THE RECIPE FOR REVENUE COMPLIANCE STARTS WITH THE CHARGEMASTER

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SETTING UP FOR SUCCESS: CHARGEMASTER GOVERNANCE

BY: NAHRI

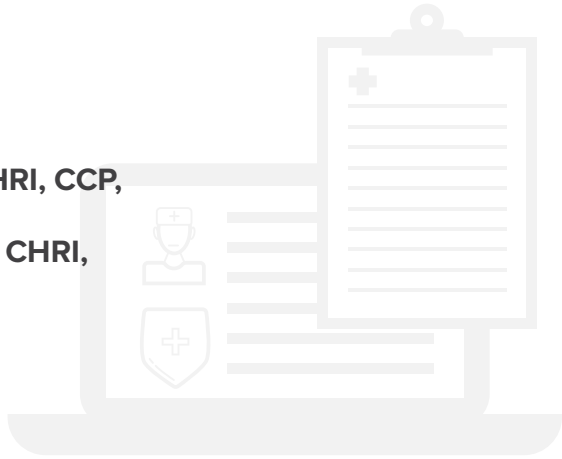
Revenue integrity professionals know that the chargemaster is more than just a list of items and services, charges, and CPT® and HCPCS codes. It's a key part of processes across departments, and its data can help a hospital develop sophisticated insights into its operations. To keep the chargemaster in top shape, don't stop at CPT/HCPCS code updates.

An effective chargemaster governance program goes beyond the basics to keep the chargemaster in order while gaining the maximum value from charge data. Start the new year off with a fresh look at your chargemaster policies and procedures and consider how you can deploy charge data to ensure revenue integrity.

Top considerations

A chargemaster governance program should be built around key considerations and processes, said NAHRI Advisory Board member **John D. Settlemyer, MBA, MHA, CPC, CHRI,** assistant vice president of revenue cycle at Atrium Health in Charlotte, North Carolina, during the session "CDM Governance: Best Practices and Processes" on day two of Revenue Integrity and Reimbursement Strategies: A NAHRI Virtual Event, Settlemyer co-presented

the session with fellow NAHRI Advisory Board members **Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS,** president/CEO and principal consultant for SLG, Inc., in Raleigh, North Carolina, and **Kay Larsen, CHRI, CRC,** revenue integrity specialist at Adventist Health Glendale in Glendale, California.

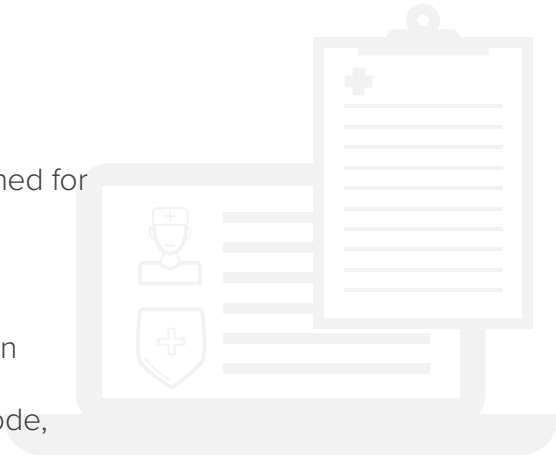


Keep the following key considerations in mind when reviewing your program:

- Operational workflow and approval
- Audit trail
- Archiving
- Annual and ongoing process for CPT/HCPCS updates
- Managed care payer policies
- Modifier management
- Ongoing and annual price changes
- Partnership with operational departments and billing operations
- Standing committee with revenue cycle representation

Approval, audit trail, and archiving

When looking at your workflow approval process, ensure that you have a defined process for moving requests through the system, Settlemyer said. Most major software vendors offer embedded workflow tools that can support request processing.



“Within that, you can build various routing hierarchies so that the appropriate level of approval is obtained for finalization,” he said.

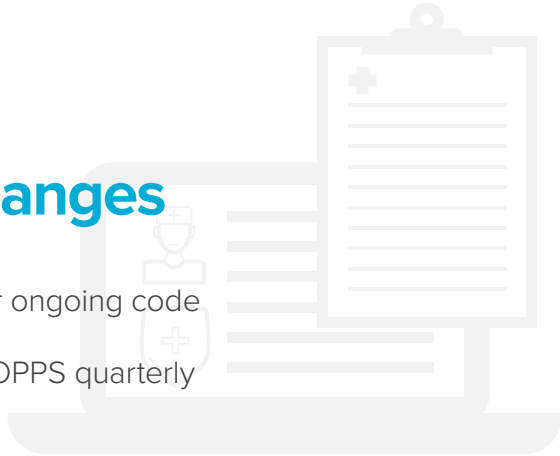
That consideration dovetails into the next: audit trails. Requests should be timestamped so that you can easily reference when someone added an item to the chargemaster or changed a field on a charge code, Settlemyer explained.

The audit trail should include clear documentation. Chargemaster compliance tools often allow file attachments. If you don’t have access to a compliance tool, explore your options for building one internally, Settlemyer recommended. Depending upon your organization’s capabilities, you could build an internal form within the information services system or use an email process to track chargemaster changes.

Then, support your audit trail efforts by regularly archiving your chargemaster. Aim to generate and archive an electronic copy at least once a month, if not once a week, Settlemyer said.

“You [should] always have an electronic copy to go back to and be able to track changes over time,” he said. “Also if you have, for instance, a rebilling project that you need to look at historical data, you would easily be able to access the information that you were looking for if you have these archive files.”

Code updates, modifier management, and price changes



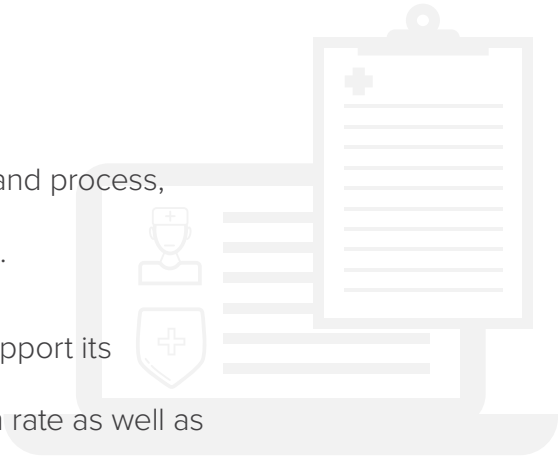
Along with the annual tradition of major year-end CPT/HCPCS updates, ensure you have a process for ongoing code updates, such as quarterly code updates, Settlemyer said. Monitor CMS regulations and transmittals, OPPS quarterly updates, and I/OCE quarterly updates.

Along with government payers, include managed care payer policies in your monitoring efforts. Most major payers publish monthly network bulletins that cover payer-specific code updates and changes, Settlemyer said.

“It’s very important for you to be cognizant of those bulletins and review them to ensure those payer-specific coding information or coding changes are being taken into account in your chargemaster management and update process,” he explained.

When you’re reviewing code update policies, take a look at how you’re managing the application of modifiers. Missing modifiers are a common source of billing edits, but modifiers can’t simply be applied to satisfy an edit. From a chargemaster standpoint, a best practice is to limit hard coding of modifiers, Settlemyer noted. Unless you can show through documentation that a particular modifier will always be appropriate, it shouldn’t be automatically included.

“A perfect example of this is modifier -59,” he said. “You would never want to hard code modifier -59 within your chargemaster unless you had some sort of documented workflow process that proved it was always true that [modifier -59] was always appropriate when that charge code was used.”



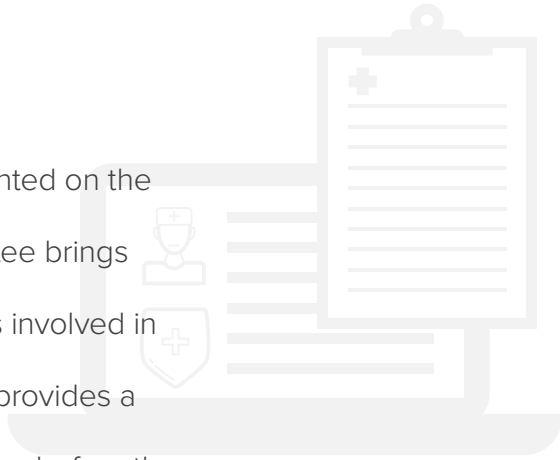
Supply markups and pharmacy markups should be supported with policies that document their basis and process, Settlemyer said. The policies should also detail the methodology used to determine procedure pricing.

Pricing policies should address what items and services are separately chargeable. For example, to support its inpatient room rate, an organization should create a policy that documents what's included in the room rate as well as what can and should be charged separately, Settlemyer explained.

Partnerships and committees

Revenue integrity should take proactive steps to build relationships with other departments, Settlemyer recommended. Key departments to reach out to include billing, compliance, and operational departments such as radiology and laboratory. Ensure that all appropriate stakeholders are included in discussions about chargemaster changes and that they sign off on finalized changes. Schedule regular meetings to secure a dedicated time to talk through routine issues such as process and workflow changes, billing issues, and other common items.

"I have a standing biweekly meeting with my billing operations office. We can talk through any issues that either of us are having with claims so that we can determine what the appropriate resolution to those are, whether that be an amendment or an alternate update within the chargemaster itself or some type of claim edit that might need to be placed somewhere downstream," Settlemyer said.



Don't let your revenue cycle committee meetings fall off the calendar. If revenue integrity isn't represented on the committee, make it one of your goals for the year to claim a seat at the table. A revenue cycle committee brings together representatives from registration, billing, HIM, case management, and other key departments involved in coding, billing, and charging. This committee is a crucial part of chargemaster governance because it provides a platform for cross-functional discussion of revenue cycle issues and an opportunity to address concerns before they cause problems, Settlemyer said.

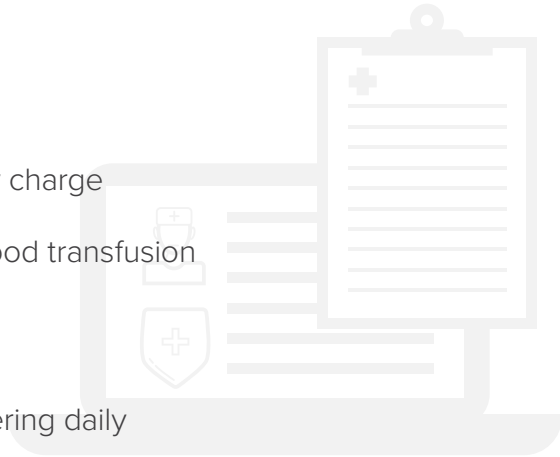
Charge analysis

Daily charges are a wealth of information and can yield crucial, actionable data simply through a daily charge download, Larsen said.

"When we first transitioned to our financial management system, we didn't have quite as many reports in place," she said. "So, I learned that my best source of information was just downloading my charges each day."

That's still Larsen's preferred method for analyzing charge data. She downloads charges to a spreadsheet and reviews and sorts the information, helping her spot patterns of charge errors as well as other various issues that might delay claims.

The charge download includes data such as who posted the charge and whether the charge was automatic or manual. That allows Larsen to track charge errors to their source, whether it's an individual or a system error.



Missing charges are a common issue, and Larsen keeps an eye out for them when reviewing her daily charge download. Be vigilant for charges that should come in pairs, such as a blood product charge and a blood transfusion charge or a vaccine charge and a vaccine administration charge, she advised.

Manual charge entry can lead to typos, particularly if the department has been busy and staff are entering daily charges late in their shift, Larsen said. Watch out for date errors or data appearing in the wrong field—such as an account number in the quantity field—and other simple errors.

Price transparency

January 1 ushered in expanded price transparency requirements and a new reality for chargemaster governance. Traditionally, hospital chargemasters haven't received much external attention, but today, their greater visibility makes a sound chargemaster governance plan more critical than ever.

Hospitals need to brace for public scrutiny, Goodman, Larsen, and Settlemyer agreed. Healthcare remains a hot-button issue for the public and policymakers. Efforts to address the cost and accessibility of healthcare will likely continue, and hospitals must be ready to participate in the discussion and help find a good solution.

"I think the posting of the comprehensive chargemaster machine-readable file with the line item detail, with the payer-negotiated rates, I really believe it's going to bring about a tremendous amount of external scrutiny from the media, from payers," Settlemyer said.

Tips and best practices

To wrap up the presentation, Goodman shared some field-tested tips and best practices.

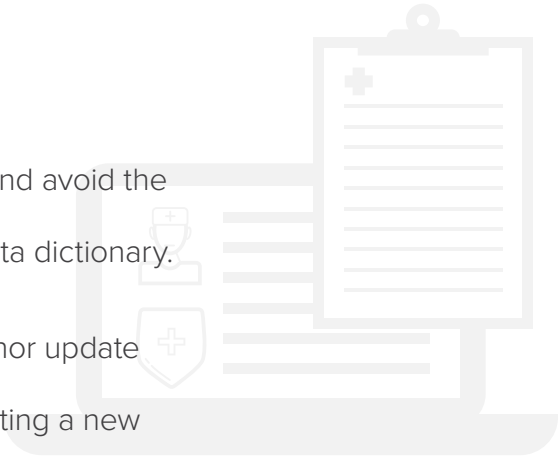
Overall, your chargemaster design should encompass coding and payer differences in a compliant fashion, according to Goodman.

“Sometimes you’ll have things behind the scenes. You’ll have your default CPT code and then maybe a HCPCS for Medicare, or [sometimes] Medicaid has their own set of codes for certain things,” she said. “So, make sure your chargemaster is as up to date as possible.”

Take a look at how your reimbursement methodologies and NCCI edits affect your chargemaster structure, Goodman advised. This will help ensure charges are set up correctly to account for covered and noncovered services, modifiers, and other considerations.

Review pricing at least annually. You should know what your organization’s pricing strategy is and how price changes are handled, Goodman said. Consider what services are included and excluded from pricing increases and who makes that determination.

Create a data dictionary to ensure consistency, Goodman recommended. A data dictionary is a list of abbreviations used in the chargemaster. Although some abbreviations are universal, some chargemasters may



need to use alternate abbreviations due to character limitations. A data dictionary will serve as a key and avoid the creation of multiple alternate abbreviations for the same term. See the figure on p. x for an example data dictionary.

Analyze chargemaster updates to determine whether they require new charge codes or whether a minor update can be made. If there's a significant change, such as to time or quantity, Goodman recommended creating a new line item so the old one can be retained for reference and historical billing purposes.

Don't neglect charge capture, Goodman cautioned. A sound chargemaster maintenance program will go to waste if charges aren't correctly captured.

Take a team approach to chargemaster management. This should include the CFO and other finance staff, the chargemaster coordinator, compliance, revenue integrity, ancillary department managers, HIM, coding, and outside consultants as necessary, Goodman said.

Organizations must be prepared to face a challenging year. By fine-tuning their chargemaster governance program, revenue integrity professionals can do their part to ensure their organizations keep their footing.

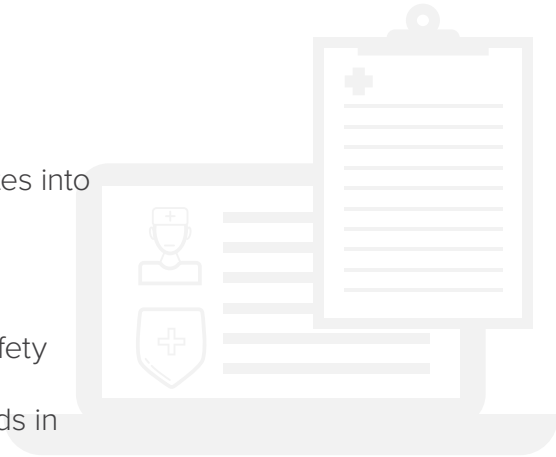
REVENUE INTEGRITY: COMPLEXITIES, COLLABORATION, AND COMMITMENT

BY: AMY TEPP, CPA

Those of us who have been in healthcare for more than a few years (maybe a few decades) came to know of revenue integrity about 15 years ago. It provided a term to describe the functions organizations had been performing but packaged them with a unique identity within the revenue cycle. The functions of charge capture, clinical documentation and coding, and chargemaster are critical components to ensuring revenue integrity while also maintaining compliance.

The onset of electronic health record (EHR) systems heightened the importance for organizations to have a defined revenue integrity function. We learned that, in some cases, charges were dropping based on flow sheets from the clinical side of the system. In other cases, charges dropped from electronic charge capture screens where the clinician would click on the services and items provided to the patient. Charge routing rules were set up in the background to point the items and services to the revenue department within the system.

In addition, these rules would select the charge amount and other relevant items found within the chargemaster (or the components making up what would be a chargemaster) to capture this from an accounting perspective and ultimately to the claim form that is submitted to the payer for payment. The variety in how charges are documented and generated, the interrelatedness of the various components within the system, the interaction of the EHR and the various billing software



modules all add to the complexity of revenue within a healthcare organization. This complexity translates into numerous opportunities for potential errors to occur.

It is this complexity that led to the development of the revenue integrity department I managed at a safety net teaching hospital for nearly seven years. At the time, this department had analysts with backgrounds in chargemaster, compliance, pricing, charge capture, revenue side of EHR, and professional and facility coding and billing. Each individual's skillsets complemented those of others on the team.

As director of reimbursement, revenue integrity, and regulatory review and analysis who reported to the CFO, I was able to connect finance and cost reporting to this group. Linking the chargemaster function to the cost report preparers opened dialogue required to ensure proper matching of revenue and expenses on the cost report. Another benefit of connecting finance to the revenue integrity group was raising awareness of the annual CPT® code changes and how they might impact budgeted revenue.

Our revenue integrity group was also responsible for analyzing and recommending the facility's annual price changes. Again, this required collaboration with finance on price increases for budget purposes and also called for connecting with payer contracting to facilitate communicating these changes with our contracted payers.

Revenue integrity may look different among organizations, but the importance of the function remains the same: to ensure compliant charges are captured for services provided and revenue is obtained and retained for long term financial stability and success.

KEEPING TABS ON COMPLIANCE WITH INTERNAL AUDITS AND MONITORING

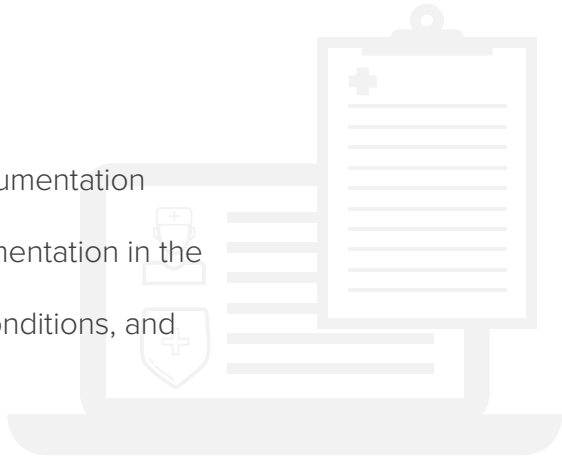
BY: NAHRI

Regular monitoring and internal auditing are critical to ensure compliance throughout the revenue cycle and protect revenue integrity. Monitoring involves overseeing all processes and functions that contribute to generating revenue for the organization. Internal audits are typically more focused and involve determining whether the organization's standards and procedures are current and accurate, validating that previously identified compliance risks have been resolved, and identifying educational needs.

The Certification in Healthcare Revenue Integrity (CHRI) holder will typically be involved in monitoring and auditing activities focused on documentation, coding, medical records, charge description master (CDM)/charging, and billing.

Documentation and chart audits

The medical record is a legal document and must meet the accepted standards of documentation as defined by CMS' Conditions of Participation and Conditions for Coverage, federal regulation, state laws, and accrediting agencies such as The Joint Commission.



An effective clinical documentation process will help avoid improper coding denials by improving documentation and promoting clinical staff engagement. Clinical documentation integrity programs ensure that documentation in the medical record provides an accurate picture of the patient's diagnoses, the care provided for those conditions, and the quality of care provided.

Overall, documentation should tell the complete, accurate story of the patient's health and the services and items provided to the patient during an encounter. The CHRI holder should be familiar with the documentation standards that apply to the service lines, facility types, and practitioners in their organization and must be able to locate specific references and guidance when questions arise. In general, when reviewing documentation, the CHRI holder should ask whether documentation satisfies the following questions:

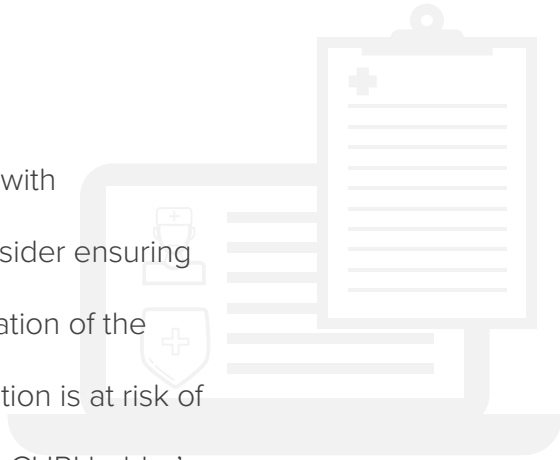
- Is the reason for the patient encounter documented in the patient's medical record?
- Are all services that were provided documented in the patient's medical record?
- Does the patient's medical record clearly explain and support the services, procedures, and supplies that were provided?
- Is the assessment of the patient's condition clearly documented in the medical record?
- Does the patient's medical record describe the patient's progress and the results of treatment?
- Does the patient's medical record include the physician's plan for care?
- Does the patient's medical record provide a reasonable medical rationale for the setting and services that are to be billed?

- Does the patient's medical record support the care given so that when another healthcare professional must assume care or perform a medical review, that professional will be able to do so?

Ideally, copying and pasting should be avoided in documentation. Overuse of copying and pasting is a serious problem because it increases the likelihood that errors will be introduced by copying old and possibly irrelevant or incorrect information. It may also make it difficult to trace the original source of the copied information and to differentiate between the copied information and new information. Documentation in the electronic medical record must show patients' changes in condition and needs for each encounter.

Chart audits should be conducted on a regular basis to ensure that documentation is complete and accurate and that codes and charges are appropriately assigned. Chart audits should include the following actions:

- Audit medical records against charges and claims to make corrections and improvements in charge capture, coding accuracy, billing, medical necessity, or documentation
- Audit patient charts and medical records to evaluate adequacy of clinical documentation, compliance, reasons for treatments, billed services/items, coding, payments, operations, or completeness of bill
- Review medical records for accuracy and billing compliance
- Review hospital (or other healthcare facility) department medical record documentation for improvement opportunities as part of a scheduled periodic review process



Revenue integrity and other revenue cycle staff will work with compliance staff to monitor compliance with documentation standards and to conduct internal audits of documentation. The CHRI holder must consider ensuring documentation compliance to be a high priority, as documentation is the basis for coding and a foundation of the entire revenue cycle. If an inaccurate claim is submitted due to poor documentation, then the organization is at risk of False Claims Act violations and other compliance risks that can carry heavy financial penalties. It is the CHRI holder's duty to ensure that the organization receives no more and no less than the appropriate reimbursement.

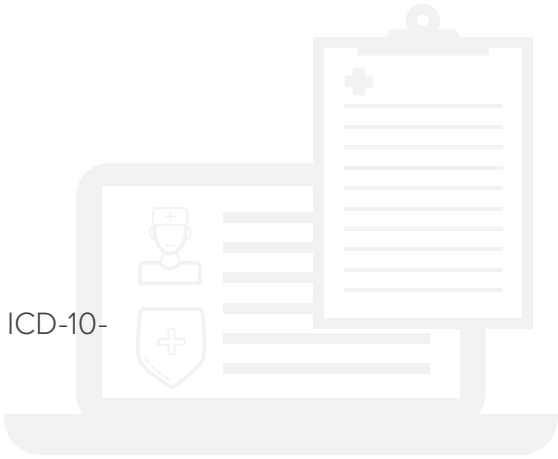
Coding

Coding audits can be prospective or retrospective. Prospective audits identify errors before claims are submitted. Errors identified during prospective audits should be corrected before the claim is submitted. Retrospective audits occur after claim submission and reimbursement. Incorrect claims identified during a retrospective coding audit should be reviewed for possible rebill or refund based on the payer's repayment or corrected claim guidelines. In both cases, audit findings should be presented to the coding and compliance departments and can be used as the basis of departmentwide education or one-on-one training.

Coding audits may also include validation of the following:

- Ambulatory Payment Classification (APC) assignment
- Current Procedural Terminology (CPT®) code and relevant modifier assignment
- Discharge disposition

- Diagnosis-related group (DRG) assignment
- Evaluation and management (E/M) leveling
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and/or ICD-10-Procedure Coding System (ICD-10-PCS) code assignment and sequencing
- Present-on-admission assignment
- Reason for visit
- Specificity of code assignment

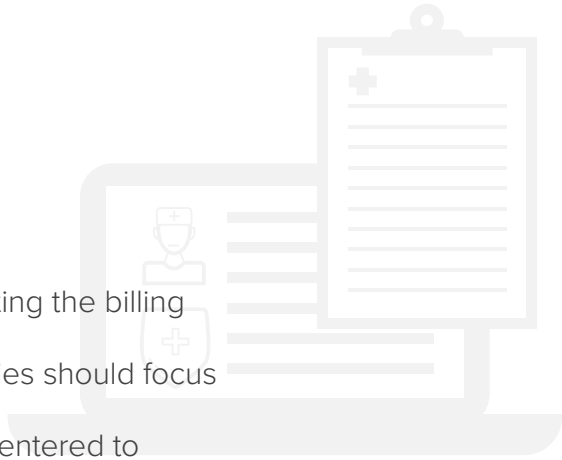


The CDM and charging

The CHRI holder should ensure that revenue integrity staff monitor and audit all charges generated through the CDM. Revenue integrity will typically collaborate with the compliance department on these activities to ensure that both departments are kept abreast of the most current government and commercial payer regulations and their interpretation and application.

If errors or other issues are reported, a corrective action plan should be developed. The specific process or processes affected should be audited to ensure resolution and optimize charge entry, billing, reimbursement, and data collection. These audits should determine whether individuals are properly carrying out their responsibilities and make recommendations for education or process improvement if necessary.

Billing



The CHRI holder should ensure revenue integrity staff work with compliance on monitoring and auditing the billing process from registration, prebilling review, and charge capture to accounts receivable. These activities should focus on ensuring accurate patient data, including payer/insurance plan information and patient status, are entered to support correct coding and billing. As a standard precaution, monitoring processes should be implemented for any new billing requirements.

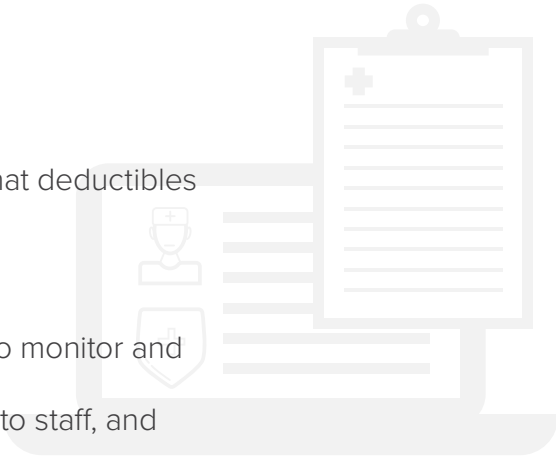
The following areas are of concern and should be the focus of regular monitoring and targeted audits:

- **Medical record numbers.** Incorrect medical record numbers pose significant risks to data integrity, patient safety and quality of care, and revenue integrity. A duplicate medical record number—which occurs when a single patient is erroneously assigned two medical record numbers—may cause services, documentation, and charges to be incorrectly split between multiple records. This may cause issues with billing for bundled or related services, for example, and poses significant risks to data and revenue integrity as well as to patient safety and quality of care.
- **Payer/insurance plan information.** Incorrect payer/insurance plan information can cause mistakes in deductibles and copayments as well as claim denials.
- **Medical necessity.** If a service or item does not meet medical necessity requirements, the payer may deny the claim in whole or in part. In addition, the organization is not in compliance with CMS regulations if it fails to notify a patient that a service is not considered medically necessary and will not be covered. Revenue integrity

staff will work with compliance on monitoring and auditing claims denied due to lack of medical necessity and ensuring that notifications of noncoverage, such as the Advance Beneficiary Notice of Noncoverage, are appropriately provided.

- **Unbundling.** Unbundling is the practice of submitting separate claims for services that could be on a single bill. It may lead to charges of fraudulent billing. Unbundling may occur due to unintentional charge entry errors or a faulty CDM. Revenue integrity staff should conduct spot checks of claims submitted for the same patient within one to two days of each other to ensure that bundled services and items are not separately billed.
- **Upcoding.** Upcoding involves adding codes or coding services at a higher level than actually provided to achieve a higher reimbursement. For example, coding additional complications or comorbidities (CC) or major CCs (MCC) to shift the designation of patient care into a higher-weighted DRG is considered upcoding. Pre-bill internal coding audits should be conducted to detect potential upcoding concerns, particularly on inpatient claims where there is only one CC or MCC that is driving the claims to a higher-weighted Medicare Severity DRG.
- **Beneficiary inducement.** The Anti-Kickback Statute and the Civil Monetary Penalty Law prohibit organizations from offering remuneration to Medicare or Medicaid beneficiaries to influence beneficiaries' choice of providers, practitioners, or suppliers. One way an organization might inadvertently violate these regulations is by not collecting a copayment when a copayment is required. Such a practice may raise accusations that the organization is doing so to induce patients to choose to receive more services. Revenue integrity staff should

monitor for potential concerns by conducting internal audits of accounts receivable to ensure that deductibles and copayments are collected and posted correctly based on the explanation of benefits.



The CHRI holder and revenue integrity staff will need to collaborate with the compliance department to monitor and audit processes across the revenue cycle and to develop policies and procedures, provide education to staff, and resolve compliance issues.

When a compliance issue is discovered, the CHRI holder is obligated to report it. The exact reporting method and individuals to whom the issue must be reported should be specified in the organization's compliance program. The CHRI holder should know how to locate information on the organization's compliance program and reporting method and should be prepared to supply that information to other staff members when necessary.

The CHRI holder may be involved in conducting interviews with staff, either to collect information on potentially unreported compliance issues or to gather more information on possible compliance issues that have been identified.

Risk reduction

If an audit identifies risk areas within the revenue cycle, the next step is to develop a method for addressing them. Generally, this will be a multidisciplinary function that includes representatives of the affected department or departments working with the compliance committee. The CHRI holder should be prepared to provide input on specific risk reduction actions and to actively participate in a leading or supporting role.

About Optum360

Optum360®, a leading health services business, is your source for top industry coding, billing and reimbursement solutions with over 25 years of experience. Serving the broad health market, including physicians, health care organizations, payers, and government, we help health systems reduce costs and achieve timely and accurate revenue.

Our solutions offer:

- Innovative chargemaster maintenance solutions
- Intuitive solutions designed to streamline efficiency
- Access to proprietary data that helps you make informed business decisions

It is our mission to simplify the business of health care by delivering technology, services, and health information to hospitals, physicians, and health systems. Our 10,000 performance experts provide revenue cycle leadership, innovation, and operational excellence to eliminate the inefficiencies in health care and prepare for value-based reimbursement. By creating solutions that leverage our resources, relationships and unparalleled industry perspective, we partner with providers to fulfill their strategic vision and enable them to focus on care and healing.