

Missed Opportunities

Your Strategy for Correct—and Complete—Charge Capture



hfma
healthcare financial management association

Just about everyone has had the experience of reaching into the pocket of an old jacket or pair of pants to find a handful of change or, even better, a few dollar bills. While the pleasant surprise is often viewed as a mini windfall, the reality is that the money was there all the time—just undiscovered.

In a similar manner, hospitals, too, may have “loose change”—not in pockets, obviously, but in places where administrators don’t have time to look. A common source of overlooked revenue is that associated with missed charges—charges for supplies, devices, services, and procedures that were entitled to be on the insurance claim, but never made it.

■ Missed Charges = Lost Revenue

A review of data from more than 100 hospitals, which encompassed more than 30,000 complete medical records and comprehensive billing and collection records, showed that, on average, the organizations were losing 1 percent of revenue to errors in the chargemaster or charge capture.¹

It’s important to note that hospitals typically are not aware of the degree to which they may be missing charges. A hospital may have a chargemaster that appears to be well maintained, yet the facility still may be losing revenue because it lacks adequate controls to identify each charge capture opportunity. It’s not necessarily that mistakes are being made. Rather, chargemaster administrators often are not able to keep up with changing codes and regulations, so those changes are not making it into the chargemaster. There is so much to know and there are so many changes occurring that opportunities for missed charges are plentiful.

Thus, hospitals may try to manage and maintain what’s in the chargemaster, but it’s also important to look at what’s not in the chargemaster. For example, associated procedures, or procedures that are often performed along with a main procedure, may be missing from the chargemaster. Hospitals may have new devices and services that don’t make it in. Some devices or supplies included within a large package of items can be billed separately, but may not be included as separate line items in the chargemaster.

Appropriate charge capture is not only important for capturing revenue but also for tracking use of resources. Missed charges may prevent the hospital from accumulating enough dollar value to hit an outlier, which also results in a missed revenue opportunity.

With so much to monitor, how can a hospital keep pace? The key to improvement is implementing an appropriate combination of procedures, staff education, and technology to ensure that charges never get lost in the first place.

■ Where to Look

Healthcare organizations use a number of strategies to identify areas where charge capture needs to be improved.

At Rush University Medical Center, a 700+ bed facility in Chicago, charges should be reconciled on a daily basis, says Jennifer Hackett, director of healthcare finance. That means if 100 patients were seen in, say, the emergency department, there should be 100 charges for that department.

The reconciliation process can begin by counting charge tickets, or the master list of services, for a particular department. The number of charge tickets should match the patient census for a given area on a given day. The next step is reconciling whether a charge has been entered for the total number of patients, Hackett explains.

“If you’re doing that within 24 hours following the date of service, you can probably capture some missed charges right away,” she says.

The hospital also monitors revenue and usage reports, Hackett adds. For example, if 50 charges for a certain item are expected during a certain time period, such as one month, but none are charged, “It might be a flag where we go back and ask ‘Is there a problem with charges being processed or did we truly just have a volume dip?’” she says.

Often hospitals will also perform an audit or charge capture review, a manual process that compares what services and devices were documented on a patient’s chart against what was charged on the claim.

¹ Duffy, J., “Are You Speeding Toward Revenue Loss?” *hfm*, Dec. 2004, p. 44-45.

Rush performs ongoing audits, including one of the chargemaster typically around October and January, when changes to Medicare's CPT codes are implemented, says Hackett.

"We will also do a charge capture audit with a department when there are changes with any kind of computer system, if there is any kind of significant staff turnover, or if it seems like it may be an area where staff would benefit to have a little bit of additional exposure to these kinds of activities," she explains.

Volume also can determine what and when to audit.

During the past 18 months, Advocate Health Care, a not-for-profit organization of eight large and small hospitals in the Chicago area, performed audits in the departments of radiology, interventional radiology, cardiac catheterization, and laboratory, according to Wendi Accardi, director of the chargemaster revenue and compliance department for the Oak Brook, Ill.-based system.

Accardi says the departments were audited because they are large departments with hundreds of line items, meaning hundreds of codes, and increased potential for error.

The health system also conducts defense audits when insurance companies request reviews of patient claims.

"We have also identified charge capture opportunities during our defense audits that provide us with the opportunity to capture lost charges as well as analyze issues we probably would not have caught by other means," Accardi notes.

Lutheran General Hospital, a 400+ bed facility that is part of the Advocate system, has created a revenue and audit department that looks for charge capture issues on a daily basis.

Among many other reviews, the department's five registered nurses audit charges for all of the hospital's observation patients, or outpatients who are being monitored in a hospital bed. Accardi says that by reviewing all observation services, the hospital is guaranteed a "clean" and accurate bill. Observation services often don't get billed properly because of confusion between inpatient and outpatient billing rules. For example, an intravenous infusion is not billed separately on the inpatient bill. However, an

IV infusion can and should be billed separately on an outpatient bill, she explains.

Beyond outpatient services, the revenue capture and audit department provides "prospective reviews when time allows."

"We tend to go with the higher dollar cases, because with larger dollar cases there are more line items, and thus greater potential for error," she says.

Marilyn Hart Niedzwiecki, manager of revenue integrity for Children's Memorial Hospital in Chicago, says more audits are in store for the 270-bed specialty hospital. Niedzwiecki, a registered nurse and CPA, has conducted random audits, but not as many as she would like, and she will increase the number in the future. As most organizations have, Children's Memorial Hospital has recognized the value of proactive auditing and is planning to expand this function, she says.

"Coming from a clinical perspective, I would say that the more audits you can do, the more missed charges you're going to find, and the more you're going to improve," she says.

Departments that present the greatest opportunities for missed charges are going to vary by facility. However, one common criterion for determining which departments to focus on is revenue. The large revenue-producing departments, such as the cardiology catheterization lab, tend to be the areas that present the greatest charge capture challenges. In addition to cardiology, other commonly targeted areas include the operating room, the emergency department, radiology, and nuclear medicine, says Advocate's Wendi Accardi.

Tips for Improved Charge Capture

- Audit regularly
- Provide clinical staff with education to help them understand their role in charge accuracy
- Optimize technology to target areas with greatest potential for error

Areas with significant coding complexity also may be particularly prone to missed charge capture. For instance, interventional radiology requires that two types of codes be on the claim—both CPT radiology codes, designated by the 70,000 series, and surgical codes, designated by the 10,000–60,000 (surgical section of CPT4) series, explains Holly McGrory, chargemaster coordinator for Conway Medical Center, a 160-bed not-for-profit hospital in Conway, S.C.

For example, for a CT-guided breast biopsy procedure, there's going to be a charge for the radiology part and a charge for the biopsy itself. "So, if they're only charging the 70,000 series code, they've lost some revenue from the surgical component," she says.

In large revenue-producing departments with high volume, even if the missed charge rate is a small percentage of overall volume, the loss of revenue can be great, notes Rush University's Jennifer Hackett.

"Areas that always benefit from audits in that way are going to be pharmacy, because charging and primarily coding for drugs is so tricky, as well as radiology, surgical services, and cardiac catheterization lab, because your reimbursement is so dependent upon making sure you have the right CPT codes and revenue codes associated with those charges on the bill," she says. "From a revenue perspective, it really pays off to be diligent in these areas. It's also typically a significant portion of a hospital's business."

Strategies for Improved Accuracy

Identifying areas of opportunity for improved charge capture is only half the battle. The other half is determining the optimal means to address them. As with most improvement plans, education and appropriate staffing levels are two central components of ensuring effective charge capture.

Much too often, hospital staff, whether they're coders or nurses, don't fully understand the role they play in the hospital's payment system—and how what they do, and

perhaps more significantly what they don't do, can directly affect the bottom line. When an organization takes the time to describe this role and its importance, an employee is more likely to want to understand the correct documentation and coding procedures.

When a problem arises, finance staff, such as the chargemaster administrator, should meet with department managers to determine a cause and then work to find a solution. Many times, that involves education, says Advocate's Accardi. For example, a coder may think that the cost of a wire that goes with a battery is included in the charge for the battery, but it may actually qualify as a separate charge.

One common problem easily resolved through training, she continues, is a missed charge for a venipuncture. Say the patient came in through the emergency department and there was a charge for the ED and a lab test, but none for a venipuncture, which is a common procedure that the department should see a charge for every day, Accardi says.

"It's not a lot of money, but still when you look at thousands of them, it adds up after a while," she says, adding that the appropriate solution is to educate the department manager on the procedure and its frequency.

Niedzwiecki, from Children's Memorial, also finds value in this type of education—especially for clinical staff.

"No one has really taught them details about charges—how you get paid, what should be on a bill, and what is a revenue code," she says. "I teach them that."

Niedzwiecki, who worked in the nursing field for many years and never even knew how the revenue cycle worked until moving to the finance side, also recommends a team approach to tackling the education issue. The chargemaster administrator and department managers should meet with clinical staff to teach about how to charge and what it means to charge. Administrators who don't have coding backgrounds should bring in staff from the healthcare information management department to help teach that aspect, she says.

Likewise, administrators without a clinical background should try to understand the language of the clinical staff. For example, she explains, there is a CPT code that defines a procedure that uses a thrombolytic medication to dissolve a clot in a central line or implanted venous access device. In layman's terms, this is known as "clotting of a catheter." In the coding world, the thrombolytic procedure involves administering an expensive medicine into the catheter. But if in explaining the coding to a nurse, the administrator used the term "clot a cath," the nurse would think this simply means flushing of a routine intravenous catheter to try to keep it free from obstruction, which is very different from a thrombolytic procedure and is not separately billable, Niedzwiecki explains.

That's why clear communication is so important. Nurses are told to charge, charge, charge, she adds: "But I don't think they understand the details of why, what it means, what happens to their charge when it goes through the system, and what a bill looks like. When I teach, I take a UB [uniform bill] and show them what it is and how it works."

With some organizations, the importance of charge capture is stressed to all levels right from the beginning.

At Pensacola, Fla.-based Baptist Health Care, which has four acute care hospitals ranging from a 25-bed rural critical access hospital to a 500-bed urban facility, the charge capture area is embedded into the not-for-profit's 10 standards of performance.

"We try to make sure that every employee recognizes that accurate charging is part of their job, even if their primary responsibilities are clinical," says Andrew Terry, vice president of revenue management.

Managers receive more detailed training in charge capture issues, and each clinical department has a chargemaster liaison who is actually located onsite within the department, Terry adds. The liaison is responsible for working with the chargemaster administrator as part of regular meetings with reimbursement department staff who oversee charge capture compliance and accuracy.

What's Missing from Your Chargemaster?

Your chargemaster may be correct, but is it complete? Common areas where hospitals miss out on billable items and services include:

- New and updated codes for devices and services
- Secondary codes, or codes for procedures and supplies that often occur with a main procedure
- Codes for devices or supplies that are often included within a large package of items that can be billed separately, but they may not be included as separate line items in the chargemaster

When an issue arises, the health system works hard to find solutions. A few years ago, Terry says, it became clear that interventional radiology had a charge capture issue because of the number of pended claims being seen. An outside audit of 100 claims showed that they weren't being processed correctly. To address the issue, Baptist created a position, located within the clinical department but budgeted to the finance department, responsible for reviewing all of the claims before they were sent out. In just six months, the auditor was able to capture \$400,000 in charges that otherwise would have been missed, more than enough to justify the cost of the position, Terry says. The position worked out so well in fact, that the auditor now handles charge capture in another challenging area—the cardiac cath lab.

"We put enough improvements in the process that the billing for interventional radiology is much better today than when we started the auditing," Terry says.

Time to Tackle with Technology?

Having the dedicated staff who are knowledgeable about compliance, coding, and even clinical procedures will go a long way toward improving charge capture—unfortunately, however, often not far enough.

Medicare regulations and coding rules have become so complex and cumbersome over the years that no one administrator or even department can keep track of all of the latest changes. Chargemasters themselves often contain thousands of items, and maintaining such an overwhelming list is often impossible without help beyond the human touch. That's why providers often turn to technology to support charge capture efforts.

At its most basic, technology simply allows people to work more efficiently. Software programs can allow fingertip access to an extraordinary amount of data that are required to keep the chargemaster up to date and compliant, making a complicated job a lot easier.

Technology is not a panacea to missed charges, but by automating processes and storing huge amounts of data, it provides more timely and convenient access to information, such as Medicare transmittals, that most revenue cycle staff simply don't have the time to hunt down. Another key benefit of technology is the power of tracking and trending data. By aggregating data, hospitals have a greater ability to see patterns of missing or inappropriate charges and use this information to highlight the importance of coding issues and identify opportunities for improved education.

Some software products have workflow communication tools that allow for convenient dialogue, via e-mail, between the chargemaster manager and the charging team, and can even include clinical staff. Baptist Health Care, for example,

uses a software system that helps hospital staff stay abreast of changes to codes and other areas via e-mail notifications, called informants, which can be tailored to specific users.

"You can send the radiology informants only to the folks in radiology without bothering lab personnel," Terry explains. "And there's an audit trail, so you can see who is actually reading their informants."

"In today's world, where policies change so often, it's just a very nice tool to use to get a reminder," he adds.

The software used by Advocate Health Care includes a comprehensive reference tool that contains the history of all the procedures, rules, and regulations for Medicare, along with the current and appropriate HCPCS/CPT codes themselves, according to Accardi. Special software can scrub the chargemaster for appropriate CPT codes and flag those that are no longer in use. A feature called a bill analyzer reviews claims for errors before they're sent out. "Our chargemaster analysts use these tools daily," she says, "When we find errors, we use them as examples to educate staff in the department."

The software also includes a corporate module, Accardi adds, that assists the health system in standardizing the chargemaster from one hospital to another.

Software filters can also monitor claims by flagging inconsistencies, such as a charge for a blood transfusion, but no charges for blood products. The system will flag CPT codes that have the potential for a missed charge by identifying all other codes and their revenue status that are associated to that specific code.

Using the interventional radiology example, the software will flag that the 10,000-60,000 CPT series codes are set up and will prompt a flag as to whether the 70,000 series codes are in the system, as well, explains Conway Medical Center's McGrory.

"That's also another place for gaining in revenue," she says.

Technology is all part of the organization's goal of hands-off billing, or to go as automatic as possible, according to McGrory.



hfma

June 2007
HFMA Educational Report
 Copyright 2007
 Healthcare Financial
 Management Association
 All rights reserved.

For reprints contact
 1-800-252-HFMA, ext. 2.

This published piece is provided solely for informational purposes. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions by participants are those of the participants and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear do not constitute endorsements by HFMA.

OUR SPONSOR SPEAKS

Are You Experiencing HCPCS Revenue Loss?

Sue Williams, project manager, 3M Consulting Ambulatory Care Services Group, 3M Health Information Systems, Atlanta, describes how failure to include accurate HCPCS descriptions as part of the charge can lead to missed revenue.

Q The Centers for Medicare and Medicaid Services states that hospitals must bill units of service for drugs, contrast material, and radioisotopes according to the HCPC description in order to receive appropriate payment. Why is this billing methodology important?

A The short answer is that the hospital is leaving money on the table if it is remiss in following these instructions. Drugs classed in status indicator “G” (Passthrough drugs and biologicals: paid under outpatient PPS with separate APC payment that includes passthrough amount) or “K” (Non-passthrough drugs and biologicals: paid under outpatient PPS with separate APC payment—applies to drugs, biologicals, and contrast material) will be paid separately when classed in UB-92 revenue code 636 (Drugs Requiring Detailed Coding), and units of service are correctly reported and the appropriate HCPCS code is applied.

For example, if the description for the drug code is 8 mg, and 8 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4.

Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered.

Radioisotopes should be reported in millicuries, microcuries, and/or study dose up to a specified number of millicuries or microcuries. Isotopes are classed in status indicator “H” Radiopharmaceutical agents and are reimbursed on a separate cost-based non-passthrough payment. In addition, these services would be classed in UB-92 revenue code 343 or 344 (Diagnostic or Therapeutic Radiopharmaceutical). When a hospital reports 1 unit of Thallium Chloride (A9505) and a charge of \$300 and the actual dose was 30 units, it is losing payment as well as incorrectly reporting services delivered.

Educating staff on proper use of HCPC descriptions is particularly important because the impact on revenue over time can become substantial. Hospitals that live with these types of errors risk compounded loss because claims submitted today are used to evaluate cost and pricing for future payments.

Source: 3M Health Information Systems

Conway Medical Center had been using software programs that ultimately proved to be incompatible with the hospital's differing operating systems, says McGrory. So, Conway switched to an online tool. The software provides one-stop shop access to information that, manually, is contained in separate publications. "We used to flip from book to book to book trying to find what we were looking for and then try to remember everything," she says. "Whereas, if you're using this tool, the information is right there and you can point, click, and get what you need."

McGrory used the technology's pricing tool to analyze whether the hospital was underpricing its ED services, a suspicion felt by the ED director. The suspicions turned out to be on target and after adjusting some prices, "We had a 52 percent increase in revenue," she says. "That's huge."

In addition to the improvements in the ED, use of the technology has resulted in an increase of between 30 percent and 50 percent in charged revenue in the areas of nursing services and interventional radiology, she says, noting another positive.

"You also have to add the benefit of having a cleaner claim, which translates to fewer people having to touch a bill. So, the percentage of electronic claims that go out untouched has increased as well," she says.



hfma™

About HFMA Educational Reports

HFMA is the nation's leading membership organization for more than 33,000 healthcare financial management professionals employed by

hospitals, integrated delivery systems, and other organizations. HFMA's purpose is to define, realize, and advance the financial management of health care. HFMA Educational reports are funded through sponsorships with leading solution providers. For more information, call 1-800-252-HFMA, ext. 330.

McGrory points out that the technology doesn't take the place of staff, like coders, but simply makes their work easier. In fact, while hospitals are often reluctant to add positions that are deemed non-revenue producing, providers need to ensure they have the appropriate staff that are knowledgeable about charge capture and technology.

"If they want to make sure they have complete and accurate charge capture, hospitals need to have these types of tools," she says, "and they need to be able to make sure they have the dedicated staff to use them."

"Otherwise," she adds, "you are losing money."



Health Information Systems

3M Health Information Systems, part of the 3M Health Care family, is a leading provider of advanced software tools and consulting services that help healthcare organizations capture, classify, and manage accurate healthcare data. As the developers of the widely used 3M™ AP DRG and 3M™ APR DRG methodologies, our experts leverage unparalleled knowledge and experience with severity- and risk-adjusted data to develop comprehensive solutions to drive quality improvement and ensure proper reimbursement. 3M Health Care is dedicated to improving the practice, delivery, and outcome of patient care. 3M Health Care is a leading provider of solutions for medical, oral care, pharmaceutical, and health information systems markets.

For more information on the APC Oversight Program from 3M Consulting Services or the 3M Chargemaster Online, visit www.3mhis.com.