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26th Annual Revenue Cycle Conference
From Kickoff to Cashflow: Building a Winning Revenue Cycle

STORIES FROM BEHIND REVENUE INTEGRITY LINES: OPPORTUNITIES IN CDM AND CHARGE CAPTURE MANAGEMENT

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AGENDA

1. This isn't your grandma's chargemaster – CDM management is as complex as ever
2. That's not my job – who is responsible for this anyway?
3. Consistency is key, but change is constant – how to keep up

ABOUT US

- We are a firm dedicated entirely to Revenue Integrity
- We review, build, maintain, and optimize chargemasters for hospitals across the country
- We present workshops and train RI staff, keeping up with the ever-changing healthcare reimbursement and regulatory environment
- We've seen some things…

“THIS IS NOT YOUR GRANDMA’S CDM”

Why is CDM management so complex?

The CDM's Many Uses

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- The chargemaster isn't just a simple fee schedule – it's a complex database with many connections that may be used for:

- Billing patients and insurance companies
- Compliance with regulations
- Revenue cycle management
- Financial analysis and budgeting
- Contract negotiation
- Internal cost control
- Transparency and patient education

- In the next few slides, we will discuss some CDM topics that may seem simple at the surface, but can have significant impacts

Modifiers

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- Some modifiers can be safely added in the CDM. Examples:
  - Laterality (LT, RT, 50)
  - Informational (GP, GO, GN)
  - Payer required (GY)
- Other modifiers can be very risky to have hard-coded in the CDM and are not recommended. Examples:
  - Separate and distinct services (25, 59)
  - Repeat lab tests (91)
- These modifiers describe *clinical situations* and require a certain level of expertise when determining when it is appropriate to assign
- These modifiers may circumvent NCCI edits, or impact reimbursement amounts

Modifiers

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- **Very important** – keep up with the ever-growing and changing list of modifiers required to report data and/or trigger reimbursement policies for Medicare

Examples:

- JW/JZ modifiers for drug waste
- PO/PN modifiers for off-campus provider-based departments
- TB modifier for 340B-acquired drugs
- FY modifier for computed radiography
- CT modifier for imaging equipment that doesn't meet NEMA standards

- Is used of modifiers defined by policy? Are assigned modifiers reviewed regularly?

Revenue Codes

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- From CMS (Medicare Claims Processing Manual, Chapter 4, Section 20.5):

- *Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.*

- Medicare's PS&R reports are categorized by revenue codes which will drive how revenue is categorized on the cost report

- Does the person managing the CDM understand the significance/impacts of revenue code assignment? Are assignments consistent throughout the CDM?

Pharmacy

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- Major risk area in CDM due to constant changes
- Who assigns HCPCS codes? Often, Pharmacy staff have more involvement in their CDM.
- When new drugs are added to formulary, are HCPCS codes always looked up?
- Many drugs have specific HCPCS codes, many of which are separately reimbursed by Medicare and other payers
- No HCPCS code = no reimbursement
- Drug may not have HCPCS code available when first created – who monitors updates?

Pharmacy

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- Additional key risk areas:
- Multipliers
  - Are they calculated correctly?
  - Has billing unit changed over time?
  - Are multiple dose drugs being handled appropriately?
- Self-administered drugs
  - Statutorily excluded from Part B coverage
  - Are these consistently identified in the CDM (e.g. via RevCode 637)?
  - Is there claim logic to ensure that they are not billed as covered for OP Medicare claims?

Pharmacy

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- Additional key risk areas:

- Drug waste: Modifier JW/JZ.
  - Amount administered vs. wasted being entered by clinical staff?
  - Are there separate charges for waste?

- New Drugs
  - Is HCPCS C9399 being used to obtain reimbursement from Medicare for new drugs?

Supplies

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- Does your facility have a written policy defining separately billable patient supplies?

- This is a major area of struggle for many facilities. Key risk areas include:

  - Routine versus non-routine supplies
  - Patient chargeable items (medically necessary, single use, patient identifiable)
  - Revenue code assignment – especially properly identifying implants with revenue code 278
  - HCPCS assignment – especially keeping up with and identifying Medicare pass-through devices
  - Non-opioid pain relief products? New Medicare reimbursement in 2025.

Patient Chargeable Supplies

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1. Medically necessary and furnished at the direction of a physician or other practitioner
   - Does not include personal convenience items (e.g, slippers, personal care items)
2. Single use/disposable
   - Cannot charge for reusable supplies
3. Patient identifiable
   - Medical record documentation must support the use of the item
   - Does not include routine items such as drapes, pads, cotton balls, urinals, bed pans, gauze, etc.

Operating Room

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- Time based or procedure based

- Supplies bundled into the procedure or itemized
- Benefits of bundling:
  - Less items to ensure chargeable vs non chargeable (chargeable threshold)
  - Less relance of documentation to support the charge (Insurance Nurse Audits)
  - Smaller chargemaster to maintain

- Recovery charges

- Anesthesia: technical vs. professional

Radiology

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- Charging for contrast?
  - Dose amount
- Correct isotopes
- Correct CPT compared to description. Easy to get W, W/O, and W W/O mixed up setting up or reviewing charges.
- Number of views correct?

Laboratory

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- Laboratory CDM management is highly complex. There are many codes that may vary based on specimen type, methodology, analyte type, and even clinical purpose (e.g., therapeutic drug monitoring versus drug testing).

- Key risk areas include:

- Panels/exploding charges
- Send out tests
- Preventive screening tests (Medicare G-codes have very specific uses)
- Pathology
- Reflexing

Emergency

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- Technical charges: Bladder scan, hydration/infusion, catheter insertion
  - How are these captured? HIM, nursing?

- Professional charges in scope? For procedures, are both the technical and professional being charged appropriately?

- Is your facility designated as a certified trauma center?
  - G0390: Trauma response team associated with hospital critical care service. APC $1,323.17

Pricing

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- Hot topic: Pricing Transparency
- Are prices appropriately tiered based on the complexity of the services?
  - e.g. Simple vs. complex or W & W/O contrast vs single scan?
- Are prices consistent?
  - e.g. right is the same price as left
  - Duplicate charges with varying prices?
- Annually reviewed against payer fee schedules? What contracts have "lesser of logic?"
- Relationship to cost?

“THAT’S NOT MY JOB”

Who is responsible for all if this?

Who Manages the CDM?

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- Is there centralized management or do departments manage their own charges?

- Workflow for requesting a new service, are there separation of duties?
  - CPT/HCPCS request/approval
  - Revenue code assignment
  - GL/Statistical components
  - Who sets the price?

- Skill set - are the appropriate people in the right position?

What About Connections to Clinical Dictionaries?

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- Role of clinical informatics - key for the end user
- Linkages
  - CDM could be perfectly clean… but are the charges linked correctly to the order/task/documentation?
- EPIC – Management of Willow, Beaker, etc..
- Other ancillary systems?
  - ED- T System, Wound, Rehab

How Are Charges Captured?

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- Charges are captured a variety of different ways:
  - Order entry
  - Documentation driven
  - Manual entry by specified staff
  - HIM/coding
  - Patient accounts? (hopefully not!)
- Does everyone involved understand when/how charges are generated and their role in the process?

Identifying Charge Capture Errors

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- Daily charge reconciliation
  - Confirm that appropriate charges are being posted to every account
- Revenue and usage reports
  - Look for trends that might identify issues
- Late charge reports
  - Excessive late charges due to charge capture breakdowns
- Denials/edits
  - Many issues stem from upstream issues in the CDM or charge capture processes
- Chart reviews
  - Identify deficiencies that might otherwise go unnoticed

Organizational Culture

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- Dept ownership
  - Backend function or backend partnership?
- Organizations who have a strong revenue cycle culture will perform the best
- Many organizations may not even realize their culture is not charge capture focused

“CONSISTENCY IS KEY, BUT CHANGE IS CONSTANT”

How to keep up with it all

Use Available Resources

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- Provide CDM and departmental staff with the education and tools that they need to manage their charges
  - Written policies and procedures
  - Training regarding billing rules and guidelines
  - Paper or electronic resources (e.g., CPT books, online reference sites, CDM management tools)
- Promote charge reconciliation
- Review Revenue and Usage reports
- Perform regular audits
  - Compare physician orders, to chart documentation, to itemized charges, to claim form – identify deficiencies or missing charges

Monitor for Changes

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- Quarterly/Annual CPT/HCPCS changes
- CMS transmittals
- Payer notifications
- Continuous education (conferences, webinars, workshops)

Prepare for Turnover

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- What's your contingency plan should your CDM coordinator win the lottery tonight?
- Who in the organization has access?
- Are there redundancies?
- Policies and procedures (CDM policy, supply policy)
- Documentation of systems/processes

CDM Maintenance

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- Obsolete Charges
  - Charges that are no longer being utilized should be removed (Inactivated)
  - Larger CDM's are more difficult and costly to maintain
  - More opportunity for error
- Supply/Pharmacy price changes
- Annual price change

SUMMARY

- CDM is not just a price list anymore!
- Do you have the right CDM person (unicorn?) overseeing the process
- Clinical ownership and buy-in is key
- CDM is only as good as its linkages
- Checks and balances strengthen the CDM
- Full CDM reviews recommended every two years

QUESTIONS?

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THANK YOU!