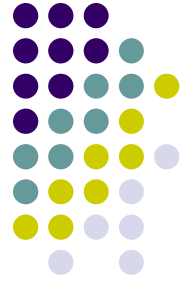


A LOOK INSIDE THE CHARGEMASTER



Objectives

- What is the chargemaster?
- What is the connection between reimbursement and the chargemaster?
- What is the connection between the chargemaster and billing?



Definition of chargemaster

- Also known as the charge description master (CDM)
- Tool used to charge for procedures, services and supplies provided to patients
- Updated frequently as departments add charges for new services or perform new procedures or terminate services
- Updated for coding and price changes



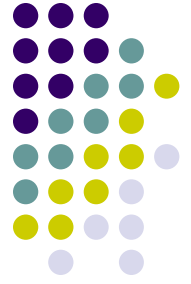
UB04 Code

- The UB04 code means Universal Billing Code
- The three digit UB04 code is also known as the revenue code
- The “UB” tells the payer where the service was performed or what type of service was provided. For example: 324 means Radiology, 420 is Physical Therapy and 750 is Endoscopy



CPT and HCPCS Codes

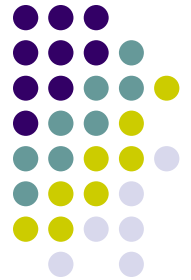
- The CPT code is a key field in the charge code
- CPT stands for Current Procedural Terminology and is copyrighted by the American Medical Association
 - 99213 – Clinic Visit, Established Patient, Level 3
- HCPCS means Healthcare Common Procedure Coding System and is authored by Medicare and the BC/BS Association
 - C1751 – Infusion Catheter



CPT and HCPCS Codes

- CPT codes describe procedures
- HCPCS codes are often used for new devices, supplies and drugs (and occasionally for new emerging procedures)
- CPT and HCPCS codes are updated annually

Sample CPT and HCPCS codes



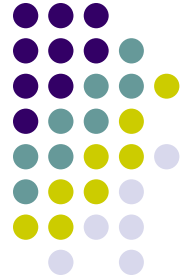
CPT / HCPCS	SIM Description	SIM
45378	COLONOSCOPY	31040
59000	AMNIOCENTESIS	30104
62270	PUNCTURE SPINAL LUMBAR	20740
76705	US ABDOMEN LIMITED	36063
80100	DRUG SCREEN URINE	47968
90772	INJECTION IM/SUBCUTANEOUS	32976
95816	EEG	31798
97110	PT EXERCISE THERAPEUTIC 15 MIN	34505
C1300	HYPERBARIC OXYGEN FULL BODY 30 MIN	18149
C1714	CATHETER ATHERECTOMY	30672
S9444	PARENTING CLASS PER SESSION	15502



CPT and HCPCS Codes

- CPT and HCPCS codes are assigned to the CDM based on the description of the procedure or service performed
- Not all charge codes have a CPT/HCPCS code, i.e., room and bed, supplies
- Assigning the wrong CPT could result in incorrect charges and payments

APCs and OPPTS

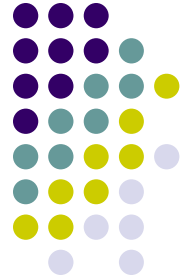


- Majority of outpatient reimbursement is tied to the CPT code
- In 2000, Medicare began reimbursing hospitals through the APC system. APC stands for Ambulatory Payment Classification
- Replaces prior OP reimbursement methods
- APCs are often referred to as OPPTS – Outpatient Prospective Payment System
- System driven by the CPT code



Payment methodologies

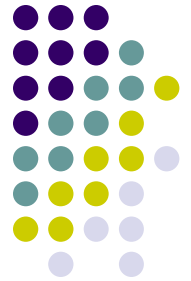
- First, payment was based on fee schedule
 - All services (CPTs) were separately paid
- Then, payment based on APC
 - Incentive to more efficiently use resources because payment based on APC rather than CPT
- Then, Composite APCs
 - Incentive to even more efficiently use resources because one payment for services within same Composite APC



Recent Changes to OPPS

- 2006 - Service families proposed but not implemented
- 2008 – More packaging/bundling of services suggested
- 2009 - Composite APCs added for imaging
- Looking forward – Move toward episode based payment. Would be similar to DRGs

Composite APC Methodology



- CMS will provide single payment for 2 or more major independent procedures performed together during a single session
- Five new APCs for composite payment (ultrasound; CT/CTA; MRI/MRA)



Charging for composite APCs

- Charging does not change for composite procedures
 - Ex. CT Abdomen and CT Pelvis continue to be separately charged so both CPTs appear on claim.
 - In the past there would be payment for both CPTs. With composite APC rate, there is one payment at a higher rate than the single procedure but at a lower rate than if the two were paid separately



CCI Edits

- CCI stands for Correct Coding Initiative
- Prevents hospitals from charging for procedures that are considered inherent to another procedure or a component of another procedure
- Prevents charging for mutually exclusive procedures - those not reasonably performed together
- At the least, component coding and mutually exclusive codes wouldn't get past the CCI edits, which slows down the revenue cycle. At the worst, it could result in overpayment



Editing for Correct Coding

- Claim “Scrubbing” is a process that uses internal edits to catch and correct coding errors before the claim goes to the payer in order to avoid the payer edits
- Payer edits will catch the errors and return the claim to the provider delaying payment



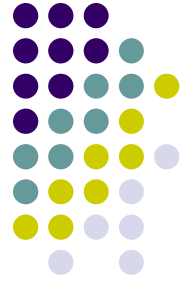
Annual coding updates

- CMS (Center for Medicare and Medicaid Services) updates are January 1 as well as quarterly
- Review transmittals from CMS detailing changes in coding and billing requirements
- AMA publishes new, revised and deleted CPT codes annually
- After communication with departments, Charge Analysis enters changes into chargemasters

Department role in annual updates



- Understand changes and determine applicability to their department
- Educate staff on changes in charging
- Update charge vouchers and department charging systems
- Provide acknowledgement indicating implementation of new codes, policies & procedures, etc.



Compliance

- Paramount when talking about the CDM
- CDM compliance is charging correctly, fairly and in accordance with national, state and local health care regulations
- Several compliance risks in the charge process



Compliance

1. Was the service provided? Cannot charge for something that was not provided
2. Is there documentation to support the charge? You've probably heard the expression, "if it's not documented, then we didn't do it!"
3. Is the most specific CPT being used?



Compliance

4. Is the item chargeable? Routine supplies such as bedpans, blankets, thermometers, bandaids, needles, syringes (bulk supplies) and equipment such as beds and IV pumps are not chargeable to patients
5. Are we charging all patients the same regardless of payer?



Charge Process

- After new CPT added to CDM it is available to be entered as a charge
- Department adds to charge voucher/system
- Be sure correct account is charged
- Charges to be entered within 5 days of discharge or outpatient visit
- Number of days does not increase for weekends or holidays
- Claim drops to HIS for entry into your billing system
- Claim is prepared for submission; edits are complete

Claim example - Outpatient



CPT

UB04 code

Modifier

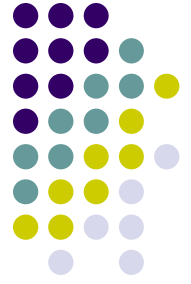
Units

RIVERSIDE METH NOS		RIVERSIDE METH NOS		PATIENT ADDRESS		PATIENT PHONE		PATIENT FAX		PATIENT EMAIL	
3535 OLENTANGY RIVER RD		DEPT L-2983		314394942 032708 032708		0131					
COLUMBUS OH 43214		COLUMBUS OH 43260									
0272	STERILE SUPPLY	73630	032708	1	14925						
0320	DX X RAY	99283	032708	1	30300						
0450	EMERGENCY ROOM	28470	032708	1	70575						
0450	EMERGENCY ROOM	28470	032708	1	26300						

Charges are summarized by UB, by CPT, and by date of service.

The description is the UB code description, not the charge code description.

Questions



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