Chargemaster Maintenance and Charge Capture Strategies for Revenue Integrity

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NAHRI
National Association
of Healthcare Revenue Integrity

hcpro

Presented By

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Disclaimer

- Every reasonable effort has been taken to ensure that the educational information provided in today's presentation is accurate and useful. Applying best-practice solutions and achieving results will vary in each hospital/facility situation.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Define the role of the chargemaster coordinator
  - Apply strategies to maintain the chargemaster
  - Demonstrate charge capture strategies for common ancillary services.

Agenda

- Overview of the chargemaster
  - Definition and structure of the chargemaster
  - Role of the chargemaster coordinator
  - Chargemaster maintenance
- Synopsis of common reimbursement methodologies and impact on the chargemaster
- Highlights of charge capture strategies for common ancillary services
- Tips for keeping the CDM up-to-date and promoting revenue integrity
- Live Q&A

Overview of the Chargemaster

STRUCTURE, ROLES, AND MAINTENANCE

Chargemaster – Definition

- What is a chargemaster?
  - A chargemaster is a file containing all of the procedures, services, pharmaceuticals, supplies, and professional fees provided by a hospital or under hospital contract and billed on a UB-04 and/or CMS-1500.
  - Sometimes referred to as a charge description master (CDM) or Epic All Procedure (EAP), it may contain several thousand lines.
  - It can be equated to a fee schedule or super bill on the professional fee side.
  - Depending upon the patient accounting system, it may be established as either “dynamic” (whereby it leverages electronic behind-the-scenes data) or “static” (mimicking a spreadsheet or database format).

Chargemaster – Example

- Here are some fields from a typical static chargemaster:

Dept	Charge Code	Description	Default/ Non-Medicare HCPCS Code	Default/ Non-Medicare Rev… Cod…	Medicare HCPCS Code	Medicare Revenue Code	SI
RX - 50	5012345	PANTOPRAZOLE 40MG INJ	S0164 or J3490	0636	C9113	0250 or 0636	N
SLP - 57	5701339	SLP LANGUAGE SCREENING	V5363	0444	*(flag as non-covered)*		E1
CAR - 32	3200678	ECHO 2D WO DPLR COMP W/CON	93307*	0483	C8923*	0483	S

Per 40mg

Per vial

** Note that while both 93307 and C8923 have a status indicator (SI)=S, base ambulatory payment classification (APC) reimbursement is significantly different: $233.52 vs. $740.75 per April 2023 Addendum B as C8923 specifies the addition of contrast.*

Chargemaster – Structure

- The following are general questions to ask when structuring the chargemaster for ancillary departments:
  - Will the services be reported on a UB-04 or CMS-1500 claim form?
    - Technical vs. professional fees
      - e.g., split-billing TC/PC onto two claims (UB-04 and CMS-1500) vs. reporting both on UB-04 with different revenue codes such as 032x and 0972
  - Must any of the services be billed globally such as in a clinic setting?
    - e.g., reporting 93000 (ECG with interpretation and report) on one claim vs. 93005 (… tracing only) and 93010 (… interpretation and report only) on separate claims
    - Generally required on the CMS-1500 and necessitates use of different sets of charge codes.

Chargemaster – Structure

- Structuring the chargemaster *(continued)*:
  - Are there coding differences by payer?
    - Level I vs. Level II codes
      - e.g., 71555 [MRA chest with or without contrast material(s)] vs. C8909–C8911 specified as with, without, or without/with contrast
      - e.g., 93318 (TEE 2D monitoring) vs. C8927 (TEE 2D monitoring with contrast)
    - Level II code variances, e.g., S-codes (non-Medicare) vs. C-codes (Medicare OPPS) or G-codes (temporary procedures)
      - e.g., G0109 (Diabetes outpatient self-management training services, group session [2 or more], per 30 minutes) vs. S9455 (Diabetic management program, group session)
    - Level III codes still in existence in some states
    - Workers' comp using outdated code sets in some locales

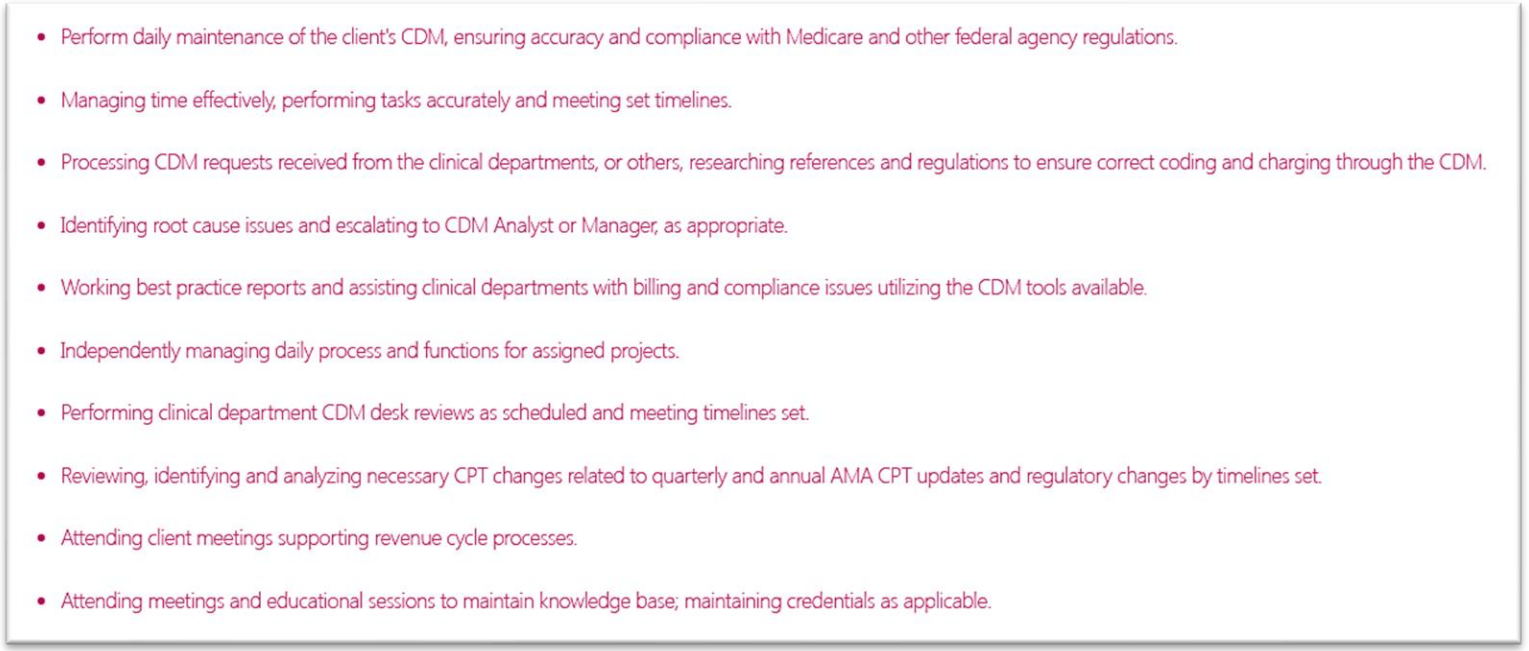
Chargemaster – Structure

- Structuring the chargemaster *(continued)*:
  - Is there a need for different revenue codes*?
    - e.g., 051x (Clinic) vs. 0761 (Treatment room)
    - e.g., 0760 (Treatment/observation—general) vs. 0762 (Observation room)
  - What about coverage issues?
    - Inpatient vs. outpatient
    - Screening vs. diagnostic
    - Medical necessity
    - Contract exclusions

** All UB-04 revenue codes are copyrighted by the National Uniform Billing Committee (NUBC).*

Chargemaster – Role of Chargemaster Coordinator

- Who is responsible for maintaining the chargemaster?
  - What is their title?
  - To whom do they report?
- Duties may include, but are not limited to:



- Perform daily maintenance of the client's CDM, ensuring accuracy and compliance with Medicare and other federal agency regulations.
- Managing time effectively, performing tasks accurately and meeting set timelines.
- Processing CDM requests received from the clinical departments, or others, researching references and regulations to ensure correct coding and charging through the CDM.
- Identifying root cause issues and escalating to CDM Analyst or Manager, as appropriate.
- Working best practice reports and assisting clinical departments with billing and compliance issues utilizing the CDM tools available.
- Independently managing daily process and functions for assigned projects.
- Performing clinical department CDM desk reviews as scheduled and meeting timelines set.
- Reviewing, identifying and analyzing necessary CPT changes related to quarterly and annual AMA CPT updates and regulatory changes by timelines set.
- Attending client meetings supporting revenue cycle processes.
- Attending meetings and educational sessions to maintain knowledge base; maintaining credentials as applicable.

Role of Chargemaster Coordinator – Getting to Know You

- Start building a department contact list.
- Who is responsible for charges in each department?
  - Who posts charges?
  - Contact person for issues or bill edits?
  - What system is used?
    - If a third-party program, who maintains the charge list within the system?
    - How often do you get updates?
- Are there any system issues?
- What is the best way to serve a department?

Role of Chargemaster Coordinator – Document, Document

- Especially as you're learning, document everything!!!
- Some examples include:
  - Charge requests
  - Chargemaster activations/deletions/changes
  - Issues
  - Insurance updates

Role of Chargemaster Coordinator – Meetings Can Be a Good Thing!

- Are there meetings you can attend?
  - New procedures/services
  - Clinical changes
  - Ancillary department meetings
  - Price increases
  - Contracting
  - Patient financial services (PFS) meetings
  - Denials

Chargemaster Maintenance – Decisions, Decisions

- How is the chargemaster maintained?
- Charge requests: Forms vs. email
  - Who can submit requests?
  - Do requests require department approval?
- Maintenance: Committee vs. sole responsibility
- Reports: Canned vs. spreadsheet
  - Daily download of charges
  - A lot can be done with a spreadsheet

Chargemaster Maintenance – Your New Best Friends

- CFO: Do you need to get prior approval for certain actions?
  - Price increase/decrease
  - Charge reversal
- IT: Reports
- PFS billers
- HIM/Coding
- Consultants

Chargemaster Maintenance – Important Things to Bear in Mind

- Be sure to evaluate:
  - Medicare
    - Status Indicators
    - Comprehensive APCs (C-APCs)
    - Packaging
  - Commercial payers
    - Contract language
    - Coverage policies
  - Managed Medicare/Medicaid
    - Not all plans the same
    - Contract language
    - Rebill policy

Chargemaster Maintenance – Know System Limitations

- Make it a priority to identifying system limitations.
- Take a proactive approach.
- Run reports to, for example:
  - Identify laboratory testing services outside the date range.
  - Locate patterns to put an end to the errors and educate staff accordingly.
- Don’t wait for trouble to find you; go look for it.
- Goal is to get the claim out the door—clean—the first time!

Chargemaster Maintenance – Pricing Considerations

- Charging differently for same Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) codes in different cost centers:
  - Can it be justified?
    - For example, is there a variance in the cost-to-charge ratio (CCR)?
    - Is the bilateral (modifier 50) service priced twice that of a unilateral one (RT/LT)?
  - Keep in mind that both prices with reference to the department or other differentiating factor must be posted for the consumer.
- Some services in certain instances or locales should not be marked up or need to be billed with the invoice:
  - Blood products
  - Laboratory procedures
  - Implants

Chargemaster Maintenance – Team Approach

- How can a facility effectively accomplish some of the aforementioned chargemaster maintenance strategies?
  - Consider a team approach.
    - Proactive.
    - Encompasses shared expertise and responsibility by involving key individuals in the process.
    - Improves documentation and communication.
    - Provides education.
- Potential team-related tasks.
  - Not accepting status quo!
    - E.g., improving claim acceptance rate by involving IT.
  - Managing patient orders.
  - Increasing or decreasing prices.
    - CFO approval and justification.

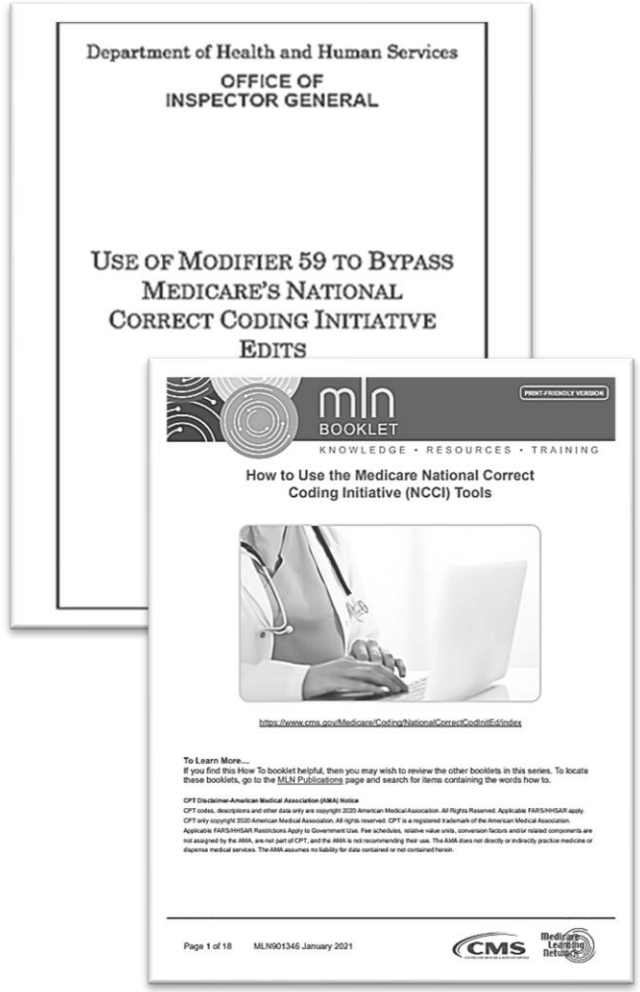
Chargemaster Maintenance – Team Approach

- Who should be included?
  - Chargemaster coordinator
  - CFO or controller and potentially other finance staff
  - Compliance
  - Revenue integrity
  - Revenue cycle
  - HIM/coding
  - Ancillary department managers
  - IT – clinical (EHR) and financial (CDM/ancillary systems)
  - Physician champion
  - Reimbursement

http://library.ahima.org/doc?oid=106784#.WsOgaC7wapo

Chargemaster Maintenance – Resources

- Do you have a corporate contact or a vendor?
- Are there other hospitals within the health system?
- Sign up for free newsletters and webinars.
- Join charge forums.
- Consult AMA CPT guidance.
- Refer to specialty societies, e.g., NAHRI, ACR, ACEP, etc.
- Look to CMS and the Office of Inspector General (OIG)
  - Medicare Learning Network tools and fact sheets
  - *NCCI Policy Manual a*nd NCCI FAQ page
  - OIG reports
  - CMS/MAC online lookups



Common Reimbursement Methodologies and Impact on the Chargemaster

Chargemaster – Reimbursement

- Medicare reimburses most outpatient services under the Outpatient Prospective Payment System (OPPS), which began in August 2000.
- Under the OPPS, Medicare pays the hospital a rate-per-service basis known as an APC or Ambulatory Payment Classification system:
  - Varies depending on the CPT/HCPCS code(s) and status indicators
  - Is CPT/HCPCS-driven and updated/published quarterly
  - Can include multiple APC payments (and even other payment methodologies) on a given claim for a given outpatient encounter.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

Chargemaster – Reimbursement

- Effective January 1, 2015, CMS established C-APCs to provide all-inclusive payments for certain procedures.
  - This policy packages payment for all items and services typically packaged under the OPPS as well as payment for other items and services that are not typically packaged under the OPPS. The single payment for a comprehensive APC excludes services that are non-covered.
- Other payment methodologies include:
  - Fee schedule/fee-for-service
  - Contracted/capitated rate
  - Percentage of charges
  - Per diem
  - Any combination of the aforementioned methodologies.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Outpatient_Methodology.pdf

Chargemaster – Reimbursement

- APC Addendum B Example (April 2023):

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
74261	Ct colonography dx	Q3	5522	1.2488	$106.88
74262	Ct colonography dx w/dye	Q3	5571	2.1071	$180.34
74263	Ct colonography screening	E1			
74270	X-ray xm colon 1cntrst std	Q1	5571	2.1071	$180.34
74280	X-ray xm colon 2cntrst std	Q1	5571	2.1071	$180.34
74283	Ther nma rdctj intus/obstrcj	S	5571	2.1071	$180.34
74300	X-ray bile ducts/pancreas	N			

https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/april-2023

Chargemaster – Reimbursement

- APC-included services
  - Surgical procedures
  - Radiology
  - Radiation therapy
  - Clinic visits
  - Emergency department (ED) visits
  - Diagnostic services
  - Partial hospitalization
  - Surgical pathology
  - Chemotherapy
  - Blood products
- APC-excluded services*
  - Diagnostic laboratory
  - Physical therapy, occupational therapy, and speech language pathology
  - Prosthetics/orthotics
  - Dialysis for end-stage renal disease
  - Ambulance services
  - Durable medical equipment
  - Inpatient skilled nursing
  - Hospice/home health
  - Screening mammography
  - Professional fees

** Paid under other methodologies, e.g., fee schedules, as mentioned previously.*

Chargemaster – Reimbursement

- Status indicators (SI) identify what services are payable under APCs, i.e., which are included, and which are excluded. Status indicators are:
  - A single alpha or dual alpha-numeric character that correlates to each HCPCS code
  - Referenced annually in Addendum B (a detailed listing by HCPCS code and its assigned status indicator) and defined in Addendum D1 of the OPPS final rule each year
  - Common status indicators include:
    - Packaged (SI = N)
      - Separately billable in most instances but payment included in related service under OPPS
      - Subject to NCCI edits and standards of coding practice
    - Examples of instances whereby “packaged” services would not be separately billable include:
      - Pulse oximetry (94760–94761) performed in conjunction with surgical procedures
      - IV starts (36000) to facilitate infusion services.

Chargemaster – Reimbursement

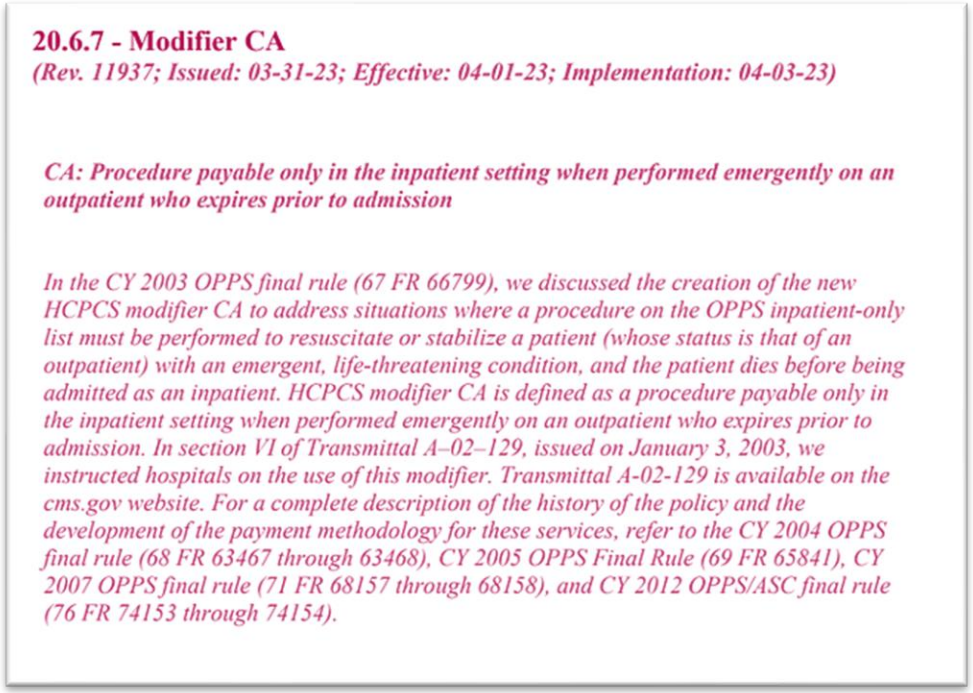
- Common status indicators *(continued)*:
  - Non-covered (SI = E1 or E2)
    - Formerly assigned SI = E
    - Separately billable but not reimbursable under OPPS
    - Should be reflected in non-covered column of UB-04
    - Statutorily non-covered items or services do not require Medicare denial
    - Beneficiary responsible for payment
  - Examples of “non-covered” services include:
    - Self-administered drugs
    - Autopsies (88000–88099)
    - Allergen Immunotherapy (95120–95134)
    - Specimen handling (99000–99001)
    - Visual acuity screen (99173)

Chargemaster – Reimbursement

- Common status indicators *(continued)*:
  - Non-reportable (SI = B)
    - Not separately billable under OPPS but may be paid by intermediaries when submitted on a different bill type, e.g., 75x (CORF)
    - An alternate code that is recognized by OPPS may be available
    - Often synonymous with the term “non-billable”
  - Examples of “non-reportable” services with alternate coding include:
    - Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral (77048 vs. C8903–C8905)

Chargemaster – Reimbursement

- Common status indicators *(continued)*:
  - Inpatient procedures (SI = C)
    - Not paid under OPPS unless patient admitted as inpatient
    - For emergently performed procedure on an outpatient who expires prior to admission, report SI = C procedure with modifier CA and discharge status code 20 (Medicare PM A-02-129).
  - Blood and blood products (SI = R) and brachytherapy sources (SI = U)
    - Became effective as of January 1, 2009
    - Formerly assigned SI = K
    - Payable under OPPS



20.6.7 - Modifier CA

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

CA: Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

In the CY 2003 OPPS final rule (67 FR 66799), we discussed the creation of the new HCPCS modifier CA to address situations where a procedure on the OPPS inpatient-only list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. HCPCS modifier CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. Transmittal A-02-129 is available on the cms.gov website. For a complete description of the history of the policy and the development of the payment methodology for these services, refer to the CY 2004 OPPS final rule (68 FR 63467 through 63468), CY 2005 OPPS Final Rule (69 FR 65841), CY 2007 OPPS final rule (71 FR 68157 through 68158), and CY 2012 OPPS/ASC final rule (76 FR 74153 through 74154).

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf

Chargemaster – Reimbursement

- Common status indicators *(continued)*:
  - Hospital Part B services paid via a C-APC (SI = J1)
    - Introduced in 2015
    - Payable under OPPS
    - All covered Part B services on the claim are packaged with the primary “J1” service for the claim, except for:
      - Services with OPPS SI = F, G, H, L or U
      - Ambulance services
      - Diagnostic and screening mammography
      - All preventive services
      - Certain Part B inpatient services.

Charge Capture Strategies for Common Ancillary Services

Charge Capture Strategies – ED/Clinics

- CDM maintenance and charge capture focus areas for ED/trauma/urgent care (UC)/clinics should include:
  - Verifying
    - 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.

Charge Capture Strategies – ED/Clinics

- ED/trauma/UC/clinics charge capture focus areas *(continued)*:
  - Ensuring:
    - Procedures such as CPR, EKGs, and venipunctures, as well as minor surgical repair, are billed separately in addition to evaluation and management (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.
  - Validating:
    - HCPCS G0463 introduced in 2014 is reported in place of outpatient visit codes 99202–99215 for OPPS hospital-based clinic services (*MLN Matters*® Special Edition Article, SE1407, January 29, 2014).
    - Physicians, critical access hospitals, and other non-OPPS entities continue to report codes 99202–99215 as appropriate or unless otherwise instructed by the MAC for the region.

https://www.federalregister.gov/articles/2013/12/10/2013-28737/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical

Charge Capture Strategies – ED/Clinics

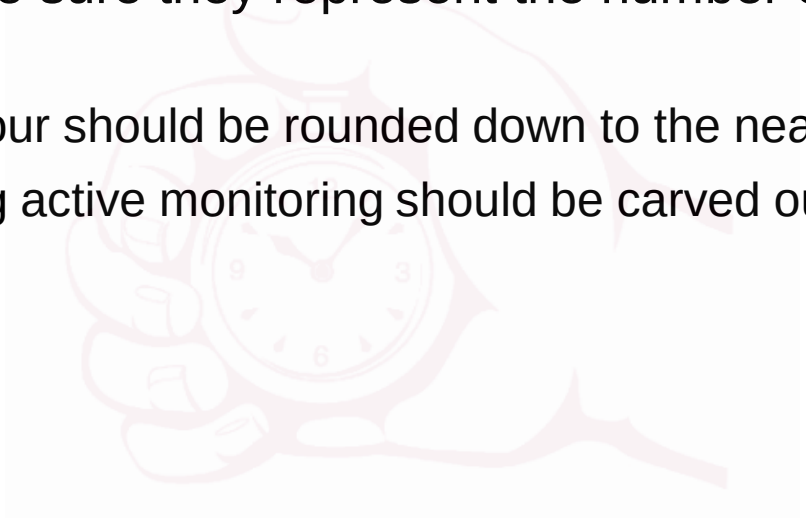
- ED/trauma/UC/clinics charge capture focus areas *(continued)*:
  - Establishing:
    - A mechanism for logging and charging non-emergent or scheduled return visits to the ED (due to lack of space elsewhere, after-hours coverage, etc.) for rabies vaccination series, blood transfusions, antibiotic therapy, 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 screen.
  - Confirming:
    - 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/HCPCS code descriptor in order to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code. In order words, facility internal E/M criteria should:
      - Be consistent
      - Meet medical necessity
      - Demonstrate stability over time
      - Be linked to hospital resources, not physician ones
      - Be available to and verifiable by outside entities.

Charge Capture Strategies – Observation

- Chargemaster maintenance and charge capture focus areas for observation services should include:
  - Ensuring:
    - 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.
      - 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 definitive observation unit or a nursing floor (CMS *Transmittal 787*, December 16, 2005).

Charge Capture Strategies – Observation

- Observation charge capture focus areas *(continued)*:
  - Reviewing:
    - Observation orders to ensure they are written by providers authorized by the facility's medical staff bylaws to admit patients or order outpatient tests
    - 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.



Charge Capture Strategies – Surgery

- Chargemaster maintenance and charge capture focus areas for surgery/anesthesia/recovery should include:
  - Verifying:
    - Appropriateness of HCPCS (including unlisted codes), i.e., 036X vs. 0761 vs. 051X vs. 052X
    - Correct use of soft-coding vs. hard-coding
    - Routine items and equipment are bundled, e.g., drapes, gowns, gloves and monitors
    - Non-routine supplies, DMEPOS items and pharmaceuticals dispensed by department are reported.
  - Note regarding time charges:
    - Time is generally charged in the operating room (OR) so that HIM can append the appropriate coding from chart documentation; however, certain minor procedures performed in treatment rooms associated with the OR may be hard-coded. Leveling of OR time is becoming more commonplace.
    - For freestanding ambulatory surgical centers, surgical procedures are normally hard-coded in the chargemaster, inclusive of routine supplies, equipment, and recovery.

What's New in Charge Capture for 2023 – Surgery

- For 2023, the surgery section included updates to the following systems:
  - Integumentary
  - Musculoskeletal
  - Respiratory
  - Cardiovascular
  - Digestive
  - Urinary
  - Male genital
  - Nervous
- While often surgical services are soft-coded to OR time, there may be instances where they are hard-coded in the chargemaster for free-standing ASCs, clinics, and physician professional fees. Ensuring the codes are updated appropriately is critical to appropriate charge capture.

What's New in Charge Capture for 2023 – Surgery

- In the Urinary system section, CPT® codes 50080 and 50081 were revised to include more detail as to clarify a percutaneous nephrolithotomy or pyelolithotomy lithotripsy procedure.

Code	Change	2023 Long Description	2022 Long Description
50080	Revised	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm
50081	Revised	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm

What's New in Charge Capture for 2023 – Surgery

- To the nervous system section, three new codes—69728–69730—describing the removal, implantation, and replacement of an osseointegrated skull implant were added.
- The following codes sustained revisions:
  - Somatic nerve injections—CPT codes 64415-64417 and 64445-64448—were revised to be inclusive of imaging guidance.
  - CPT codes 66174 and 66175 were revised to include an example procedure.
  - CPT codes 69716–69717, 69719, and 69726–69727 were revised to clarify the description of an osseointegrated skull implant replacement or removal.

Charge Capture Strategies – Supplies

- Chargemaster maintenance and charge capture focus areas for supplies should include:
  - Verifying:
    - Appropriate reporting of device-dependent codes
    - Routine items and equipment are bundled, e.g., drapes, gowns, gloves and monitors
    - Non-routine* supplies, DMEPOS items, and implants dispensed by department are reported
  - Note that routine supplies, such as gloves, drapes, and blood pressure cuffs, and equipment, such as monitors and pumps, should be bundled into surgery time or the related accommodation code or service. Non-routine items and services may be billed separately when they are:
    - Directly identifiable items and services provided to individual patients*
    - Furnished under the direction of an MD/DO because of specific medical needs
    - Not reusable or represent a cost for each preparation

** This also means that such items should generally be charted in the patient's permanent medical record.*

Charge Capture Strategies – Pharmacy

- Chargemaster maintenance and charge capture focus areas for pharmacy should include:
  - Verifying
    - Units of service
      - HCPCS code description vs. manufacturer dose
      - Wastage documentation (modifier -JW or new modifier -JZ, as required)

Code	Description
JW	DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT
JZ	ZERO DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT

    - Self-administered drugs have been established as non-covered for Medicare outpatients under most circumstances, but covered for inpatients and other payers
    - Accuracy of National Drug Code data

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55932

Keeping the Chargemaster Up-to-Date and Promoting Revenue Integrity

TIPS TO TAKE AWAY

Tips to Take Away

- Charge capture strategies should be employed to promote revenue integrity and prevent revenue leakage.
- Chart-to-bill audits should be performed periodically.
- Pricing should be done strategically and reviewed at least annually.
- System constraints should be analyzed periodically to ensure compliance and improve revenue projections.
- Claims edit resolution processes should resolve errors at their source.
- Pertinent resources should be used to stay up-to-date.
- Departmental and interdepartmental communications should be promoted enterprise-wide—knowledge is meant to be shared!

Questions & Answers

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To Submit a Question: Go to the Q&A box located in the lower left area of your screen. Type your question in the lower text box, then press your "Enter" key.

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This concludes today's program.

Be sure to register for our upcoming program:

Solidify ICD-10-CM Coding for Social Determinants of Health

Presented on: Thursday, June 22, 2023 | 1:00–2:00 p.m. Eastern

For more information on this event, please visit our website at: https://hcmarketplace.com/solidify-icd-10-cm

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