Value Cycle Excellence: Chargemaster Review and Communication

Tuesday, September 20, 2016
Noon – 1:00 Pacific / 1:00 – 2:00 Mountain / 2:00 – 3:00 Central / 3:00-4:00 PM Eastern

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Beebe Healthcare
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Presenters

Kerry Topper, RHIA
Manager of Revenue Integrity
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Kerry Topper is an experienced health care professional with more than 19 years of experience related to Revenue Integrity. As the Revenue Integrity Manager at Beebe Healthcare in Lewes, Delaware she focuses on a hospital-wide revenue integrity program as it relates to billing, coding, auditing, and charge capture and manages all aspects of the chargemaster. She recently completed revenue builds for Beebe’s first EMR and Operating Room implementations. In previous roles, Kerry has performed consulting, auditing, coding, private practice management, and provider and network account management. She has worked with all sizes of acute care facilities and has a love for teaching and education. She is an active member of AHIMA and MDHIMA and currently holds the RHIA credential.

Margene Holak, MHA, CRCR, COC
Business Solutions Consultant, Craneware

Margene Holak is an experienced health care professional with more than 30 years of work in a variety of health care setting. She has been employed in local public health, specialty physician clinics, Federally Qualified Health Centers, and hospitals. Her roles have encompassed many aspects of the revenue cycle, including patient access, patient financial services, provider enrollment, data analytics, and CDM maintenance. She holds a Master of Health Administration from St. Francis University and has been a member of the Health Care Financial Management Association for more than 20 years, previously in Illinois and currently in North Carolina.

In her work on Craneware’s Professional Services team, Margene uses her hands-on knowledge and experience, coupled with a love for teaching, as a Business Solutions Consultant to help customers in securing healthcare operational insights that advance business performance using modern revenue integrity strategy.

Margene works with hospitals and health systems of all sizes, assisting healthcare leaders with strategic project management, implementation of performance improvement methods and revenue cycle measurement tools, and best practice processes.
Agenda

• What is value-based healthcare? What is a CDM?
• Why does the CDM matter in a value-based payment model?
• How do we communicate about the CDM?
• Who should share in CDM responsibilities?
• What impact can the CDM have on hospital operations?
• How can CDM management and communication be streamlined?
• How to improve supplies and OR revenue integrity?
• How to maintain revenue integrity during and after an EMR conversion?
An evolving healthcare marketplace is rapidly driving shifts to new financial performance metrics focused on value.
Revenue Cycle

- Fee-for-service
- Connect charges to units of service provided

“All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue”

Value Cycle

- Value-based and other alternative payment models
- Connect costs to units of service and charges
- Evolves from acute/ambulatory to comprehensive care strategy
- “The process and culture by which healthcare providers pursue quality patient outcomes and optimal financial performance through the management of clinical, operational and financial assets.”
What is a CDM?

• CDM is the acronym for Charge Description Master (CDM), also often referred to as the Chargemaster.

• The CDM is the list of the services offered within an organization.

• It “translates” what is performed by clinicians for patient care into charge language that can be understood by payers and patients.

• It is the basis for data analytics, for both payers and healthcare providers.

• It provides detail for analyzing variations in outcomes by identifying differences in the specific tests, procedures, supplies, and medications provided to a patient.
“...there seems to be no process, or rationale, behind the core document that is the basis for hundreds of billions of dollars in health care bills.”

Steven Brill, Time Magazine Feb. 22, 2013
"We lose money on 60 percent of what we do, and we actually generate a margin on 40 percent of what we do. In aggregate, hopefully, we break even or have a 1 or 2 percent margin at the end of the year. The things that we get overpaid on allow us to do the things that we get underpaid on"

— David Torchiana, CEO of Partners HealthCare in Boston. From "Partners CEO makes his pitch" via CommonWealth Magazine (April 2016).
Why does the CDM matter?

• All payment methodologies need details.
• Standard transactions sets (part of HIPAA legislation) define patient care details.
• Claims are processed with automation.
• Aggregated claims data drives decisions about quality care and value.
• New comprehensive, bundled payment methodologies need clean, organization-specific details.
Comparison of Traditional vs Bundled Payments

<table>
<thead>
<tr>
<th>Traditional Fee-for-Service</th>
<th>Bundled Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for each service regardless of quantity or quality</td>
<td>Payment for comprehensive, coordinated outcomes</td>
</tr>
</tbody>
</table>

### Traditional Fee-for-Service:
- Pre-admission Services
- Part A Inpatient Services
- Part B Inpatient Services
- Post Acute Care
- Readmissions

### Bundled Payments:
- Pre-admission Services
- Part A Inpatient Services
- Part B Inpatient Services
- Post Acute Care
- Readmissions
Anticipated Bundled Payment Results

• Savings for payers
• Alignment of incentives among all episodic providers of care
• Reduction in hospital readmissions
• Increased patient satisfaction
• Better outcomes
  – Right care
  – Right location
  – Right provider
APC History

- HCPCS codes assigned to APCs
- Packaging services into an APC
From the “Why” to the “How”

CDM Review and Communication
### Chargemaster Data Elements

<table>
<thead>
<tr>
<th>Service Code 1234</th>
<th>Charge Description</th>
<th>Revenue Code</th>
<th>CPT or HCPCS code</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique number created by a facility</td>
<td>Unique description of a procedure, drug or supply created by a facility</td>
<td>National Uniform Billing Committee (NUBC) – represents the type of bill you are submitting on the claim</td>
<td>Standardized coding system that is used primarily to identify products, supplies, and services not included in the <em>CPT procedural codes</em>. A CPT code is a five digit numeric code that is used to describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation/management services of physicians, hospitals, and other health care providers</td>
<td>The charge a patient is billed for a service, drug or device</td>
</tr>
</tbody>
</table>
Partnership of Financial/Clinical Teams

• Each knows something the other doesn’t.
• No margin, no mission.
• Integration for success in the “value cycle”.
• Expectations for working together.
  – Regular, scheduled internal sessions.
  – Professional organizations.
  – Vendor networking opportunities.
CDM Contributors - Internal Resources

- CDM Manager
- HIM and Coding
- Finance/Reimbursement
- Auditing
- Managed Care Contracting
- Patient Financial Services
  - Billers
  - Denials management
- New Resource - Post Acute Care Manager
CDM Contributors – External Resources

- CMS – Manuals and Articles
- Payer Provider Participation Guidance
- Professional Organizations
- Vendors/Suppliers
- New Resource – Episodic Care Partners
Step-by-Step CDM Review

- Schedule regular individual department sessions.
- Provide detailed CDM for each department, with 12 months of charge line utilization.
- Identify unused charge lines and determine why.
  - Obsolete?
  - Duplicate of another charge line?
  - Missing legitimate volumes?
Step-by-Step CDM Review

- Deactivate charge lines with no usage or no anticipated usage
- Review all CPT/HCPCS codes currently assigned
  - Valid for current dates of service?
    - Replace/update/create new charge lines as needed
    - Inactivate charge lines with outdated CPT/HCPCS codes
Step-by-Step CDM Review

- Review revenue codes and update if needed
  - Are they in sync with the CPT/HCPCS?
  - Do they reflect the actual site of service?
  - Has regulatory guidance changed?
  - Are there special requirements for specific payers?
  - Are there cost report considerations?
Step-by-Step CDM Review

• Review modifiers if attached to the charge line.

• Review compliance guidance for the charge CPT/HCPCS.

• Verify that the description of the charge in the CDM matches the AMA/CMS description for the CPT/HCPCS code.

• Verify that the service performed matches the CPT/HCPCS code description.
Step-by-Step CDM Review

• Review the services provided in the department
  – Is there anything that is being done that does not have a charge?
  – Is there anything that is being charged with a description that does not match the CDM?
  ▪ Pay special attention to charge lines used for services with a number of minutes, views, or other measurement
Step-by-Step CDM Review

- Verify that the charge capture tool is complete and accurate for all department charges.
  - Paper charge capture tools should have an update date and all old versions discarded.
  - Order entry systems and documentation-based charges should be tested through the system interfaces to the claim for accuracy.
Step-by-Step CDM Review

Analyze charge line pricing.

– Filter to identify exceptions to established hospital policy.

– Validate CDM prices.
  ▪ Is price consistent for the same CPT/HCPCS code?
  ▪ Does price reflect current technology?
  ▪ Is price defensible?
  ▪ Is price transparent?
Key Times for CDM Communication

Code Changes

– Codes undergo annual additions, deletions, revisions.
– Codes can be changed throughout the year as needed, including the addition of temporary use codes.

Service Changes

– When you begin a new service, update the CDM.
– When you discontinue a service, update the CDM.
CDM Review and Communications Summary

- CDM is the source document for capturing patient care.
- CDM is not a mysterious document.
- CDM translates patient care into the language of claims – CPT/HCPCS codes, revenue codes, modifiers, multipliers.
- CDM is essential for the details needed to understand what is the right care by the right provider for better outcomes – the foundation for success in a quality, value-cycle healthcare world.
• 210 Bed, Not-for-Profit Community Hospital located in Lewes, DE (resort town)
• Specializing in Cardiovascular, Oncology, Women's Health, and Orthopedics
• FY16 11,176 inpatient admissions
• FY16 376,745 outpatient encounters
• FY16 48,337 ED visits
• 7 Outpatient Service Locations including: Lab, Imaging and Rehabilitation
Business Objectives:

To take an old, manual, and broken process and initiate change through automation, communication and integration of systems.

Use this automation to finally be able to identify and acknowledge revenue enhancement opportunities.

Let’s talk more about….

- Automation of CDM Management / Communication.
- Consolidation and Clean Up of OR Supplies.
- Implementation of a new EMR.
And so the Story Begins: From a Very Basic and Manual CDM Process.....
Old CDM Communication Process

**Department requestor fill out change request spreadsheet**

**Charge Services Reviews**

**Charge Services enters into Patient Accounting System CDM build screen**

**New charges process at midnight run for use next day**

**Charge Services emails Department requestor that charge is available, alerts IT to needed subsystem maintenance.**

**Manual Charge Form Issues**

- Spreadsheet not completely filled out
- Needed subsystem updates missed
- Wait for response if information is missing or if we have questions
- Manual data entry / human error
- Time spent writing / managing emails to 15+ departments. Unclear audit trails.
## Old Manual Charge Form

<table>
<thead>
<tr>
<th>Add Service Code</th>
<th>Description (max 30 characters including spaces)</th>
<th>Price 1</th>
<th>Price 2</th>
<th>Medicare Rev Code</th>
<th>Medicare CPT/HCPCS</th>
<th>Vendor Item Number</th>
<th>Vendor Name</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>A Y 1622659</td>
<td>REALIZE GASTRIC CALIBRATION TUBE</td>
<td>195.00</td>
<td>272</td>
<td>N</td>
<td>LAP BAND</td>
<td>JOHNSON &amp; JOHNSON HSP</td>
<td>RGCT-360</td>
</tr>
<tr>
<td>7</td>
<td>A Y 1622659</td>
<td>ANASTOCLIP VCS MEDIUM</td>
<td>568.50</td>
<td>278</td>
<td></td>
<td>VASCULAR</td>
<td>LEMAITRE</td>
<td>4000-02</td>
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<td>8</td>
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<td>ANASTOCLIP VCS LARGE</td>
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<td>VASCULAR</td>
<td>LEMAITRE</td>
<td>4000-03</td>
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<tr>
<td>9</td>
<td>A Y 1622661</td>
<td>CLIP REMOVER DISPOSABLE</td>
<td>148.50</td>
<td>272</td>
<td>N</td>
<td>VASCULAR</td>
<td>LEMAITRE</td>
<td>4001-00</td>
</tr>
</tbody>
</table>
Manual Charge Form Issues:

- Manual Process “This is how it’s always been done.”
- Very time consuming to fill out and then process.
- Could have several hundred to add from the OR Department every couple of weeks (the OR was holding charges until they filled spreadsheets!).
- CDM staff needed dedicated concentration as to avoid interruptions, errors, or research further.
- No “real” audit trail (only paper copies kept).
- Important billing information often left off (ex: device codes – C Codes) “Not my responsibility but yours” attitude from departments submitting requests.
- “Too manual – we need a change in process now!”
Improving Process Flow: Incorporate Chargemaster Software

• Department submits CDM Additions, Modifications, and Inactivations through new chargemaster software tool.
• Required Fields: (Depending upon Supply, Drug or Procedure Charge).
  – Service Type (0=charge, 1=room and board, 2=statistical)
  – Service Code Description (*use vendor website tool as reference)
  – Department/GL
  – CPT/HCPCS code
  – Modifiers if necessary
  – Revenue Code
  – Pricing (Hospital Mark-Up Policy Applied)
  – Notes section: details on why charge added, manufacturer/vendor info, billable units, provider #’s, etc.
  – CDM # if modification or inactivation only
Example of New CDM Communication Process: New Item request from OR

OR sends CDM request to Charge Services via CDM tool. Software ensures request is complete.

Charge Services adds new CDM to CDM tool. Interface scripts run to update Patient Accounting System.

Email sent via CDM tool to Dept. requestor and IT w/ change details

OR builds item in Materials Management System, creating item # with required details including CDM

Materials Management System / EMR item master interface runs next morning, Item is added to EMR.

Item is added to Charge Services Pricing Tool via ops job

OR sends email to Rev Integrity w/ description, item number, and assigned CDM

Update Pricing tool by Charge Services w/ existing CDM for this item
Example of New CDM Communication Process: 
Charge Services Charge Error Process

Revenue Integrity Reconciliation Analyst (RIRA) runs Suspended Charge report and Bill Item Not Found Report

RIRA emails Dept. Manager or analyst responsible for error with screenshot of error

Dept. Manager / Analyst oversees corrections are made

All Corrections are picked up nightly when the charge interface runs.
Improving Change Request Process

• Every charge looked at thoroughly before approval to make sure the hospital markup policy was applied correctly and all items needed are filled out.
• Notes must be added on every charge to indicate purpose for addition, modification or inactivation (audit trail).
• Vendor/Manufacturer, cost, unit of measure, etc. are also needed in notes section for supplies for Materials Management.
• If rejected, notification sent to department requestor for correction.
• Once approved, charges processed through chargemaster software. Interface scripting is performed immediately to patient accounting system. Charge(s) will process through at midnight and be available next business day for use.
• Auto notification email from chargemaster software sent out to the Department Requestor and the Revenue Integrity Manager. This email is then customized and sent on to PBS IT Analyst, IT staff, Contract Management/Denial Manager and Materials Management Director for notification of system updates.
Chargemaster Automation Advantages:

- Speed and ease-of-use.
- Training rolled out to all Directors/Managers and Department Analysts – Requirement for educational purposes and to access charges (feedback was astonishing!).
- Process Flow significantly reduced (two weeks to 1-4* days, pro fee set up takes a couple days longer).
- Identifies inconsistencies quickly and accurately, changes can be made immediately.
- Compliant audit trail.
- One central location for all needs (diagnosis and procedure code info, Medicare regulations and manuals, CCI edits, MUEs, LCDs, customized pricing, etc.).
- Reduction in # of code books purchased by departments.
- **REVENUE INTEGRITY FINALLY BEING UNDERSTOOD!!**
WIN-WIN Situation for All!!

Happy Clinical Departments = Happy Patient Business Services
Revenue Enhancement: Supplies Consolidation and Clean Up of OR Supplies

- High Volume of Duplicate Supply Items are located in the Operating Room. Why is this happening?
Problem:

• The OR Department and several other high volume supply areas were identified to have numerous duplicate charges that contained the same identifiers:
  – Similar description
  – Same CPT/HCPCS code
  – Same Revenue code
  – Similar if not the same pricing
• Charges that are no longer used in the OR have never been inactivated!
• Greatly complicates the daily charging and overall CDM maintenance process.
• Questions Asked:
  – Why has the OR and other areas been allowed to do this?
  – Where do we begin to fix this HUGE problem?
  – Who ultimately takes responsibility for this project?
Added Issues:

• Most of the systems at Beebe Healthcare didn’t have the capability to “talk” to one another:
  – OR Department, Materials Management, Patient Business Services all on separate systems

• Departments had a disconnect in working with each other. Relationships have been strained in the past due to:
  – Turnover of Directors in the OR.
  – Projects started but left undone.
  – Vendors were bringing in supplies and using them in the OR without going through the Materials Management approval process. They only found out after the fact! = Late Charges.
  – Staff who didn’t fully understand the “BIG” picture with Revenue Integrity.
Identified Operational Efficiencies:

• With the help of a consultant firm, we came up with a solution to condense the Chargemaster from over 15,000 supply line items down to only 1,500.

• These 15,000 supply line items would be “mapped” to new CDM “levels” based upon cost.
  – Example: Screw LV1 $0-100
  – Screw LV2 $101-200

• Although various departments are affected, the growth is most pronounced in the OR which is a device-heavy clinical areas. Cardiac Cath, and Interventional Radiology departments would follow at a later time.

• Materials Management would own responsibility and be the actual “gate-keeper” of all supply charges for the entire hospital.

• All systems would “talk” based upon new “level” groupings.
New CDM “Levels” Created (Example):

CDM Information:
- CDM#16189789 Global Hum Stem SZ10
- Price $5,048.00

Materials Management Information:
- Item #16189789
- Manufacturer #: 1137-10-050
- Description: Global Hum Stem SZ10
- Cost=Not Recorded

Surgery Information (now using EMR for OR)
- OR Description: Imp Dep Global Humeral Stem SZ10
- 1137-10-050
- Pick Location: Deputy Sales Rep
- Item Cost: $3,064.50
- Item Charge: $3,525.50 (may or may not be updated – no need to keep current pricing)

New Level Proposed CDM Category: (Based upon Cost)
- Implantable Joint LV9
- HCPCS/Revenue Code: C1776/278
- Charge $12,623.75
## OR Supply Level Mapping Example:

<table>
<thead>
<tr>
<th>CDM#</th>
<th>Description</th>
<th>HCPCS</th>
<th>Revenue Code</th>
<th>Cost</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>31102601</td>
<td>IMPLANTABLE JOINT LV 1</td>
<td>STAT</td>
<td></td>
<td>&lt; $10.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>31102619</td>
<td>IMPLANTABLE JOINT LV 2</td>
<td>C1776</td>
<td>278</td>
<td>$10.01-$25.00</td>
<td>$70.25</td>
</tr>
<tr>
<td>31102627</td>
<td>IMPLANTABLE JOINT LV 3</td>
<td>C1776</td>
<td>278</td>
<td>$25.01-$50.00</td>
<td>$140.75</td>
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<tr>
<td>31102635</td>
<td>IMPLANTABLE JOINT LV 4</td>
<td>C1776</td>
<td>278</td>
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<tr>
<td>31102643</td>
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<td>31102650</td>
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<tr>
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<td>$5000.01-$10000.00</td>
<td>$18,081.00</td>
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<tr>
<td>31190515</td>
<td>IMPLANTABLE JOINT LV 11</td>
<td>C1776</td>
<td>278</td>
<td>$10000.01-$20000.00</td>
<td>$36,162.00</td>
</tr>
</tbody>
</table>
Time to implement an EMR and keep everything revenue neutral....
Implementation of New EMR

- Enhanced automation of the CDM - Charges now drop based upon documentation by clinical staff.
- Required multiple database “dumps” and the linking up of multiple systems that contained CDM information.
- Maintained OR revenue neutrality for charges by reviewing CDM usage, past years volume, and what new charges would equate to (used Access database for crosswalk and analysis)
  - Anesthesia acuity to Anesthesia type
  - GI suite set up fees
  - Incorporated RNFA (nurse assists) into minute charges
- Required new charge build and review
- Buy in from areas that would now “document” charges
  - “We’re clinical – we only care about patient care!”
- Accountability and reporting
- Continuing education is key!
Enhancements of New EMR

• Daily revenue reporting and auditing
• Review suspended and free text items on a daily basis
• Drill down capability by department
• Easy identifiable areas where revenue issues may lie
• Accountability to correct charges timely
• Accountability by person/department
• Interdepartmental communication
• More accurate revenue capture!!

“TEAM” = Together Everyone Achieves More
Best Practice Recommendations:

• Fully engage departments—the more knowledgeable they are, the better understanding they will have and will want to work together.

• Everyone is responsible for Revenue Integrity – explain the “BIG” picture.

• Don’t be afraid to challenge department processes (ways to improve current or outdated processes).

• Rely on knowledgeable consultants (if needed).

• Hold team members accountable, make them understand the role they play in patient care and new revenue enhancements.

• Look for revenue opportunities everywhere! You won’t know the true impact without having tools there to assist you!
QUESTIONS?
To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

Enter this Meeting Code: 16AT48

URL: http://www hfma.org/awc/evaluation.htm

Your comments are very important and enables us to bring you the highest quality programs!