CDM Maintenance and Charge Capture

prepared for
HomeTown Health Revenue Integrity

Presenters

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  Participating Partner
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Disclaimer

• Every reasonable effort has been taken to ensure that the educational information provided in today’s presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation.
Agenda

- Overview of the Chargemaster
  - Definition/Example
  - Reimbursement
- CDM Compliance Risks for 2015
- Ancillary Department Review
  - Structural Issues
  - Ongoing Maintenance/Charge Capture Strategies
- Discussion

Learning Objectives

- Participant will understand the structure of a chargemaster (CDM) and common reimbursement methodologies.
- Participant will learn general tips for maintaining an up-to-date and compliant CDM.
- Participant will be able to identify charge capture strategies for typical ancillary services.

Chargemaster – Definition

- What is a Chargemaster?
  - A Chargemaster is a file containing all of the procedures, services, pharmaceuticals, supplies, and professional fees provided by a hospital or under hospital contract and billed on a UB-04 and/or CMS-1500.
  - Sometimes referred to as a CDM or Charge Description Master, it may contain several thousand lines.
  - It can be equated to a “Super Bill” on the pro fee side.
Chargemaster - Example

- Here are some fields from a typical CDM:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RX</td>
<td>PANTOPRAZOLE 40MG INJ</td>
<td>01164 or 02490 0636</td>
<td>C5113</td>
<td>0250 or 0036</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td>SLP SPEECH SCREENING</td>
<td>V5362 0444 (non-covered)</td>
<td>E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARD</td>
<td>ECHO 2D W/O DPLR COMB W/CON</td>
<td>93107 0481</td>
<td>C8923 0481</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chargemaster – Reimbursement

- Medicare reimburses most outpatient services under the OPPS
  - OPPS stands for Outpatient Prospective Payment System, which began in August 2000.
  - However, those of us who have been in the industry a while know that it really means... "Oh Please Pay Something"... and especially after some of the changes for 2015!

https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage

Chargemaster – Reimbursement

- Under the OPPS, Medicare pays the hospital a rate-per-service basis known as an APC or Ambulatory Payment Classification system that:
  - Varies depending on the CPT/HCPCS code(s) and status indicators
  - Is CPT/HCPCS-driven and updated/published quarterly
  - Can include multiple APC payments (and even other payment methodologies) on a given claim for a given outpatient encounter

Chargemaster – Reimbursement

• Other outpatient payment methodologies include:
  – Fee schedule/Fee-for-service
  – Contracted/Capitated rate
  – Percentage of charges
  – Per diem
  – Any combination of the aforementioned methodologies

Chargemaster - Reimbursement

• APC Addendum B Example:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>CI</th>
<th>SI</th>
<th>APC</th>
<th>Relative Weight</th>
<th>Payment Rate</th>
<th>National Unadjusted Copayment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>70010</td>
<td>Contrast x-ray of brain Q2</td>
<td>0274</td>
<td>8.2817</td>
<td>$614.04</td>
<td>. $12</td>
<td>2.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70015</td>
<td>Contrast x-ray of brain Q2</td>
<td>0274</td>
<td>8.2817</td>
<td>$614.04</td>
<td>. $12</td>
<td>2.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70030</td>
<td>X-ray eye for foreign body CH Q1</td>
<td>0260</td>
<td>0.8004</td>
<td>$59.34</td>
<td>. $11.87</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70100</td>
<td>X-ray exam of jaw &lt;4 views CH Q1</td>
<td>0260</td>
<td>0.8004</td>
<td>$59.34</td>
<td>. $11.87</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70110</td>
<td>X-ray exam of jaw 4/&gt; views CH Q1</td>
<td>0261</td>
<td>1.2810</td>
<td>$94.98</td>
<td>. $19.00</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70120</td>
<td>X-ray exam of mastoids CH Q1</td>
<td>0260</td>
<td>0.8004</td>
<td>$59.34</td>
<td>. $11.87</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
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<td>$94.98</td>
<td>. $19.00</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chargemaster – Reimbursement

• APC-Included Services
  – Surgical Procedures
  – Radiology
  – Radiation Therapy
  – Clinic Visits
  – ED Visits
  – Diagnostic Services
  – Partial Hospitalization
  – Surgical Pathology
  – Chemotherapy
  – Blood Products

• APC-Excluded Services*
  – Molecular Pathology
  – PT, OT, and SLP
  – Prosthetics/Orthotics
  – Dialysis for ESRD
  – Ambulance Services
  – DME
  – Inpatient SNF
  – Hospice/Home Health
  – Screening Mammography
  – Professional Fees

* Paid under other methodologies, e.g., fee schedules, as mentioned previously.
Chargemaster – Reimbursement

• Status Indicators (SI) identify what services are payable under APCs, i.e., which are included and which are excluded. Status Indicators are:
  – A single alpha or dual alpha-numeric character that correlates to each HCPCS code
  – Referenced annually in Addendum B (a detailed listing by HCPCS code and its assigned status indicator) and defined in Addendum D1 of the OPPS Final Rule each year

Chargemaster – Reimbursement

• Status Indicators (continued):
  – Packaged (SI = N)
    • Separately billable in most instances but payment included in related service under OPPS
    • Subject to Correct Coding Initiative (CCI) edits and standards of coding practice
    – Examples of instances whereby ‘Packaged’ services would not be separately billable include:
      • Moderate Sedation (99143-99145) performed in conjunction with procedures in Appendix G or other packaged services such as Pulse Oximetry (94760-94761)
      • IV Starts (36000) to facilitate infusion services

Chargemaster – Reimbursement

• Status Indicators (continued):
  – Non-reportable (SI = B)
    • Not separately billable under OPPS but may be paid by intermediaries when submitted on a different bill type, e.g., 75x (CORF)
    • An alternate code that is recognized by OPPS may be available
    • Often synonymous with the term ‘non-billable’
    – Examples of ‘Non-reportable’ services with alternate coding include:
      • Magnetic resonance imaging breast, without and/or with contrast material(s); unilateral (77058 vs. C8903-C8905)
Chargemaster – Reimbursement

• Status Indicators (continued):
  – Non-covered (SI = E)
    • Separately billable but not reimbursable under OPPS
    • Should be reflected in non-covered column of UB-04
    • Statutorily non-covered items or services do not require Medicare denial
    • Beneficiary responsible for payment
  – Examples of “Non-covered” services include:
    • Self-administered Drugs*
    • Autopsies (88000-88099)
    • Acupuncture (97810-97814)
    • Specimen Handling (99000-99001)
    • Visual Acuity Screen (99173)
  * Refer to note on next slide.

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Chargemaster – Reimbursement

• Note regarding Self-administered Drugs:
  – Neither the OPPS nor other Medicare payment rules regulate the provision or billing by hospitals of non-covered drugs to Medicare beneficiaries. However, a hospital’s decision not to bill the beneficiary for non-covered drugs potentially implicates other statutory and regulatory provisions, including the prohibition on inducements to beneficiaries, section 1128A(a)(5) of the Act, or the anti-kickback statute, section 1128B(b) of the Act (Medicare Program Memorandum, A-02-129, Jan 3, 2003).

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Chargemaster – Reimbursement

• Status Indicators (continued):
  – Blood and Blood Products (SI = R) and Brachytherapy Sources (SI = U)
    • Became effective as of January 1, 2009
    • Formerly assigned SI = K
    • Payable under OPPS
  – Inpatient Procedures (SI=C)
    • Not paid under OPPS unless patient admitted as inpatient
    • For emergently performed procedure on an outpatient who expires prior to admission, report SI=C procedure with modifier CA and discharge status code 20 (Medicare PM A-02-129).
Chargemaster – Reimbursement

• Status Indicators (continued):
  – Hospital Part B Services Paid via a Comprehensive APC (SI = J1)
    • New for 2015
    • Payable under OPPS
    • All covered Part B services on the claim are packaged with the primary “J1” service for the claim, except for:
      – Services with OPPS SI=F, G, H, L or U
      – Ambulance services
      – Diagnostic and screening mammography
      – All preventive services
      – Certain Part B inpatient services

CDM Compliance Risks for 2015

• What are some compliance risks in the CDM for 2015?
  – CPT vs. HCPCS coding variances particularly in GI, Radiation Oncology and Lab*
    • For example:
      – A major change in the Drug Assay section is the deletion of the Drug Screening services (codes 80100, 80101, 80102, 80103, and 80104) and their replacement with new codes that more clearly define the drug class and the methodologies involved (80300, 80301, 80302, 80303, 80304); however, Medicare is still requiring HCPCS G0431 and G0434.

* Refer to a sample crosswalk on the next slide.
CDM Compliance Risks for 2015

• What are some compliance risks in the CDM for 2015? (continued)
  – Some codes applicable only to professional services* and others to facility billing
  • For example:
    – Lower GI endoscopy coding (i.e., colonoscopy, colonoscopy through stoma, ileoscopy, pouchoscopy, and flexible sigmoidoscopy) should be reported with combination CPT/HCPCS G-codes for physician services provided to Medicare beneficiaries while facilities should utilize the 2015 CPT code.

* Refer to sample pro fee crosswalks on the next few slides.

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CDM Compliance Risks for 2015

<table>
<thead>
<tr>
<th>SCCT</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44381</td>
<td>G6021</td>
<td>Ileoscopy w/dilation 44380, G6021</td>
</tr>
<tr>
<td>44403</td>
<td>G6021</td>
<td>C-stoma w/endoscopic mucosal resection (EMR) 44388, G6021</td>
</tr>
<tr>
<td>44404</td>
<td>G6021</td>
<td>C-stoma w/submucosal injection 44388, G6021</td>
</tr>
<tr>
<td>44405</td>
<td>G6021</td>
<td>C-stoma w/dilation 44388, G6021</td>
</tr>
<tr>
<td>44406</td>
<td>G6021</td>
<td>C-stoma w/endoscopic ultrasound (EUS) 44388, G6021</td>
</tr>
<tr>
<td>44407</td>
<td>G6021</td>
<td>C-stoma w/EUS-guided fine needle aspiration (FNA) 44388, G6021</td>
</tr>
<tr>
<td>44408</td>
<td>G6021</td>
<td>C-stoma w/decompression 44388, G6021</td>
</tr>
<tr>
<td>45349</td>
<td>G6021</td>
<td>Flexible sigmoid w/endoscopic mucosal resection (EMR) 45330, G6021</td>
</tr>
<tr>
<td>45350</td>
<td>G6021</td>
<td>Flexible sigmoid w/banding (e.g. hemorrhoids) 45330, G6021</td>
</tr>
<tr>
<td>45390</td>
<td>G6021</td>
<td>Colonoscopy w/endoscopic mucosal resection (EMR) 45378, G6021</td>
</tr>
<tr>
<td>45393</td>
<td>G6021</td>
<td>Colonoscopy w/decompression 45378, G6021</td>
</tr>
<tr>
<td>45398</td>
<td>G6021</td>
<td>Colonoscopy w/banding (e.g., hemorrhoids) 45378, G6021</td>
</tr>
</tbody>
</table>

Source: American Gastroenterological Association (AGA) Coding FAQs

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CDM Compliance Risks for 2015

<table>
<thead>
<tr>
<th>SCCT</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44383</td>
<td>G6018</td>
<td>Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>44393</td>
<td>G6019</td>
<td>Colonoscopy through stoma; with ablation of tumor(s), polyp(s) or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>44397</td>
<td>G6020</td>
<td>Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)</td>
</tr>
<tr>
<td>44799</td>
<td>G6021</td>
<td>Unlisted procedure, intestine</td>
</tr>
<tr>
<td>45339</td>
<td>G6022</td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>45345</td>
<td>G6023</td>
<td>Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)</td>
</tr>
</tbody>
</table>

Source: American Gastroenterological Association (AGA) Coding FAQs

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CDM Compliance Risks for 2015

<table>
<thead>
<tr>
<th>SCCT</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4401</td>
<td>G6023</td>
<td>Intraocular foreign body removal (intracapsular)</td>
</tr>
<tr>
<td>4402</td>
<td>G6031</td>
<td>Intraocular foreign body removal (extracapsular)</td>
</tr>
<tr>
<td>4404</td>
<td>G6033</td>
<td>Intraocular foreign body removal (combined approach)</td>
</tr>
<tr>
<td>4407</td>
<td>G6035</td>
<td>Intraocular foreign body removal (with laser photocoagulation)</td>
</tr>
<tr>
<td>4408</td>
<td>G6036</td>
<td>Intraocular foreign body removal (with phacoemulsification)</td>
</tr>
<tr>
<td>4409</td>
<td>G6037</td>
<td>Intraocular foreign body removal (combined laser and phacoemulsification)</td>
</tr>
</tbody>
</table>

Source: American Gastroenterological Association (AGA) Coding FAQs

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CDM Compliance Risks for 2015

• What are some compliance risks in the CDM for 2015? (continued)
  – Many-to-one relationship between old and new codes, Medicare vs. non-Medicare* and/or codes applicable to pro fee vs. facility billing
    • Complexity in pricing
    • Increased potential for error
    • Inability to split-bill
  
* Refer to breast tomosynthesis example on the next slide.

CDM Compliance Risks for 2015

<table>
<thead>
<tr>
<th>Service Description</th>
<th>New Code</th>
<th>Modifier</th>
<th>Typical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>77053</td>
<td>59</td>
<td>59 + 77063</td>
</tr>
<tr>
<td>Breast Diagnostic Mammogram</td>
<td>77055</td>
<td>20</td>
<td>20 + G0205 + G0279</td>
</tr>
<tr>
<td>Breast Diagnostic Mammogram</td>
<td>77056</td>
<td>20</td>
<td>20 + G0204 + G0279</td>
</tr>
<tr>
<td>Breast Diagnostic Mammogram</td>
<td>77061</td>
<td>20</td>
<td>20 + G0202 + G0279</td>
</tr>
<tr>
<td>Breast Diagnostic Mammogram</td>
<td>77062</td>
<td>20</td>
<td>20 + G0203 + G0279</td>
</tr>
</tbody>
</table>


• What are some compliance risks in the CDM for 2015? (continued)
  – Certain modifiers may no longer be appropriate
    • Modifier 59 vs. the new X(EPSU) modifiers*
      – XE (separate encounter—service that is distinct because it occurred during a separate encounter)
      – XP (separate practitioner—a service that is distinct because it was performed by a different practitioner)
      – XS (separate structure—a service that is distinct because it was performed on a separate organ/structure)
      – XU (unusual non-overlapping service—the use of a service that is distinct because it does not overlap usual components of the main service)

* Refer to breast tomosynthesis example on the next slide.
CDM Compliance Risks for 2015

• What are some compliance risks in the CDM for 2015? (continued)
  – Certain modifiers may no longer be appropriate (cont’d)
    • LT, RT and 50 for breast biopsy and localization procedures per recent clarification from the AMA*
      – Essentially, if procedures are performed in both breasts, report only one initial code per imaging modality. All the rest become add-on codes.

* Refer to AMA Errata and Technical Corrections, November 11, 2014.

Ancillary Depts – Structural Issues

• The following are general questions to ask when structuring the CDM for ancillary departments:
  – Will the services be reported on a UB-04 or CMS-1500 claim form?
    • Technical vs. Professional Fees
      – e.g., split-billing TC/PC onto two claims (UB-04 and CMS-1500) vs. reporting both on UB-04 with different revenue codes such as 032x and 0972

Ancillary Depts – Structural Issues (continued):

• Structuring the CDM (continued):
  – Must any of the services be billed globally such as in a clinic setting?
    • e.g., reporting 93000 (ECG with interpretation and report) on one claim vs. 93005 (…tracing only) and 93010 (…interpretation and report only) on separate claims
    • Generally required on the CMS-1500 and necessitates use of different sets of chargecodes
Ancillary Depts – Structural Issues

• Structuring the CDM (continued):
  – Are there coding differences by payer?
    • Level I vs. Level II codes
      – e.g., 71555 [MRA Chest with or without contrast] vs. 8909-8911 specified as with, without, or without/with contrast
      – e.g., 59318 (TEE 2D monitoring) vs. 8917 (TEE 2D monitoring with contrast)
    • Level II code variances, e.g., S-codes (non-Medicare) vs. C-codes (Medicare OPPS) or G-codes (Temporary Procedures)
      – e.g., G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes) vs. S9455 (Diabetic management program, group session)
    • Level III codes still in existence, e.g., Medi-Cal
    • Worker’s Comp using outdated code sets in some locales

Ancillary Depts – Structural Issues

• Structuring the CDM (continued):
  – Is there a need for different revenue codes?
    • e.g., 051x (Clinic) vs. 0761 (Treatment Room)
    • e.g., 0760 (Treatment/Observation—General) vs. 0762 (Observation Room)
  – What about coverage issues?
    • Inpatient vs. Outpatient
    • Screening vs. Diagnostic
    • Medical Necessity
    • Contract Exclusions

ED/Clinics – Charge Capture

• CDM maintenance and charge capture focus areas for the ED/Trauma/Urgent Care/Clinics should include:
  – Verifying
    • Appropriateness of HCPCS, hard-coded modifiers, i.e., 25, and revenue code assignment, i.e., 045X vs. 051X
    • Clarity of CDM vs. HCPCS descriptions, e.g., levels, size or type of repair, etc.
    • Surgical component setup, i.e., soft vs. hard-coding
    • Routine items and equipment are bundled, e.g., IV start kits, tongue depressors and 4x4s
    • Non-routine supplies, DMEPOS items and pharmaceuticals are reported
ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Ensuring
    • Procedures such as CPR, EKGs, and venipunctures, as well as minor surgical repair, are billed separately in addition to E/M level of service while being careful to avoid potential duplicate billing when multiple departments respond to, assist with, provide over-reads for, or attach such services to ancillary system order sets.

ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Confirming
    • Facility E/M criteria adhere to CMS's 11-point guidance introduced in 2008, i.e., coding guidelines should follow the intent of the CPT code descriptor in order to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code. In other words, facility internal E/M criteria should:
      – Be consistent
      – Meet medical necessity
      – Demonstrate stability over time
      – Be linked to hospital resources, not physician ones
      – Be available to and verifiable by outside entities

ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Verifying
    • HCPCS G0463 introduced in 2014 is reported in place of outpatient visit codes 99201–99215 for OPPS hospital-based clinic services (MLN Matters® Special Edition Article, SE1407, January 29, 2014).
    • Physician, CAH and other non-OPPS entities continue to report codes 99201-99215 as appropriate.

ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Establishing
    • A mechanism for logging and charging non-emergent or scheduled return visits to the Emergency Department (due to lack of space elsewhere, after-hours coverage, etc.) for Rabies vaccination series, blood transfusions, antibiotic therapy, dressing changes, and other minor procedures. Such services should be billed as ‘outpatient’ not ED visits, as they have separate revenue coding requirements, and generally should be identified on a separate encounter form or order entry screen.

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ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Reviewing
    • Policies for Critical Care reporting. Note that as of January 1, 2011, hospitals may separately report the services that are included in 99291 and 99292 for physicians, but Medicare will not separately reimburse for them. Facilities that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

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ED/Clinics – Charge Capture

• ED/Trauma/Urgent Care/Clinics charge capture focus areas (continued):
  – Capturing
    • Infusions started via ambulance, which may be billed separately when properly documented, including the 1st hour received at the hospital and subsequent hours as necessary (CMS Transmittal 785, December 16, 2005).
    • Up to a 24-hour supply of certain anti-cancer take-home medications as they are a covered service under Medicare. Multi-day supplies of certain take-home drugs, however, must be billed to the DMERC and require a separate provider number (CMS Transmittal 882, March 3, 2006).
Observation – Charge Capture

• CDM maintenance and charge capture focus areas for Observation services should include:
  – Ensuring
    • Validity of a dated and timed physician order
    • Documentation of Placement/discharge times
    • Medical necessity
    • Accuracy of the hourly calculation, i.e., rounding, as well as total number of hours
    • There is an initial E/M assessment, i.e., direct admit (HCPCS G0379) or one originating from a Clinic visit (HCPCS G0463), Critical Care or the ED, reported in conjunction with HCPCS G0378 (Hospital observation services, per hour) when appropriate.

Observation – Charge Capture

• Observation charge capture focus areas (continued):
  – Reporting
    • HCPCS code G0378 (Hospital observation services, per hour) for Medicare and other payers as required. Note that a composite APC may be triggered when certain criteria are met. One is that the patient must be observed for a period of eight or more hours, so it is imperative that observation time begin as soon as the order is written, not when the patient reaches the DOU or a nursing floor (CMS Transmittal 787, December 16, 2005).

Observation – Charge Capture

• Observation charge capture focus areas (continued):
  – Reviewing
    • Observation orders to ensure they are written by providers authorized by the facility’s medical staff bylaws to admit patients or order outpatient tests.
    • Units of service to be sure they represent the number of hours the patient spent in observation status.
      – Fractions of an hour should be rounded down to the nearest hour.
      – Services requiring ‘active monitoring’ should be carved out of observation time.
Imaging – Charge Capture

- CDM maintenance and charge capture focus areas for Imaging services should include:
  - Verifying
    - Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., LT/RT/50, and revenue code assignment, i.e., 032X vs. 036X range
    - Clarity of CDM vs. HCPCS descriptions, e.g., number of views, type of imaging, with or without contrast, etc.
    - Surgical component setup*, i.e., soft vs. hard-coding
    - Routine items and equipment are bundled, e.g., film, drapes, tubing and oximeters
    - Contrast, radiopharmaceuticals and non-routine supplies dispensed by department are reported

* Refer to example crosswalk on next slide.

Imaging to Surgical Code Crosswalk Example

<table>
<thead>
<tr>
<th>Radiology Code</th>
<th>Related Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>70170</td>
<td>68850</td>
</tr>
<tr>
<td>70332</td>
<td>21116</td>
</tr>
<tr>
<td>70390</td>
<td>42550</td>
</tr>
<tr>
<td>70450, 70460, 70470</td>
<td>61751</td>
</tr>
<tr>
<td>70551-70553</td>
<td>61751</td>
</tr>
<tr>
<td>76942</td>
<td>see appropriate organ or site</td>
</tr>
</tbody>
</table>

Lab/Pathology – Charge Capture

- CDM maintenance and charge capture focus areas for Laboratory/Pathology should include:
  - Verifying
    - Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., 91, and revenue code assignment, i.e., 030X or 031X range
    - Clarity of CDM vs. HCPCS descriptions, e.g., methodology vs. specific testing, number of specimens, etc.
    - No non-approved/unbundling of panels
    - Routine items and equipment are bundled, e.g., specimen containers and empty blood bags
Lab/Pathology – Charge Capture

• Laboratory/Pathology charge capture focus areas (continued):
  – Reviewing
    • The Lab National Coverage Determinations (NCD) database, which can be found on the CMS web site at:
      https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html

Cardiopulmonary – Charge Capture

• CDM maintenance and charge capture focus areas for Cardiopulmonary should include:
  – Verifying
    • Appropriateness of HCPCS (including unlisted codes), tracking code usage, and revenue code assignment, i.e., 041X vs. 046X vs. 048X range
    • Clarity of CDM vs. HCPCS descriptions, e.g., initial vs. subsequent, frequency, etc.
    • Routine items and equipment are bundled, e.g., suction tubing and electrodes

Rehabilitation – Charge Capture

• CDM maintenance and charge capture focus areas for Rehab (PT/OT/SLP) should include:
  – Verifying
    • Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., GO/GP/GN, and revenue code assignment, i.e., 042X vs. 043X vs. 044X vs. 047X
    • Clarity of CDM vs. HCPCS descriptions, e.g., per 15 minutes, untimed modalities, etc.
    • Routine items and equipment are bundled, e.g., cold packs and traction
    • DMEPOS items and equipment dispensed by department are reported
Rehabilitation – Charge Capture

• Rehab (PT/OT/SLP) charge capture focus areas (continued):
  — Capturing
    • Functional data reporting and collection system requirements, which became effective for therapy services with dates of service on and after January 1, 2013 and required as of July 1, 2013. For more information, refer to CMS’s National Provider Call summary and therapy required functional reporting implementation resource:

Surgery – Charge Capture

• CDM maintenance and charge capture focus areas for Surgery/Anesthesia/Recovery should include:
  — Verifying
    • Appropriateness of HCPCS (including unlisted codes), i.e., 036X vs. 0761 vs. 051X vs. 052X
    • Correct use of soft-coding vs. hard-coding
    • Routine items and equipment are bundled, e.g., drapes, gowns, gloves and monitors
    • Non-routine supplies, DMEPOS items and pharmaceuticals dispensed by department are reported

Surgery – Charge Capture

• Note regarding time charges:
  — Time is generally charged in the operating room (OR) so that HIM can append the appropriate coding from chart documentation; however, certain minor procedures performed in treatment rooms associated with the OR may be hard-coded.
Supplies – Charge Capture

- CDM maintenance and charge capture focus areas for Supplies should include:
  - Verifying
    - Appropriate reporting of device-dependent codes
    - Routine items and equipment are bundled, e.g., drapes, gowns, gloves and monitors
    - Non-routine supplies, DMEPOS items and implants dispensed by department are reported

* Refer to note on next slide.

Supplies – Charge Capture

- Note that routine supplies such as gloves, drapes, and blood pressure cuffs and equipment such as monitors and pumps should be bundled into surgery time or the related accommodation code or service. Non-routine items and services may be billed separately when they are:
  - directly identifiable items and services provided to individual patients*
  - furnished under the direction of a physician because of specific medical needs
  - not reusable or represent a cost for each preparation

* This also means that such items should be charted in the patient's permanent medical record.

Supplies – Charge Capture

- Medical/Surgical Supplies and Devices 027X*:
  - General 0270
  - Nonsterile Supply 0271
  - Sterile Supply 0272
  - Take-Home Supplies 0273
  - Prosthetic/Orthotic Devices 0274
  - Pacemaker 0275
  - Intraocular Lens 0276
  - Oxygen (Take-Home) 0277
  - Other Implants 0278
  - Other Supplies/Devices 0279

- Medical/Surgical Supplies (Extension of 027X) 062X*:
  - Supplies Incident to Radiology 0621
  - Supplies Incident to Other Diagnostic Services 0622
  - Surgical Dressings 0623
  - FDA Investigational Devices 0624

* All UB-04 Revenue Codes are copyrighted by the American Hospital Association.
Pharmacy – Charge Capture

• CDM maintenance and charge capture focus areas for Pharmacy should include:
  – Verifying
    • Units of Service
      – HCPCS code description vs. manufacturer dose
      – Waste documentation (modifier JW, if required)
    • Self-administered drugs have been established as non-covered for Medicare outpatients under most circumstances, but covered for inpatients and other payers
    • Accuracy of NDC data

Discussion

• Questions?
  – Thank you!

Contact Information

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