Compliant Charge Capture to Improve Cash Flow

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HEALTHCARE CODING, COMPLIANCE & STANDARDIZATION SERVICES

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Compliant Charge Capture to Improve Cash Flow

Learning Outcomes

After you have completed this session, you should be able to:

- Describe new process improvement strategies in the area of outpatient charge capture
- Identify charge capture strategies for common ancillary services through system conversions and beyond
- Be familiar with some EMR charge capture risks
- List charge capture “best practice” tips.

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Agenda

- Overview of Charge Description Master (CDM)/Coding
  - Compliance Risks for 2016
  - Process Improvement Strategies for Addressing
- Review of Ancillary Departments
  - Charge Capture Issues and Strategies
- EMR Risks
- Summary of Best Practice Tips
- Discussion

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Compliance Risks for 2016

- With the new year upon us, there are always a number of new codesets, fee schedule changes and resulting compliance risks to be addressed. Some of these may be touched upon in other sessions. On the next few slides, highlights from each of these areas will be covered.
- Process improvement and charge capture strategies for addressing them have been provided where applicable.

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Compliance Risks for 2016

- Place of Service (POS) Codes
  - As the result of increased focus on physicians using wrong place of service, the following changes were made for 2016:
    - New place of service code was added.
      - POS 19 Off Campus-Outpatient Hospital
        - Paid at the same fee schedule as POS 22
        - Located more than 250 yards from the main provider's main buildings (facilities) (42 C.F.R. § 413.65(d))
    - Existing place of service code was revised.
      - POS 22 On Campus-Outpatient Hospital
  - Strategy to address?
    - Identify what buildings are considered off-campus, if any, and educate department and billing staff accordingly.

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Compliance Risks for 2016

- Modifiers
  - New modifier -CT *(computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association [NEMA] XR-29-2013 standard)* was added.
    - Append to the following codes for CT scans on services furnished on equipment that doesn't adhere to NEMA standard XR-29-2013:
      - 70450-70498
      - 71250-71275
      - 72125-72133
      - 72191-72194
      - 73200-73206
      - 73700-73706
      - 74150-74178
      - 74261-74263
      - 75571-75574

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Compliance Risks for 2016

- Modifiers *(continued)*
  - When these codes are reported with modifier -CT on a claim to be paid separately (i.e., not packaged into a composite APC or comprehensive APC), CMS will impose a 5% payment reduction in 2016 and a 15% payment reduction beginning in 2017. This payment reduction applies under both the Medicare Physician Fee Schedule and the OPPS.
  - Strategy to address?
    - First, determine if your equipment is not compliant, and if not, contact your vendors immediately to see if you can become compliant as soon as possible
    - If that's not possible, then immediately determine how to operationalize reporting modifier -CT, likely through hard-coding in the CDM.

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Compliance Risks for 2016

- Modifiers *(continued)*
  - Existing modifier -59 *(distinct procedural service)* was updated.
    - Review the 2016 NCCI manual, which includes new information regarding modifier -59 use for procedures performed at the same patient encounter when timed services are involved:
      - *There is an appropriate use for modifier -59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two separate and distinct timed services are provided in separate and distinct time blocks, modifier -59 may be used to identify the services. The separate and distinct time blocks for the two services may be sequential to one another or split. When the two services are split, the time block for one service may be followed by a time block for the second service followed by another time block for the first service. All Medicare rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable units of service is based on the total time, and these units of service are allocated between the HCPCS/CPT codes for the individual services performed. The physician is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate units of service. (e.g., A physician or therapist performs eight minutes of neuromuscular reeducation (CPT code 97112) and eight minutes of therapeutic exercises (CPT code 97110). Since the physician or therapist performed 16 minutes of related timed services, only one unit of service may be reported for one, not each, of these codes.)*

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Compliance Risks for 2016

- Modifiers *(continued)*
  - In addition, CMS added a new example for describing use of modifier -59 to report procedures performed on different anatomic sites as well as a new example to explain proper coding for infusions involving double lumen catheters.
  - Strategy to address?
    - First, download (if you haven't already) and review the red italicized sections of the latest NCCI manual.

      https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/

    - Hard-coding of subjective modifiers is not recommended so work with HIM and ancillary department staff as well as IT system vendor(s) to determine if modifier -59 should best be appended at the dept level or during the coding/billing process.
    - Note that chart documentation should be consulted before appending modifiers.

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Compliance Risks for 2016

- Coding Updates
  - Surgery
    - New code 69209 *(Removal impacted cerumen using irrigation/lavage, unilateral)* was added.
      - Performed by physician/QHP or clinical staff
        - When performed by clinical staff, billing physician/QHP must be physically present in the office and immediately available
      - Documentation must indicate impacted cerumen
        - Irrigation for nonimpacted cerumen is part of the physician/QHP's E/M code and not separately reported
      - Do not report with 69210, which requires instrumentation
      - Medicare recognizes "unilateral" for this code
        - Append -50 modifier to indicate bilateral procedure
        - 2016 Medicare APC rate (unilateral) $55.94
    - Strategy to address?
      - Ensure the CDM and forms/order entry screens are updated and staff educated accordingly.

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Compliance Risks for 2016

- Coding Updates *(continued)*
  - Medicine
    - All of the vaccine codes (90476 – 90749) were updated to include Advisory Committee on Immunization Practices (ACIP) abbreviations.
      - Codes representing obsolete vaccine products were deleted
      - New codes were added to report the administration of serogroup B Meningococcal (MenB) vaccines, live oral cholera vaccine and a combination DTaP-IPV-Hib-HepB vaccine.
    - Strategy to address?
      - Review CMS immunization guidance:

        https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf

      - Work with pharmacy and clinic staff to identify what vaccines are stocked and/or in the formulary.
      - Ensure the CDM and forms/order entry screens are updated and staff educated accordingly.

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Compliance Risks for 2016

- Coding Updates *(continued)*
  - Evaluation & Management (E/M)
    - New codes 99415 and 99416 *(Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision . . .)* were added.
      - A physician or qualified health care professional must be present to provide direct supervision of the clinical staff
      - Report in addition to the designated E/M services and any other services provided at the same session as E/M service
      - Do not report prolonged services of less than 45 minutes in duration.
    - Strategy to address?
      - Review coding guidelines and time elements (1st hour, additional 30 minutes) in detail.
      - Ensure the CDM and forms/order entry screens are updated and staff educated accordingly.

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Compliance Risks for 2016

- Coding Updates *(continued)*
  - Laboratory/Pathology
    - In molecular diagnostics, the scope of the molecular pathology services codes were increased yet again for 2016, with the addition of 8 new Tier 1 codes and 7 new genomic sequencing procedures (commonly referred to as Next Gen Sequencing) as well as 10 multianalyte assay with algorithmic analyses (MAAAs), which are procedures that utilize multiple results derived from assays of various types, including molecular pathology, FISH and non-nucleic acid based assays.
    - The G-codes for drug testing were also again overhauled for 2016.
    - Strategy to address?
      - Review all new and revised code descriptors in detail and the CMS final CLFS regs:

        https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf
      - Work with reference labs to ensure all billable services are correctly identified and reported.
      - Ensure the CDM and forms/order entry screens are updated and staff educated accordingly.

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Ancillary Dept Charge Capture

- Emergency Department (ED)/Trauma/Urgent Care/Clinics
  - Verify
    - Appropriateness of HCPCS, hard-coded modifiers, i.e., -25, and revenue code assignment, i.e., 045X vs. 051X
    - Clarity of CDM vs. HCPCS descriptions, e.g., levels, size or type of repair, etc.
    - Surgical component setup, i.e., soft vs. hard-coding
    - Routine items and equipment are bundled, e.g., IV start kits and 4x4s
    - Proper reporting of non-routine supplies, DMEPOS items and pharmaceuticals.
  - Ensure procedures such as CPR, EKGs, and venipunctures, as well as minor surgical repair, are billed separately in addition to E/M level of service while being careful to avoid potential duplicate billing when multiple departments respond to, assist with, provide over-reads for, or attach such services to ancillary system order sets.

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Ancillary Dept Charge Capture

- ED/Trauma/Urgent Care/Clinics *(continued)*
  - Confirm facility E/M criteria adhere to CMS's 11-point guidance introduced in 2008, i.e., coding guidelines should follow the intent of the CPT code descriptor in order to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
  - Verify HCPCS G0463 introduced in 2014 is reported in place of outpatient visit codes 99201–99215 for OPPS hospital-based clinic services *(MLN Matters® Special Edition Article, SE1407, January 29, 2014)*.
  - Establish a mechanism for logging and charging non-emergent or scheduled return visits to the ED (due to lack of space elsewhere, after-hours coverage, etc.) for Rabies vaccination series, blood transfusions, antibiotic therapy, dressing changes, and other minor procedures. Such services should be billed as 'outpatient' not ED visits, as they have separate revenue coding requirements, and generally should be identified on a separate encounter form or order entry/EMR screen.

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Ancillary Dept Charge Capture

- Observation
  - Ensure
    - Validity of a dated and timed physician order
    - Documentation of Placement/discharge times
    - Medical necessity
    - Accuracy of the hourly calculation, i.e., rounding, as well as total number of hours
    - There is an initial E/M assessment, i.e., direct admit (HCPCS G0379) or one originating from a Clinic visit (HCPCS G0463), Critical Care or the ED, reported in conjunction with HCPCS G0378 *(Hospital observation services, per hour)* when appropriate.
  - Review observation orders to ensure they are written by providers authorized by the facility's medical staff bylaws to admit patients or order outpatient tests.

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Ancillary Dept Charge Capture

- Observation *(continued)*
  - Report HCPCS code G0378 (Hospital observation services, per hour) for Medicare and other payers as required. Note that a composite APC may be triggered when certain criteria are met. One is that the patient must be observed for a period of eight or more hours, so it is imperative that observation time begin as soon as the order is written, not when the patient reaches the DOU or a nursing floor *(CMS Transmittal 787, Dec 16, 2005)*.
    - Note that for 2016 all surgical procedures will be excluded from being bundled into the observation C-APC, regardless of date of service, and instead paid under the surgical APC. All ED visits, not just high-level ED visits, will qualify for the observation C-APC, as this is more consistent with a comprehensive payment policy.
  - Verify units of service to be sure they represent the number of hours the patient spent in observation status.
    - Fractions of an hour should be rounded down to the nearest hour.
    - Services requiring 'active monitoring' should be carved out of observation time.

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Ancillary Dept Charge Capture

- Imaging Services
  - Verify
    - Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., -LT/-RT/-50, and revenue code assignment, i.e., 032X vs. 036X range
    - Clarity of CDM vs. HCPCS descriptions, e.g., number of views, type of imaging, with or without contrast, etc.
    - Surgical component setup, i.e., soft vs. hard-coding
    - Routine items and equipment are bundled, e.g., drapes, tubing and oximeters
    - Proper reporting of contrast, radiopharmaceuticals and non-routine supplies.
  - Note that for 2016 the term “film(s)” was replaced with “image(s)” to conform to the current practice for imaging procedures. The definition of “written report” was also revised: “A written report (i.e., handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiological procedure or interpretation…”

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Ancillary Dept Charge Capture

- Lab/Pathology
  - Verify
    - Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., -91, and revenue code assignment, i.e., 030X or 031X range
    - Clarity of CDM vs. HCPCS descriptions, e.g., methodology vs. specific testing, number of specimens, etc.
    - No non-approved/unbundling of panels
    - Routine items and equipment are bundled, e.g., specimen containers and empty blood bags.
  - Review the Lab National Coverage Determinations (NCD) database, which can be found on the CMS web site at:

    https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html

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Ancillary Dept Charge Capture

- Rehab (PT/OT/SLP)
  - Verify
    - Appropriateness of HCPCS (including unlisted codes), hard-coded modifiers, i.e., -GO/-GP/-GN, and revenue code assignment, i.e., 042X vs. 043X vs. 044X vs. 047X
    - Clarity of CDM vs. HCPCS descriptions, e.g., per 15 minutes, untimed modalities, etc.
    - Routine items and equipment are bundled, e.g., cold packs and traction
    - Proper reporting of DMEPOS items and equipment dispensed by dept.
  - Report the functional data reporting and collection system HCPCS G-codes and modifiers, which became effective for therapy services in 2013. For the latest list, refer to:

    https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/G-Codes-Chart-908924.pdf

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Ancillary Dept Charge Capture

- Pharmacy
  - Verify
    - Units of Service
      - HCPCS code description vs. manufacturer dose
      - Wastage documentation (modifier -JW, if required)
    - Self-administered drugs have been established as non-covered for Medicare outpatients under most circumstances, but covered for inpatients and other payers
    - Accuracy of NDC data.
  - Review the latest ASP and other pricing info available on the CMS web site at:

    https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html

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EMR Risks

- Potential for duplication and overcharging
  - Examples
    - Respiratory
    - Laboratory
- Missed charges and/or late charges
  - Examples
    - Observation
    - Supplies
- Mismatch between ancillary systems and the CDM
  - Examples
    - Radiology
    - Pharmacy

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Best Practice Tips Summary

- Identify your facility's coding and billing compliance risks
- Review AMA and CMS guidance
- Ensure your CDM is up-to-date
- Review/revise charge encounter forms and/or order entry/EMR screens as appropriate
- Create a charge capture or revenue integrity "team" (including HIM, ancillary department staff, IT vendors, clinicians, etc.) to address ongoing issues
- Perform chart-to-bill assessments on a periodic basis or as needed to ensure charge capture accuracy.

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Discussion

- Questions?
  - *Thank you!*

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Further Questions?

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