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How a 3-phase approach can rebuild your chargemaster

By Caroline DeLaCruz and Joseph J. Gurrieri

Review, analysis and revision are key components
of a successful chargemaster review.

Final print edition

While this is the final print edition of *Revenue Cycle Strategist* newsletter, we are pleased to announce that, starting next year, our new monthly *Revenue Cycle Insights* will be delivered to your inbox filled with the latest news, tools and tips. Our revenue cycle editor Erika Grotto will handpick the best-of-the-best content from HFMA and elsewhere, just for you.

How a 3-phase approach can rebuild your chargemaster

Caroline DeLaCruz and Joseph J. Gurrieri

Review the entire process including policies and procedures.

The process of updating the chargemaster is often labor intensive and time consuming. It requires detailed work including investigation and research to ensure correct coding, charging and pricing. Yet, it must be done to ensure the following:

- > All charges are available for capture.
- > Correct HCPCS/CPT codes are assigned.
- > Charges are current.
- > Descriptions are clear and non-duplicative.
- > Respective revenue codes are accurate.

The outcome is worth the effort to help eliminate denials and achieve optimal revenue. However, a patchwork approach creates more problems than it solves.

If not performed routinely, chargemaster cleanup can be a daunting task. At one facility, less than 40% of the charge description items were being used. In such cases, the solution is an overhaul of the chargemaster using a three-phase approach.

Phase 1: Process review

Conduct in-depth interviews with each department — radiology, emergency department, laboratory, pharmacy, oncology, respiratory, physical therapy and all others. Include department heads of service areas, lead departmental operational team members, and a representative from finance and revenue integrity. For example, a thorough review would involve interviewing two dozen or more clinical departments to determine services provided; procedures performed; and medications, devices and supplies used.

It is important to review the entire process along with policies and procedures. Ask the following questions about the process for charge posting:

- > Does everyone know what items are billable?
- > How is a billable procedure or supply posted on the patient's bill?
- > Are charges verified?

For each department, use this information to create a detailed workflow diagram and conduct a chart-to-bill audit. Do the charges make it to the bill?

Finally, compile a report that includes a record of the following problems:

- > Charges that never made it to a bill
- > Incorrect charges
- > Incorrect HCPCS/CPT codes mapped to charges
- > Incorrect revenue codes
- > Duplicate charges

Phase 2: Analysis

Before updating charge code items, use data analysis to generate a report that shows specific issues. These might include charge codes missing a revenue code, charge codes with incorrect revenue codes or charge codes with invalid or missing HCPCS/CPT codes.

Strategies for positive impact on revenue integrity

- > Follow the three-phase model — process review, analysis, review and revise — to perform a complete update of your chargemaster.
- > Designate someone with extensive coding experience to verify/validate charges.
- > Conduct a periodic chart-to-bill audit for each department.
- > Bring charging and coding to one place on the front end.

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Next, begin updating the charge code items. This is an arduous task that requires going through each charge code to ensure accuracy. However, the outcome — accurate payment that represents the actual care and resources provided — supports revenue integrity.

Phase 3: Review and revise

This is an educational phase that involves review and revision of the workflow diagrams for each individual department. The purpose is to optimize workflow and identify and address gaps. As part of the process, develop policies and procedures on how to update and maintain the chargemaster. For example, when you have a new service or supply, document the steps required to add that item to your chargemaster. Then follow up with training and education. For good measure, consider a quarterly maintenance program, which involves a quick scan using data analysis to check for invalid codes.

Bring coding and charging together

In addition to chargemaster cleanup, or as an alternative to an entire chargemaster update, some progressive organizations are bringing charging to the point of coding. This approach also consistently promotes chargemaster integrity following a cleanup.

Involving coders on the front end enables them to see what has been charged from the chargemaster and ensure accurate charge verification. And because coders know how to properly assign HCPCS/CPT codes, they can resolve edits at the point of coding, verify all charges, add missing charges and remove charges that are not supported by the clinical documentation.

This practice helps to uncover chargemaster issues by coders who are experts at identifying a missing or incorrect charge and determining how the HCPCS/CPT codes mapped to the charges affect the overall coding for payment. The coders are best equipped to resolve edits that surface

once the charges (via hard coding) and the soft coding (coded by coders) are brought together. If a coder attempts to add a missing charge and finds no corresponding charge code in the chargemaster, there is an opportunity to create a new one. From that time forward, you can charge for that item.

For example, one health system in the Northeast recouped \$1.5 million within three months in radiology charges alone.

Over time, breaking down silos to bring coding and charging together up front serves as a chargemaster maintenance tool that can significantly decrease denials, correctly capture and represent charges and result in a boost and retention of revenue. •

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5 new code changes focus on new medical technologies

Kim Felix

Expected sweeping changes did not materialize.

Every October, ICD-10-CM and ICD-10-PCS provide updates for the upcoming fiscal year, and this year was no different. There was a lot of hype in the proposed changes that implied there would be sweeping updates to the complication/comorbidity and major complication/comorbidity lists. These were intended to be mostly downgrades. In fact, there were to be approximately 1,400 severity changes that would have a significant impact on payment. Public comment was tremendous, so these changes were delayed because of the magnitude of the revisions. Who knows what will happen next year? Keep your eyes and ears open.

This leads to less significant coding updates for 2020. But rather than focus on what might have been, the following are ICD-10-PCS codes for new technology to assist with proper payment.

1. Flow diverter device. This is a new ICD-10-PCS device character under root operation “restriction,” and it is used to treat non-ruptured intracranial aneurysms. There are two brand names currently on the market that have FDA approval: Stryker’s Surpass Streamline Flow Diverter and Pipeline Flex embolization device manufactured by Medtronic.

This device is implanted into the parent blood vessel from where the aneurysm is located. Rather than placing a device inside the aneurysm, as is done with coiling, this device diverts blood flow away from the aneurysm itself. While this technology may appear similar to a traditional vascular stent, these devices have a significantly higher mesh density, which prevents flow in the parent artery from entering the aneurysm, thus eliminating the need for a coil. The risk of rupturing the aneurysm during surgery is greatly diminished by not placing a device inside the aneurysm.

2. T-cell depleted allogeneic hematopoietic stem cell transplant. This is a new ICD-10-PCS substance character under root operation “transfusion.” This type of transplant is performed in patients with high-risk cytogenetics and/or relapsed multiple myeloma. It is expected that this procedure can reduce or prevent acute and chronic graft versus host disease (GVHD) in both human leukocyte antigen (HLA) matched and haplotype disparate hosts, without post-transplant prophylaxis with immunosuppressive drugs.

GVHD remains one of the leading causes of morbidity and mortality associated with conventional allogeneic hematopoietic stem cell transplantation (HCT). In simple terms, the functional immune cells in the transplanted graft recognizes the recipient as “foreign” and mounts an immunological attack that usually takes place within the first 100 days after the transplant. The use of T-cell depletion significantly reduces this complication.

3. Indocyanine green dye. This is a new ICD-10-PCS qualifier character under root operation “monitoring of physiologic systems.” Although this technology is not new, it does have a new use. It is being used to help navigate sentinel lymph node biopsies. Sentinel lymph nodes are the hypothetical *first* lymph node or group of lymph nodes that a primary cancer would metastasize to. Previously, the indocyanine green dye (a true fluorescent green dye) was used for assessing cardiac function and hepatic function and with ophthalmic angiography. Its advantage is that it allows for imaging of deeper patterns of circulation than fluorescein angiography. It is simple, radiation-free and has an uncomplicated application.

4. Aminolevulinic acid. This is a new ICD-10-PCS qualifier character under root operation “other procedures” in the “head and neck” body region. Aminolevulinic acid is used to treat actinic keratosis (small crusty or scaly bumps that result from exposure to sunlight and can lead to skin cancer) and advanced head and neck squamous cell carcinoma. It is used in combination with a special blue light/photodynamic therapy not to be confused with a laser. The light is used to activate the drug and is typically used only on the face or scalp.

5. Unidirectional source for brachytherapy using palladium 103. This is a new ICD-10-PCS isotope and qualifier character under modality *brachytherapy*. The radioactive element called CivaSheet is the only FDA-cleared, unidirectional, planar brachytherapy source. The device is applied intraoperatively during tumor resection used for difficult to reach cancer sites.

One of the unique features of the device is that it has an active (delivers the brachytherapy/palladium-103) and an inactive (gold shielding) side. The active side delivers a full dose of radiation to surgical margins, while radio-sensitive and healthy tissues on the inactive side are shielded from unnecessary and potentially harmful radiation. This configuration means that clinically effective doses of radiation can be delivered without toxicity to adjacent tissues. This provides an alternative to external beam radiation, particularly in patients that have already received maximum doses from prior radiation treatments. •

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Defining revenue integrity KPIs

Accuracy, productivity and reconciliation are three key KPI categories.

To develop successful revenue integrity programs, teams should pay close attention to key performance indicators (KPIs). Doing so can help them build on what's working and change course when metrics warn of impending danger ahead.

A strong revenue integrity program can help revenue cycle departments preserve the margins that further the mission of delivering high-quality healthcare. Revenue integrity programs accomplish this by mitigating any inaccurate billing while also ensuring hospitals are not under-billing for services that have been delivered.

Thus, the desired goals of revenue integrity are focused on two key concerns:

- > Lowering compliance risk
- > Ensuring accuracy of charges

Revenue integrity managers should pay attention to coding and charging metrics, as well as revenue reconciliation metrics. These metrics can gauge how well people and processes are executing revenue integrity efforts and how successfully they are accomplishing desired goals.

Coding and charging accuracy

Coders convert the information contained in medical reports for procedures into accurate, usable medical code. It then becomes the coding department's responsibility to ensure that the DRG codes accurately reflect patients' conditions and the care delivered. Coding accuracy also takes into consideration information that is captured beyond DRG codes, such as operative and attending physicians, dates of procedures and disposition of the patient upon discharge.

The coding developed also helps create the superbill, an itemized form that details services provided to the patient that is then sent to the billing department. The billing department is responsible for ensuring the

bill meets the regulations determined by the patient's insurance.

Revenue integrity efforts examine all workflows in charging to determine the greatest efficiency and to identify patterns that need correcting. In order to monitor this closely, some of the most important KPIs include the following:

Overall coding accuracy. Coding managers or designees should look for accuracy rates of 95% from an individual record. They should expect higher accuracy for DRG coding. Poor coding accuracy can result in failed audits.

Missed charges. Revenue integrity should examine missed charge patterns. Missed charges mean lost payment. Sometimes these errors are caused by problems with the process or training. In some cases, they are caused by technology gaps.

Coding and charging productivity

Revenue integrity and coding managers are responsible for monitoring coding and charging accuracy. In addition to accuracy, claims need to be filed as soon as possible so that payer payments and patient billing can be handled quickly.

Two KPIs that revenue integrity managers should monitor, in particular, are the following:

Discharged, not final billed (DNFB). Claims that have not been filed and are waiting for coding or billing work are concerning to facilities. Tracking the number and dollar amount of DNFB files can enable a revenue integrity manager to diagnose and solve specific workflow issues.

Coding productivity. Throwing more coders at the system won't help reduce the volume of coding if the real problem is with process

or technology. Revenue integrity managers should expect coding productivity of 95%, which means that only 5% of the coding load should be in the queue.

3 revenue reconciliation KPIs

Information gleaned after coding and the submission of charges can reveal valuable insights to revenue integrity leaders. There are three KPIs, in particular, you should watch to determine how to address the problems in the revenue cycle:

1. Denial volume. Payer denials of claims can reveal process problems that occur at the coding, charging or billing level or even contracting concerns. Analyzing claim denial patterns can help the workflows that cause the submission errors. Keep an eye on denials percentages, as well as the dollar amounts from denied claims. Standard industry denial rates range from 5% to 10%, with 2% to 3% considered to be successful.

2. Avoidable write-off as a percentage of revenue. This KPI is typically tracked as a percentage of gross revenue and a percentage of net revenue. While there is an acceptable level of write-off to be expected, facilities look to limit this to 2% to 5% of net patient revenue.

3. Underpayment recoveries. Estimates are that hospitals are underpaid between 2% and 5% of net patient revenue ("Identifying and Collecting Underpayments: 7 Ways to Increase Your Success," *Becker's Hospital CFO Report*, Aug. 9, 2011). Revenue integrity should monitor underpayment levels and measure the success of efforts to recover those dollars.

These are just a sampling of the KPIs that revenue integrity leaders should monitor, but they are keys in identifying where compliance risks are high and payment is low. Altogether, these KPIs can help fix the problems that cause people, processes and platforms to underperform. •

For more information, contact Parallon (business.solutions@parallon.com).

E/M coding changes require education and technology updates

Jennifer Swindle

The major change is that patient history and examination will no longer be key components to determine the level of service.

Evaluation and management (E/M) services occur in the hospital as inpatient or observation visits. They also occur in nursing homes, physicians' offices, emergency departments and even in the home. Between 2001 and 2010, Medicare payments for E/M services increased by 48%, from \$22.7 billion to \$33.5 billion, according to *Coding Trends of Medicare Evaluation and Management Services*, published by the Office of the Inspector General, Department of Health and Human Services.

While there have been guidelines since 1995 and guidelines updated in 1997, both of which are still used, E/M services still have been vulnerable to fraud and abuse.

There is need for change. It has been more than 20 years since the documentation criteria has been evaluated and the guidelines are often cumbersome to interpret. With the advent of electronic health records (EHRs), documentation is also significantly different, and many elements can auto-fill or be copied forward. As a result, there may be more documentation than may be medically necessary.

In 2021, major changes will be implemented for new and established patient office visits. Is this good news or are the changes going to increase the confusion? CMS's goal is to put additional focus on the Patients over Paperwork initiative. The goal is to reduce the administrative burden on providers so they can spend more time with patients. This is great news for providers and patients, but what does it mean to E/M coding and the role of the coder?

The American Medical Association (AMA) made recommendations to CMS in response to the original proposal to collapse the levels. CMS has agreed with the proposed changes, and they will be

implemented in 2021. However, there are some immediate concerns because the changes only apply to new and established office visits. Rules and documentation requirements for all other types of E/M are not included in the change, so there will be multiple rules. In addition, at this point, there is no indication of whether commercial payers will follow the new requirements, or if they will continue to use the current 1995 and/or 1997 documentation guidelines.

The major change is that patient history and examination will no longer be key components to determine level of service. Instead, medical decision-making based on new guidance or on time will be used.

Although it does not eliminate the need to capture a history and examine a patient, it does remove the required documentation elements to allow a provider to perform only the history and examination that they deem medically necessary to appropriately treat the patient, without having to quantify the amount of documentation.

This change will also eliminate the 99201, new patient visit, E/M level, as both 99201 and 99202 levels of service currently have straightforward medical decision-making. With the implementation of the new guidelines and medical decision-making being the stand-alone element, if not billed on time, there is not a need for two different codes. The other codes, 99211-99215 for established patients and 99202-99205 for new patients, will all remain active and appropriate codes.

3 criteria

Medical decision-making will still focus on three different criteria, and providers must meet two of the three elements to establish

the E/M level, which is consistent with the current guidelines. However, there is much more clarity in the elements and changes in the requirements. The elements of medical decision-making will include:

- > The number and complexity of problems that are addressed.
- > The amount and complexity of the data that needs to be ordered, reviewed, and/or analyzed.
- > The risk complications to the patient and/or the morbidity or mortality of the patient management.

Recommended treatments and interventions, even if the patient chooses not to have the intervention or treatment can also impact the overall risk and should be considered when calculating the E/M level. Comorbid or underlying conditions are only considered to select the level of E/M when their presence increases and impacts the work done or impacts the complexity of the risk or the data that must be reviewed.

Time-based billing

Time-based billing has also been redefined to identify how time should be determined. The requirement that time can only be used to determine E/M level when more than 50% of the time is spent in counseling or coordination of care has been eliminated. Time is for the total time and has clear definitions of the time that can be utilized, which include the following:

- > Preparation work to see the patient
- > Review of previous records and history
- > Counseling and education
- > Documentation in the EHR
- > Interpreting results of testing
- > Care coordination
- > Face-to-face time with the patient

However, if more than one provider sees the patient concurrently, overlapping time is not added together.

Relative value units

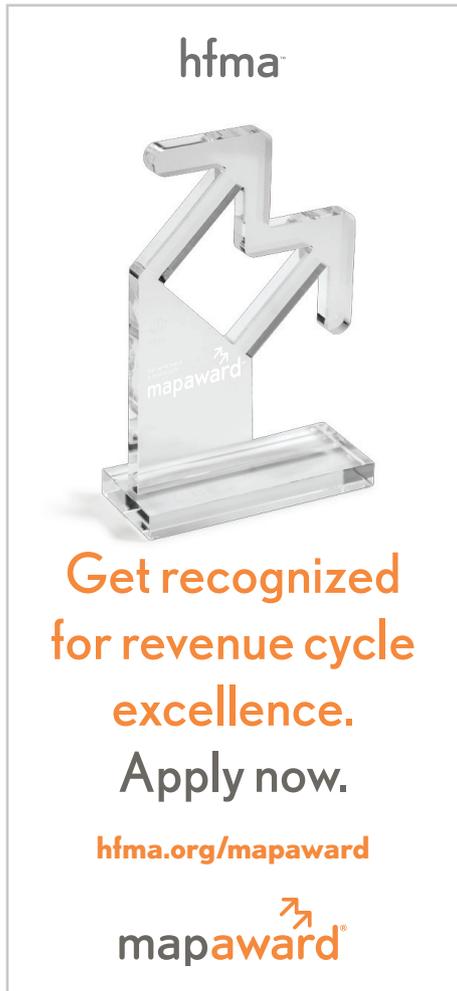
There will be changes to the relative value units of the office visits, except for 99211 and 99202. There also will still be the ability to report prolonged services, however,

there will be changes to this as well, as prolonged face-to-face services will be reported in 15-minute increments and can only be utilized with the highest level of services, so either the 99205 for a new patient or a 99215 for an established patient.

E/M office visit coding will be significant, and education of all providers will be necessary. Updates to EHR systems that have current E/M calculators will need to be revised and careful attention paid to monitoring the changes and learning the new medical decision-making requirements. Understanding that this will only apply to office visits, and other E/M services will follow the current rules also needs to be clearly communicated. Stay alert, stay tuned and watch for upcoming changes. •

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• Medicare payment and reimbursement •

OPPS final rule keeps site-neutral payments and 340B cuts; finalizes transparency requirements separately

Rich Daly

Medicare kept two major hospital payment cuts in a 2020 final payment rule, released Nov. 1. In addition, on Nov. 15, CMS finalized a requirement for hospitals to share negotiated health plan payment rates.

The controversial major hospital payment cuts in the Outpatient Prospective Payment System (OPPS) final rule were retained from the proposed rule even though hospitals successfully have challenged them in federal court.

Although CMS initially split off the highest-profile provision requiring hospitals to make public a list of their standard charges, the administration eventually finalized it.

Site-neutral payments

CMS completed a two-year phase-in of payment cuts for clinic visits furnished in off-campus hospital outpatient departments, which comprise the most common OPPS billed service. The cut was estimated to save Medicare and enrollees \$800 million in 2020. CMS said it will pay back the 2019 cuts after they were struck down by a district court, but the agency will continue them for 2020, pending possible appeal.

340B cuts

CMS also will continue the 340B program's reduced Medicare and health plan payments, which were cut from average sale price (ASP) plus 6% to ASP minus 22.5% for separately payable drugs or biologicals. The cut is being maintained even though a court rejected the policy. The administration is appealing the decision. CMS plans a survey of 340B hospitals to collect cost data for CY18 and CY19, which "may be used to craft a remedy," CMS stated.

OPPS rates for hospitals that meet applicable quality-reporting requirements will increase by 2.6% in 2020. Similarly,

the agency increased ambulatory surgical center (ASC) rates for CY20 by 2.6%.

Other significant policy changes

Other changes affecting hospital finances:

- > Removing total hip arthroplasty, six spinal surgical procedures and certain anesthesia services from the Inpatient Only (IPO) list, which will allow those procedures to be performed in the hospital outpatient setting
- > Establishing a two-year exemption, beginning in CY20, from certain medical-review activities relating to patient status for procedures removed from the IPO list beginning in CY20
- > Barring Beneficiary Family Centered Care-Quality Improvement Organizations from denying claims for those procedures for two years
- > Barring for two years referral of those procedures to recovery audit contractors for noncompliance with the two-midnight rule
- > Adding total knee arthroplasty, knee mosaicplasty, six additional coronary intervention procedures and 12 procedures with new CPT codes to the ASC Covered Procedures List
- > Continuing the policy of assigning procedures involving skin substitutes to the low-cost or high-cost group
- > Changing the minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and critical access hospitals from direct supervision to general supervision. •

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• figure at a glance •

Long-term financing rises as top patient concern

Three quarters of respondents to a patient payment experience survey said they would ask their provider about payment options, according to the *ClearBalance 2019 Healthcare Consumerism Study*.

In addition, 94% of respondents expect that their providers can share ways to repay medical bills, including long-term financing. An overwhelming majority (89%) of the more than 45,000 survey respondents say they need more than 12 months to repay their healthcare costs.

Other findings confirm the need for long-term financing. Only 29% of consumers have emergency savings to cover six months' worth of medical expenses, according to Bankrate.com. Sixty-three percent of respondents in the Healthcare

Consumerism study save less than \$1,000 for medical care.

The silver lining, despite the perception that healthcare is expensive, is most consumers want to pay for their cost of care and they aren't surprised about having financial conversations.

"Several years ago, we anticipated that revenue cycle management would evolve to a consumer-centric approach," says April York, senior director of revenue administration for Novant Health. "We've been ahead of others in our market, collaborating with patients on payment options that are reasonable while significantly reducing bad debt. The strategy benefits patients, creates loyalty and supports our financial performance goals year-after-year." •

Patient responses as a result of patient financing availability

Very likely will return to health system because of availability of patient financing	90%
Will recommend health system to others because financing is available	87%
Ask health system about payment options to cover out-of-pocket costs	75%
Would delay care without long-term financing to help pay out-of-pocket costs	37%
Consumers worry about healthcare costs and want financing of 12 months or more	89%

Source: 2019 Healthcare Consumerism Study, ClearBalance