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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 because of its extensive amount of detail and the time required to maintain it.
 - Changes in organizational structure and programs
 - Changes in payor rules



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



Medicare Cost Reimbursement

- 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

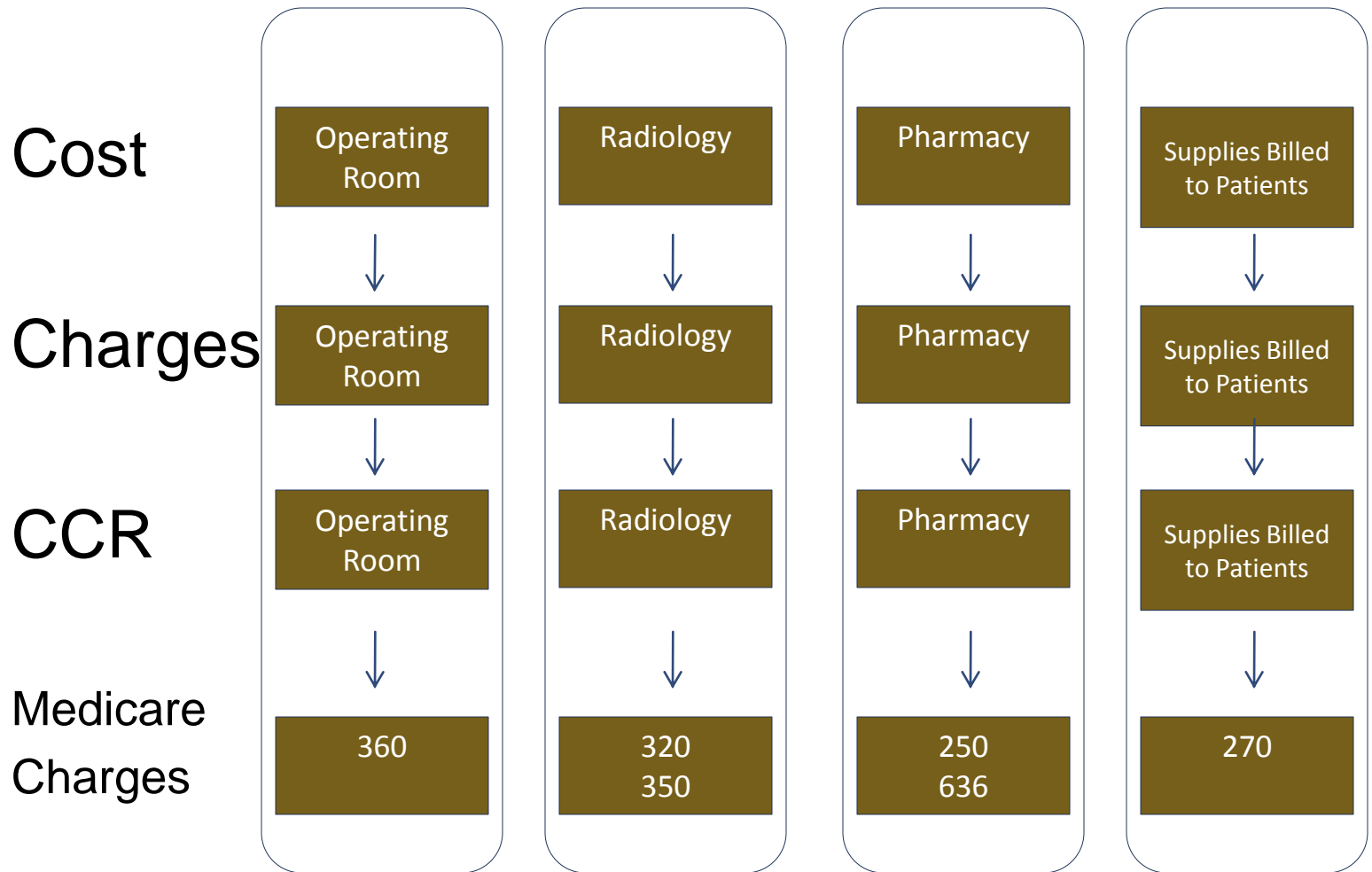


Medicare Cost Report

- 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
 - Blood Administration
 - IV Therapy
 - Injections
 - Sleep Studies
 - 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
 - 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 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

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 – 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

- 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 – Billable Hours

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



Observation – non-billable Hours

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



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?



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
 - 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 762.



Chemotherapy

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



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
- Must provide cost report preparer with PSR revenue allocation for revenue codes 331 and 335.



Blood Administration

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



Blood Administration

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



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

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



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



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



Injections

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



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



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
 - Establish services based on length of service (i.e., Sleep Study – 8 hours, Sleep Study – 9 hours, etc.)



Treatment Rooms

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



Treatment Rooms

- Recommendations for revenue vary based on location
 - Separate 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

- “*Infusion Confusion*”-----everyone has it
- 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
- 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
 - 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
 - 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



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

- 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

- 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 68 – Medical Supplies Charged to Patients
 - Line 69 – 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



Supplies

- Chemotherapy?
 - Same issues and opportunities as high cost supplies
 - Drugs
 - Nursing and other expenses



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



Questions??

