

# CPR for your CDM

**“A hospital bed is a parked taxi with the meter running.”**

Groucho Marx

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# Crash Cart Items

(i.e., today's topics)

**Sometimes we get a little complacent with reviewing our CDM's when there has not been a big change in coding or reimbursement methods for a few years.**

**It is up to you to call Code Blue on your charge document.**

**“How” You say?**

# Crash Cart Items

(i.e., today's topics)

**The devil is in the details. The details we will explore today are:**

- New instruction may lead to indirect revenue
- Outlier Payments
- Language
- Supplies - No CDM lecture would ever be complete without discussing supplies!
- Data Mining

## New Instructions May Lead to Indirect Revenue

The CDM drives revenue in different ways. The most obvious of these is patient charges. It also is responsible for driving revenue in indirect ways; i.e. cost report payments and outliers.

# Indirect Revenue

Lets take a look at CMS Transmittal 1599 - October 2008 update of the hospital outpatient prospective payment system.

Key Sections pertinent to the CDM:

- Revenue Codes
- Medicare Cost Apportionment Regulation

# Medicare/Medicaid Cost Reporting

- Medicare Cost Report is a large financial report that a hospital gives to Medicare on a yearly basis. Contained in this report is data on total gross charges (list price), gross and net revenues, expenses, patient visits, payer mix (how many patients have Medicare, Medicaid or Private Insurance.) This data is broken down by hospital service.
- The report is very long, several hundreds of pages, and may reach into the thousands with supporting documents.

# Revenue Code Reporting

- CMS is now giving us guidance on the General Revenue Code vs. Specific Revenue Code debate.
- “Hospitals should choose the most precise revenue code, or sub-code. It is recommended that providers use the more detailed subcategory when applicable rather than revenue codes that end in “0” or “9”.

# Medicare Cost Apportionment/Revenue Code Reporting

- We rely on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies because we use a revenue code to cost center crosswalk to estimate the service costs that underpin OPPS payment rates.
- The current revenue code to cost center crosswalk that we use for setting annual hospital outpatient payments may be found on the CMS web site at:  
[http://www.cms.hhs.gov/HospitalOutpatientPPS/03\\_crosswalk.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage)
- The accuracy of hospital outpatient payments for future years depends on hospitals appropriately implementing NUBC instructions and reporting appropriate revenue codes, and following all cost report instructions.

# Medicare Cost Apportionment

- One of the components of the Medicare Cost Report is the PS and R
  - Your Fiscal Intermediary prepares this information for each hospital.
  - The report is a summary of Medicare payments, categorized by the revenue codes you reported thru your CDM for each charge.
- Hence, the crosswalk!

Rvenue center ID	Revenue Code Description	Used in OPPS	Primary cost center source for CCR	Primary cost center name	Secondary cost center source for CCR	Secondary cost center name	Tertiary cost center source for CCR	Tertiary cost center name
0273	Medical/Surgical Supplies: Take home supplies	Y	5500	Med Supplies Charged to Patient				
0274	Medical/Surgical Supplies: Prosthetic/Orthotic devices	Y	3540	Prosthetic Devices	5500	Med Supplies Charged to Patient		
0275	Medical/Surgical Supplies: Pacemaker	Y	3540	Prosthetic Devices	5500	Med Supplies Charged to Patient		
0276	Medical/Surgical Supplies: Intraocular lens	Y	3540	Prosthetic Devices	5500	Med Supplies Charged to Patient		
0277	Oxygen-Take home	N						
0278	Medical/Surgical Supplies: Other implants	Y	5500	Med Supplies Charged to Patient				
0279	Medical/Surgical Supplies: Other supplies/devices	Y	5500	Med Supplies Charged to Patient				
0280	Oncology	Y	3480	Oncology				
0289	Oncology: Other oncology	Y	3480	Oncology				
0290	Durable Medical Equipment	Y	6700	Durable Medical Equip. - Sold	5500	Med Supplies Charged to Patient		
0291	Rental	N						
0292	Durable Medical Equipment: Purchase - new equipment	Y	6700	Durable Medical Equip. - Sold	5500	Med Supplies Charged to Patient		
0293	Purchase of used DME	N						
0294	Supplies/Drugs for DMEeffectiveness (HHA only)	N						
0299	Durable Medical Equipment: Other equipment	Y	6700	Durable Medical Equip. - Sold	5500	Med Supplies Charged to Patient		
0300	Laboratory - Clinical Diagnostic	Y	3390	Laboratory - Clinical	4400	Laboratory		
0301	Laboratory - Clinical Diagnostic: Chemistry	Y	3180	Chemistry	3390	Laboratory - Clinical	4400	Laboratory
0302	Laboratory - Clinical Diagnostic: Immunology	Y	3380	Immunology	3390	Laboratory - Clinical	4400	Laboratory

# Indirect Payment – Outlier Payments How they Are Calculated?

- It may be more effective to insure that all services and supplies are accounted for, and properly reported.
- How many times have you heard “We won’t get paid any more for adding inpatient charges”. Not always true!!!

# Indirect Payment – Outlier Payments How they Are Calculated?

Outliers – Complex inpatient cases whose costs far exceed the costs of typical cases within that DRG.

- Outlier formula multiplies the hospital's actual charges by the hospital's cost-to-charge ratio.
- The cost-to-charge ratio used to calculate outlier reimbursement is taken from the most recent settled cost report.

# Indirect Payment – Outlier Payments How they Are Calculated?

- All of the services and supplies provided to a patient, whether inpatient or outpatient, must be represented on the account. It is these services that determine whether an account will qualify for additional payment.
- Raising the price of a service will also increase your outlier threshold, but might price you out of the market, cause your patients to revolt, and really make your commercial payers angry!

# Indirect Payment To Do List

- Spend some time understanding the full impact of a comprehensive and correctly detailed CDM
- Fix those Revenue Codes!
- Learn the basics of hospital cost report accounting (the parts that touch the CDM).

# Learn the Language

- Yes, we conduct business in English, but clinicians in each specialty have their own idiosyncrasies, as does CPT and CMS. Not always do we understand what we are adding to the CDM, what their acronyms mean, and how to marry the two together.
- Lab, Pharmacy, and Diagnostics account for most of these issues.

## Real Life Example of Language Snafu

- Pharmacy - This hospital has a separate Pharmacy Formulary that interfaces with the hospital billing system. The multipliers and prices are driven by the formulary. In the formulary there is a line that is defined as:
- Dexamethasone 120/30ml with a multiplier of 1
- CDM line= Dexxa 1 mg J1100 with a unit of 1

## Real Life Example of Language Snafu

- Do these two match? Are the units correct? Do you know how to do the math?
- (Obviously, I would not have included it in this presentation if the math was correct)
- In this example, the formulary was dispensing a multi-dose vial that should not have been billed to one patient, and the CDM analyst matched it to a single dose with an incorrect HCPCS and a billing unit of 1

## Real Life Example of Language Snafu

- The Radiologist, in conjunction with an Ortho Surgeon, developed an x-ray study with some special views for his Spine surgical patients and called it Dr Buckland Study
- It was coded as 71035 for several years. Correct??

## Real Life Example of Language Snafu

- Several years and three employees later, it was discovered that a Dr Buckland Study was not really a Bucky Study. What happened? The abbreviation in order entry and the CDM was” BUCK. Study.” Because the acronym matched something in the CPT, no one thought to ask more questions.

## Real Life Example of Language Snafu

- It turns out that the Dr Buckland study was actually a chest series, an abdominal series and a spine series.
- How much money was left on that table!

## SUPPLIES.....again

OPPS has left us with many different interpretations of “separately billable”. Since 2000, many hospitals have decided to bundle things like supplies into other charges, like Room and Board. But unless your hospital has a REALLY diligent cost accountant, you may think that you are charging for things that in fact you are not.

# SUPPLIES.....again

CMS authoritative sources used for classifying a service supply or equipment as routine are:

PRM 15-1 section 2202.6

PRM 15-1 section 2202.8

PRM 15-1 Chapter 22 section 2203

# SUPPLIES.....again

Most FI's agree that provisions of PRM 2203.2, apply to hospitals, as well as to SNFs. Charges for items and services meet the requirements for recognition as ancillary charges if they are:

- Direct identifiable services to individual patients, and
- Not generally furnished to most patients, and
- One of the following:
  - Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;
  - Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing.

# SUPPLIES.....again

Some FI's have issued additional guidelines, but not many So... where is this" list " of bundled supplies?

- CMS does not have one!!!!
- Commercial Carriers develop their own
- Have you?
- Do you have a list of all things considered in a bundled charge?

## SUPPLIES.....again

- Do you have an up to date routine supply policy? If not, you are probably leaving money on the table (or sending it back to the commercial payers).
- Do you have the criteria for developing each bundled charge? If not, you are probably not charging for things you only THINK are included

## Why develop a routine supply policy?

- It defines your charging philosophy for all payers in case of an audit
- It is the first response when a payer sends an overpayment letter
- It gives guidance to materials management and billing

## Data Mining and other technology assisted techniques

- Data Mining and Relational databases are not new tools in the payers refund request (or fraud detection) arsenal. Hospitals should employ the same techniques when looking at the integrity of their own data.

## Example of Data Mining

This hospital employs the Emergency Room Providers, and bills for their professional services on a different system. A report was created that merged the CPT codes from both systems into one revenue and use report. This pro/tech duplicates report uncovered many errors. One of those was the loss of over 600 EKG interpretations.

# Data Mining

- Can You Do Your Own Data Mining?
- Yes! Find your own common patterns
- Look at other hospital systems to help. Use supply inventory, Pharmacy formulary, lab dictionaries to help in your investigations
- Don't forget to review your denials, both pre-bill and post-bill

# Types of Data Mining Reports

- Pro fee/technical fee matches
- Patient Registration/E/M matches-Are the numbers for each clinic close?
- Supply inventory/billed supply report- how do the two numbers compare?
- Lab review of purchased tests-any missing from your CDM?

## To Do List

- Develop routine supply policy
- Update revenue codes
- Learn about cost reports and outlier payments
- Keep a spreadsheet on bundled charges
- Broaden your horizons - learn another language
- Use other hospital systems and your imagination to look for opportunity and compliance.

# Concluding Thoughts

- Keeping today's chargemaster compliant and complete is constant work, and a continuous education for the analyst.
- Make sure you understand all aspects of the Revenue Cycle
- The End

# Contact us – we like to “talk”!

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