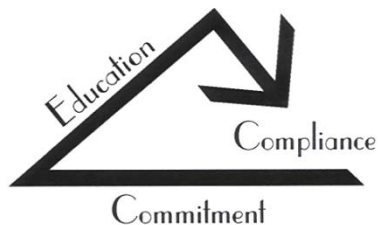
- ◉ Using the benchmark audit, track and trend new dollars identified, dept specific
- ◉ Using the benchmark audit, report audit variances with accuracy and corrective action taken
- ◉ Using the benchmark audit, report new revenue, improved ownership and other cultural changes



FINALLY, CREATE TRACKING SYSTEMS

- Using the ongoing department-specific audits, create tracking systems/T-N-T
 - Accuracy of claims
 - Revenue identified
 - Lost charges lost no more!
 - New understanding of ownership
 - Change of culture
 - REPORT progress at Dept head meetings





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NEXT STEPS - YEARLY (AT LEAST)

REVIEW

- Brainstorm broken processes, per department
- Brainstorm/identify opportunities, per department.
- Categorize into three divisions:
 - Revenue, compliance, customer service.
 - Then prioritize the 'to do' list
 - Finally, identify owners and timelines
 - CELEBRATE baby steps - report progress frequently

ROLE OF CDM/REVENUE INTEGRITY TEAM

The CDM Integrity Team is integral to the long-term success of the CDM.

Members: CDM Coordinator, IS, BO, Compliance, Contracting, Finance, administrative representative, key department heads, HIM (change makers/ambassadors) Guests can be added as needed.

General Functions

❖ Oversees all activity in the CDM

○ Includes:

Developing and oversight of the organization-wide policy and procedure-including adapting the change-form as necessary.

Reviewing and educating on new Medicare regulations and other payer requirements. (contracts)⁴⁶



ROLE OF CDM/REVENUE INTEGRITY TEAM

Diagramming the process flow for updating, changing, etc. the CDM-including assessment the volume of items for activity level.

Reviews all new or change items to the CDM with a focus on standardizing like items, looking throughout the organization for other areas providing similar services and educating on same. (Focus on Routine supplies)

Providing yearly department head education on CDM issues.

Like-Item Pricing audits - as new items are added to specific area.

**FOCUS ON PATIENT FRIENDLY
and SIMPLIFY!**



NOT SEPARATELY BILLABLE ITEMS (KANSAS FI 10/00)

- The purpose of this bulletin is to provide cost report reimbursement instructions for supplies/items pertaining to hospital patients. A list such as this cannot be all inclusive nor can it be current with all technology advances. The final determination of an item or service as routine or non-routine is that of the fiscal intermediary. Generally, the definitions listed below and section 2202.6 of HCFA Pub 15-1, should be used to determine if an item/service is routine or ancillary. Your facility should coordinate these cost report reimbursement instructions with its UB-04 billing procedures.

ROUTINE OR ANCILLARY SUPPLIES / EQUIPMENT (EXAMPLES)

THE FOLLOWING IS A REFERENCE TOOL (NOT ALL INCLUSIVE) TO BE USED TO DETERMINE WHETHER A SUPPLY ITEM SHOULD BE CONSIDERED ROUTINE (AND THEREFORE NOT SEPARATELY BILLABLE TO MEDICARE) OR ANCILLARY (SEPARATELY BILLABLE TO MEDICARE) [SOURCE: MEDICARE PART A BULLETIN, NO. 95-10-12- BY ADMINASTAR FEDERAL, OCT 17, 1995]:

Preparation Kits	Any linen
Gowns	Gloves
Oxygen masks	Syringes and needles
Saline solutions	Sponges
Reusable items	Cardiac monitors
Oximeters	Oxygen supplies
IV pumps	Blood pressure monitors
Thermometers	Ice bags or packs
Heat light or heating pad	Wall suction
Specimen collection containers	Alcohol or peroxide

ROUTINE OR ANCILLARY SUPPLIES / EQUIPMENT (EXAMPLES)
CONTINUED...

Betadine / phisohex solution	Slippers
Iodine swabs / wipes	Powders
Lotions	Blood pressure cuffs
Pads	Drapes
Cotton balls	Urinals / bedpans
Irrigation solutions	Pillows
Towels	Diapers
Soap	Tourniquets
Gauze	Supplies (self-admin inj)
IV tubing	

CHARGEMASTER COORDINATOR

(SAMPLE)

STATEMENT OF PURPOSE

The hospital must be diligent in assuring accurate and appropriate charging for all services performed for its patients. This coordinator will focus on accuracy and appropriateness of charges, coding and billing as it relates to Medicare and other payer issues. A primary focus will be on leading the organizational efforts in Outpatient Prospective Payment.

Major Tasks, Duties, and Responsibilities

1. Ensure the facility knows keys for CDM Integrity
 2. Updated CPT-4 coding manuals - yearly
 3. Payer changes/updates - ongoing education
4. Evaluate like item pricing - throughout each department
5. Lead the CDM Integrity Team -grow champions
6. Evaluate new revenue opportunities while 'keeping it simple.'
7. Focus on patient friendly charge masters - Mom Test!