Get Reacquainted With Your Chargemaster

Oregon HFMA
Summer Meeting & 60th Anniversary Celebration
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Session Roadmap

01 Warm Up
02 Meet the CDM
03 Manage the CDM
04 CDM and Charge Capture
05 Challenges & Opportunities
06 Proposed OPPS CY2015 Hot Topics
07 Questions
08 Wrap Up
First Things First…

The Robert M. Shelton Award for Sustained Chapter Excellence

Congratulations Oregon HFMA!

2014 Shelton Award Recipient

(3-Time Winner!!)
Second Things Second…

Happy 60th Anniversary Celebration!!
Next Things Next…

Let’s get acquainted!
Learning Objectives

- Define the basic structure and function of a CDM
- Describe the roles and responsibilities of the CDM Team
- Identify critical steps in the CDM management process
- Define CDM management “workflow”
- Explain the relationship between the CDM and the charge capture process
- Recognize potential risk areas related to CDM management
- Recognize CDM optimization opportunities
MEET THE CDM
Meet the CDM

- A CDM is to a hospital like...

...a purchase inventory is to a retail store
Meet the CDM

A CDM by any other name is still a CDM...

- Charge Description Master (CDM)
- Chargemaster (charge master)
- Line item master
- EAP File (Epic)
- Financial Item Master
- Service Item Master
- Price List
- Charge list
- ???
Meet the CDM

A CDM is a multi-purpose tool...

- Comprehensive and compliant billing
- Capture and categorize revenue
- Assess and manage resource utilization
- Manage inventory
- Facilitate Medicare cost reporting
- Items and services
- ???
Meet the CDM

**Typical CDM Data Elements**
- Charge code
- Department identifier
- Item/service description
- Revenue code
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

**Data Element Characteristics**

?
# Meet the CDM

**Typical CDM Data Elements**
- Charge code
- Department identifier
- Item/service description
- Revenue code
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

**Data Element Characteristics**
- Hospital-specific
- Unique line-item identifier
- May or may not be department specific
- Typical system interface between order entry and billing
- A.K.A. ...
  - CDM number
  - Line-item number
  - Financial Item Number (FIN)
# Meet the CDM

## Typical CDM Data Elements
- Charge code
- **Department identifier**
- Item/service description
- Revenue code
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

## Data Element Characteristics
- Hospital-specific
- Revenue centers vs. cost centers
- Typically equates to general ledger (GL) number
- Departmentalized vs. standardized CDM
- Link between department and charge code for revenue and usage reporting
- Varies by system, e.g., Epic, Cerner, Meditech, McKesson
## Meet the CDM

### Typical CDM Data Elements
- Charge code
- Department identifier
- **Item/service description**
- Revenue code
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

### Data Element Characteristics
- Hospital-specific
- Variable character limitation
- Pros and cons of description standardization
- Clinically relevant descriptions
- Patient friendly descriptions
- Supports hard-coded CPT/HCPCS
- Designed to prevent duplication and support consistency
# Meet the CDM

**Typical CDM Data Elements**

- Charge code
- Department identifier
- Item/service description
- **Revenue code**
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

**Data Element Characteristics**

- Universal; NOT hospital-specific
- NUBC (AHA) proprietary
- General vs. detailed classification

...more
## Meet the CDM

<table>
<thead>
<tr>
<th>Typical CDM Data Elements</th>
<th>Data Element Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge code</td>
<td>The “right” revenue code</td>
</tr>
<tr>
<td>Department identifier</td>
<td>• Payer mandated</td>
</tr>
<tr>
<td>Item/service description</td>
<td>The “best” revenue code</td>
</tr>
<tr>
<td>Revenue code</td>
<td>• Payer preferred</td>
</tr>
<tr>
<td>CPT/HCPCS code</td>
<td>• Relationship to cost report</td>
</tr>
<tr>
<td>• Medicare</td>
<td>• Nature of service or item vs. “location”</td>
</tr>
<tr>
<td>• Other payers</td>
<td>• Facility vs. professional</td>
</tr>
<tr>
<td>Charge amount</td>
<td></td>
</tr>
</tbody>
</table>
### Meet the CDM

#### Typical CDM Data Elements
- Charge code
- Department identifier
- Item/service description
- Revenue code
- CPT/HCPCS code
  - Medicare
  - Other payers
- Charge amount

#### Data Element Characteristics
- Specific to item or service
- Level I vs. Level II
  - CPT = Level I (AMA)
  - HCPCS = Level II (CMS)
- Level III
  - Oregon??
  - California??
- May vary by payer
- Must accurately reflect service or item provided to individual patient
Meet the CDM

Typical CDM Data Elements

- Charge code
- Department identifier
- Item/service description
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Data Element Characteristics

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<tr>
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Meet the CDM

GOAL: CDM Integrity!!

- Comprehensive
- Accurate
- Compliant
MANAGE THE CDM
Manage the CDM

Focus

Who

How

Discussion

?
Manage the CDM: Who?

Who?

“Approximately forty percent of hospitals pay outside companies to help create and then adapt their chargemasters on a yearly basis.”

Manage the CDM: Who?

Focus

Who?
- Ownership
- Clinical input
- Coding input
- Billing input
- Financial input
- Compliance input

Discussion
Manage the CDM: Who?

Who?

- Ownership
- Clinical input
- Coding input
- Billing input
- Financial input
- Compliance input

Focus

Discussion

- Dedicated point person
  - Candidates

- Typical responsibilities
  - Analysis
  - Request facilitation
  - Change facilitation
  - Interface integrity
  - Auditing
  - Compliance
Manage the CDM: Who?

**Who?**
- Ownership
- **Clinical input**
- Coding input
- Billing input
- Financial input
- Compliance input

**Focus**

**Discussion**
- Patient care departments
  - Leadership
- Typical responsibilities
  - Departmental CDM
  - Scope of service
  - Departmental protocols
  - Staffing credentials
  - Departmental charge capture
  - Revenue reconciliation
Manage the CDM: Who?

Focus

Who?

- Ownership
- Clinical input
- Coding input
- Billing input
- Financial input
- Compliance input

Discussion

Coding expertise

- Qualifications

Typical responsibilities

- Line-item code assignment or validation
- CPT/HCPCS coding guidelines
- Payer coverage policies, e.g., NCD/LCD/Articles
- Edit resolution
# Manage the CDM: Who?

## Who?
- Ownership
- Clinical input
- Coding input
- **Billing input**
- Financial input
- Compliance input

## Focus

### Billing expertise
- Payer knowledge

### Typical responsibilities
- Coverage guidelines
- Billing guidelines
- Routine vs. non-routine items and services
- Edit resolution
Manage the CDM: Who?

**Who?**

- Ownership
- Clinical input
- Coding input
- Billing input
- **Financial input**
- Compliance input

**Focus**

**Discussion**

**Financial expertise**

- Contract knowledge
- Revenue budget
- Pricing strategy

**Typical responsibilities**

- Mark-up guidance
- Pricing protocols
- Revenue analysis
Manage the CDM: Who?

Who?
- Ownership
- Clinical input
- Coding input
- Billing input
- Financial input
- Compliance input

Discussion
- Regulatory expertise
  - Payment methodology
- Typical responsibilities
  - Charge auditing
  - Reimbursement auditing
  - Adjustment and denial reconciliation
  - Process improvement
Manage the CDM: How?

Focus

Discussion

How
Manage the CDM: How?

How?

- People
- Process
- Tools
Manage the CDM: How?

**Focus**

- People
- Process
- Tools

**Discussion**
# Manage the CDM: How?

**Focus**

- **How**
  - People
  - **Process**
  - Tools

**Discussion**

- Systematic approach
- Defined and documented
- Key processes
  - Workflow
  - Analysis
  - Interface integrity
  - Pricing integrity
Manage the CDM: How?

Workflow (a.k.a. Line-Item Change Management)

- Individual/department requests for additions, revisions, deactivations
- Analysis results
- Monthly, quarterly, annual updates
- Regulatory updates
- Form-driven, email, software system
- Required vs. optional data elements
Manage the CDM: How?

**Workflow** (a.k.a. Line-Item Change Management)

- Request routing, i.e., who does what and in what order?
- Which data elements?
  - New line item? Billable item/service?
  - Description formatting
  - Revenue code assignment
  - CPT/HCPCS: Required or not? Hard-code or soft-code? Modifier?
  - Price with appropriate mark-up (if applicable)
Manage the CDM: How?

Workflow (a.k.a. Line-Item Change Management)

- Who approves what and in what order?
  - Clinical Department
  - Coding Department
  - Billing Department
  - Finance
  - Revenue Cycle
  - Compliance
- CDM Manager responsibility
Manage the CDM: How?

Workflow (a.k.a. Line-Item Change Management)

- Initiate
- Validate
- Approve
- Update

- CDM update
  - Manual vs. automated
  - Audit history captured
- Charge capture system update
  - Manual vs. automated
  - Exact match or clinically meaningful variance
- Educate
Manage the CDM: How?

Analysis

- Frequency
- Focus
  - Comprehensive and optimal
    - Billable items/services
    - Optimal pricing
  - Accurate
    - Descriptions
    - Revenue codes
    - CPT/HCPCS codes
  - Compliant
Manage the CDM: How?

Interface Integrity

- Charge Capture
- Billing/CDM
- Billing/CDM
- Coding

Arrows indicate the flow of information between the components.
Manage the CDM: How?

Pricing Integrity

- Transparency
- Relative to payment
- Relative to cost
- Strategic mark-up
Manage the CDM: How?

Focus

How
- People
- Process
- Tools

Discussion
- HIS vendor tools
- Email and spreadsheets
- Reference library
  - Coding
  - Billing
  - Payer coverage guidelines
  - Compliance regulations
- Other vendor tools
CDM AND CHARGE CAPTURE
CDM and Charge Capture

Chargemaster

<table>
<thead>
<tr>
<th>Charge Code</th>
<th>Description</th>
<th>Charge Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>Labor Cast Cutting</td>
<td>345</td>
<td>Service Cast Cutting</td>
</tr>
<tr>
<td>678</td>
<td>Lab Cast Cutting</td>
<td>901</td>
<td>Service Cast Cutting</td>
</tr>
<tr>
<td>234</td>
<td>Charge Capture</td>
<td>567</td>
<td>Service Cast Cutting</td>
</tr>
</tbody>
</table>

Charge capture tool

Charge Code

![Barcode Image]

Libby's Whole Kernel Sweet Corn

![Image of corn]
Items and services must be ordered and adequately documented to facilitate compliant coding and billing.

Charge capture may be accomplished manually or electronically and the captured charge should be supported by documentation.

Charges captured manually require manual data entry; charges captured electronically auto-interface.

Charges in the billing system are typically available for review by the coders through an interface to the coding system.
Charge Capture Flow

- **Soft Coding Completed**: Documentation is reviewed; diagnosis codes are assigned and soft coding of specific items and services is completed.
- **Coding Interface To Billing**: Diagnosis codes and procedure codes interface to billing system and procedure codes are matched to corresponding charges.
- **Final Bill Review**: Bill is checked against internal edits and then sent to external clearinghouse for additional editing or claim scrubbing.
- **Bill Drop**: After all edits are resolved, claim is sent to payer (direct or via clearinghouse) and is considered “final billed”.
CDM and Charge Capture

Bottom line...

- All billable items and services are included in the CDM
- All billable items/services in CDM are available for charge capture
- Item and service descriptions are explicit and unambiguous
- Bundled charges are identifiable, manageable and clearly understood
- CDM to charge capture linkage (i.e., charge code) is valid and accurate
- Hard-coded CPT/HCPCS assignments are valid and accurate
- Audit, audit, audit!!
  - Billed items and services are supported by documentation
  - Items and service that are billable and documented are captured
CHALLENGES & OPPORTUNITIES
Challenges and Opportunities

Line-item Descriptions

- System character limitations
- Standardization
- Patient Friendly Billing®
- CPT/HCPCS mapping accuracy
- Bundled line items
- CDM vs. Charge capture
Challenges and Opportunities

Revenue Code Mapping

- Payer specific requirements
- General vs. detailed
- Location vs. nature of service
- Cost report implications
- Inpatient vs. outpatient
- “right” vs. “wrong”

<table>
<thead>
<tr>
<th>Code</th>
<th>0636</th>
<th>J0287</th>
<th>J0287</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMPHOTERICIN B LIPID <em>R</em> IVPB</td>
<td>0636</td>
<td>J0287</td>
<td>J0287</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPOSOME SY 2MG/ML DSW</td>
<td>0636</td>
<td>J0289</td>
<td>J0289</td>
</tr>
<tr>
<td>AMPHOTERICIN B IVPB 50 MG</td>
<td>0636</td>
<td>J0285</td>
<td>J0285</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPOSOME 100MG</td>
<td>0636</td>
<td>J0287</td>
<td>J0287</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPID IRTC 100MG</td>
<td>0636</td>
<td>J0287</td>
<td>J0287</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPID INJ<em>R</em> S</td>
<td>0636</td>
<td>J0287</td>
<td>J0287</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPOSOME NEB 100MG</td>
<td>0636</td>
<td>J0287</td>
<td>J0287</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPID IVPB</td>
<td>0636</td>
<td>J0289</td>
<td>J0289</td>
</tr>
<tr>
<td>AMPHOTERICIN B LIPOSOME 100MG</td>
<td>0636</td>
<td>J0285</td>
<td>J0285</td>
</tr>
<tr>
<td>AMPHOTERICIN B SUSP 100 MG/ML</td>
<td>0636</td>
<td>J0285</td>
<td>J0285</td>
</tr>
<tr>
<td>AMPHOTERICIN INJ 50 MG</td>
<td>0636</td>
<td>J0285</td>
<td>J0285</td>
</tr>
</tbody>
</table>
Challenges and Opportunities

HCPCS Code Mapping

• Hard-coding vs. soft coding
• Accurate to line-item
• Accurate to documentation
• CPT for “facility” billing
• Charge distribution
• Maintenance
Challenges and Opportunities

Emergency Department Services

• Visit codes 99281-99285, 99291-99292
• Type B visit codes G0380-G0384
• Modifier 25
• Separately billable services
• Trauma activation codes
• Injections and infusions
Challenges and Opportunities

Injections and Infusions

- Initial service
- Hierarchy by substance
- Concurrent vs. subsequent
- Subsequent infusions
- IV pushes
- Time documentation
- Injections
- Don’t forget the medication!!
### Challenges and Opportunities

#### Devices and Device-Dependent Procedures (1)

- CDM considerations

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92933</td>
<td>Percutaneous transluminal coronary atherectomy, with coronary stent, with coronary angioplasty when performed; single major coronary artery or branch</td>
</tr>
</tbody>
</table>
Challenges and Opportunities

Devices and Device-Dependent Procedures (2)

- **CDM considerations**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1874</td>
<td>Stent, coated/covered, with delivery system</td>
</tr>
<tr>
<td>C1875</td>
<td>Stent, coated/covered, without delivery system</td>
</tr>
<tr>
<td>C1876</td>
<td>Stent, non-coated/non-covered, with delivery system</td>
</tr>
<tr>
<td>C1877</td>
<td>Stent, non-coated/non-covered, without delivery system</td>
</tr>
</tbody>
</table>
### Challenges and Opportunities

#### Devices and Device-Dependent Procedures (3)

- **CDM considerations**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1714</td>
<td>Catheter, transluminal atherectomy, directional</td>
</tr>
<tr>
<td>C1724</td>
<td>Catheter, transluminal atherectomy, rotational</td>
</tr>
<tr>
<td>C1885</td>
<td>Catheter, transluminal angioplasty, laser</td>
</tr>
</tbody>
</table>
Challenges and Opportunities

## Devices and Device-Dependent Procedures (4)

- Device pricing, packaged payment, and offset amounts

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>92933</td>
<td>PTCA, with stent, with angioplasty if performed, single</td>
<td>$6,363.75</td>
</tr>
<tr>
<td>C1874</td>
<td>Stent, coated/covered, with delivery system</td>
<td>$3,228.33</td>
</tr>
<tr>
<td>C1875</td>
<td>Stent, coated/covered, without delivery system</td>
<td>$3,228.33</td>
</tr>
<tr>
<td>C1876</td>
<td>Stent, non-coated/non-covered, with delivery system</td>
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Challenges and Opportunities

Devices and Device-Dependent Procedures (5)

- Charge capture and billing considerations

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<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Device A</th>
<th>Device A Description</th>
<th>Device B* (See note)</th>
<th>Device B Description</th>
</tr>
</thead>
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<tr>
<td>92933</td>
<td>Prq card stent/ath/angio</td>
<td>C1874</td>
<td>Stent, coated/cov w/del sys</td>
<td>C1714</td>
<td>Cath, trans atherectomy, dir</td>
</tr>
<tr>
<td>92933</td>
<td>Prq card stent/ath/angio</td>
<td>C1875</td>
<td>Stent, coated/cov w/o del sy</td>
<td>C1724</td>
<td>Cath, trans atherectomy, rotation</td>
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<td>Prq card stent/ath/angio</td>
<td>C1876</td>
<td>Stent, non-coa/non-cov w/del</td>
<td>C1885</td>
<td>Cath, translumina angio laser</td>
</tr>
<tr>
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<td>Prq card stent/ath/angio</td>
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<td>C1714</td>
<td>Cath, trans atherectomy, dir</td>
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Challenges and Opportunities

Modifiers (1)

- Maximum of 2 modifiers per HCPCS
- Level I vs. Level II
- Required vs. optional
- Purpose
- CDM considerations
- Reimbursement impact
- A few modifiers up close and personal
Challenges and Opportunities

Modifiers (2)

- Modifier 25
- Modifier 27
- Modifiers RT, LT, 50
- Modifier 59
- Modifiers 73, 74
- Modifier 91
- Modifiers GN, GO, GP

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service
Challenges and Opportunities

Modifiers (3)

• Modifier 25
• **Modifier 27**
• Modifiers RT, LT, 50
• Modifier 59
• Modifiers 73, 74
• Modifier 91
• Modifiers GN, GO, GP

*Multiple Outpatient Hospital Evaluation and Management (E&M) Encounters on the Same Date*
Challenges and Opportunities

Modifiers (4)

- Modifier 25
- Modifier 27
- **Modifiers RT, LT, 50**
- Modifier 59
- Modifiers 73, 74
- Modifier 91
- Modifiers GN, GO, GP

RT – Right Side
LT – Left Side
50 - Bilateral
Challenges and Opportunities

Modifiers (5)

- Modifier 25
- Modifier 27
- Modifiers RT, LT, 50
- **Modifier 59**
- Modifiers 73, 74
- Modifier 91
- Modifiers GN, GO, GP

Distinct Procedural Service
Challenges and Opportunities

Modifiers (6)

- Modifier 25
- Modifier 27
- Modifiers RT, LT, 50
- Modifier 59
- **Modifiers 73, 74**
- Modifier 91
- Modifiers GN, GO, GP

73 – Discontinued Outpatient Hospital / Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

74 – Discontinued Outpatient Hospital / Ambulatory Surgery Center (ASC) Procedure After the Administration of Anesthesia
Challenges and Opportunities

Modifiers (5)

- Modifier 25
- Modifier 27
- Modifiers RT, LT, 50
- Modifier 59
- Modifiers 73, 74
- **Modifier 91**
- Modifiers GN, GO, GP

Repeat Clinical Diagnostic Laboratory Test
Challenges and Opportunities

Modifiers (6)

- Modifier 25
- Modifier 27
- Modifiers RT, LT, 50
- Modifier 59
- Modifiers 73, 74
- Modifier 91
- **Modifiers GN, GO, GP**

- GN – Services delivered under an outpatient speech language pathology plan of care
- GO - Services delivered under an outpatient occupational therapy plan of care
- GP - Services delivered under an outpatient physical therapy plan of care
Challenges and Opportunities

Medicare “Alternate” Codes

- CDM considerations
- Billing considerations
- One-to-one, one-to-many, many-to-one
- Examples
  - J9031 vs. 90586
  - G0463 vs. 99211, 99212, 99213, 99214, 99215
  - C8900, C8901, C8902 vs. 74185
Challenges and Opportunities

Units of Service


Incorrect Billing of Number of Units

Medicare payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act, § 1833(e)). The Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2). The Manual also states: “It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient” (chapter 17, § 90.2.A). If the provider is billing for a drug, according to the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 … “ (chapter 17, § 70).

For 81 of 105 selected claims, [redacted] billed Medicare with an incorrect number of units for injectable drugs administered. [redacted] stated that the billing system had the incorrect unit descriptions for the corresponding HCPCS codes selected. As a result of these errors, [redacted] received overpayments of $45,301.
Challenges and Opportunities

Medically Unlikely Edits

• Purpose
• Some public, some secret!
• New information in Q3 update
  • Indicator for type of edit
  • Rationale for edit
• FAQ2277 and FAQ8119
Challenges and Opportunities

**Supplies**

- **Billable vs. routine (a.k.a., non-billable)**

- **Typical guidelines**
  - Directly identifiable to a single patient
  - Provided at the direction of a physician based on the documented medical needs of the patient
  - Typically single use items or items with a distinct cost related to each preparation

- **Examples of supply items often considered routine (a.k.a. non-billable)**
  - Gloves, gowns, drapes, pads, wipes, IV tubing, bed linens, towels, pillows, diapers, syringes, masks, soap, pulse ox
Challenges and Opportunities

**Supplies (2)**

- Revenue and HCPCS code assignments

<table>
<thead>
<tr>
<th>RevCode</th>
<th>RevCode Description</th>
<th>HCPCS Req?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0270</td>
<td>Medical/Surgical Supplies and Devices - General Classification</td>
<td>No</td>
</tr>
<tr>
<td>0271</td>
<td>Medical/Surgical Supplies and Devices - Non Sterile</td>
<td>No</td>
</tr>
<tr>
<td>0272</td>
<td>Medical/Surgical Supplies and Devices - Sterile</td>
<td>No</td>
</tr>
<tr>
<td>0273</td>
<td>Medical/Surgical Supplies and Devices - Take Home</td>
<td>No</td>
</tr>
<tr>
<td>0274</td>
<td>Medical/Surgical Supplies and Devices - Prosthetic/Orthotic Devices</td>
<td>Yes</td>
</tr>
<tr>
<td>0275</td>
<td>Medical/Surgical Supplies and Devices - Pace Maker</td>
<td>Sometimes</td>
</tr>
<tr>
<td>0276</td>
<td>Medical/Surgical Supplies and Devices - Intraocular Lens</td>
<td>No</td>
</tr>
<tr>
<td>0277</td>
<td>Medical/Surgical Supplies and Devices - Oxygen-Take Home</td>
<td>No</td>
</tr>
<tr>
<td>0278</td>
<td>Medical/Surgical Supplies and Devices - Other Implants</td>
<td>Sometimes</td>
</tr>
<tr>
<td>0279</td>
<td>Medical/Surgical Supplies and Devices - Other Supplies/Devices</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>
Challenges and Opportunities

Other miscellaneous challenges and opportunities

• Add-on codes
• Time-based services
• Interventional radiology
• Ultrasound and CT
• Interdepartmental price inconsistencies
PROPOSED OPPS CY2015
HOT TOPICS!
Proposed OPPS CY2015

Hot Topics

Discussion

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 410, 418, 419, 421, 422, 423, and 424
(CMS-1325-F)

KEY HISP-LATINO Medicare and Medicaid Programs: Hospital Outpatient Payment System
Ambulatory Surgical Center Payment System and Ambulatory Surgical Center (ASC) payment systems. This final rule makes changes to the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. In addition, this proposed rule would update and clarify the requirements for the Hospital Outpatient Quality Reporting (HOQR) program and the ASC Quality Reporting (ASCQR) program.

SUMMARY: This proposed rule revises the Medicare OPPS and ASC payment systems by making changes to the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. The revisions are based on recommendations from the Medicare Payment Advisory Commission (MedPAC) and other sources, including input from industry stakeholders, and are intended to improve the fairness and accuracy of the OPPS and ASC payment systems. The proposed changes are intended to provide a more accurate representation of the costs of providing Medicare services and to ensure that beneficiaries receive the best possible care.
QUESTIONS

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WRAP UP
Web Resources

**Outpatient Prospective Payment System- Final Rule**

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html

**Inpatient Prospective Payment System- Final Rule**

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteinpatientPPS/index.html

**CMS Transmittals and Med-Learn Matter Articles**

Web Resources

- **CMS Manuals**
  

- **National Uniform Billing Committee**
  

- **CMS- Addendum A and B**
  
  [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html)
Web Resources

**CMS-Physician Fee Schedule**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

**CMS-Clinical Lab Fee Schedule**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html

**CMS- Addendum AA and BB for Ambulatory Surgery Centers**
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
Learning Objectives Revisited

- Define the basic structure and function of a CDM
- Describe the roles and responsibilities of the CDM Team
- Identify critical steps in the CDM management process
- Define CDM management “workflow”
- Explain the relationship between the CDM and the charge capture process
- Recognize potential risk areas related to CDM management
- Recognize CDM optimization opportunities
Working Together to Achieve Next Generation Revenue Cycle Success

**iDocuMint**
- Complete Documentation Capture
- Identify What’s Missing in Clinical Documentation
- Physician Productivity Enhancement

**VitalChargemaster**
- Charge Capture Maintenance
- Coding Regulations
- Next Generation Workflow
- Benchmarking/Pricing

**VitalCDI**
- Concurrent Review
- Dynamic Clarifications
- Tracking & Monitoring
- Workflow & Reporting

**VitalCoder**
- Access CPT/ICD/APC LCD/NCD/DRG…etc.
- CodeCheck
- Regulatory Content
- CPT Assistant and Coding Clinics

**VitalAuditor**
- Retrospective Documentation and Coding Review
- Identify Immediate Re-Bill Opportunities
- Pinpoint Areas for Documentation and Coding Improvement
THANK YOU FOR THIS OPPORTUNITY

The Company you trust to deliver innovative healthcare intelligence and technology for enhanced, next generation revenue cycle success

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