Protecting Revenue: Managing Your Risks with RACs

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Executive Summary

Hospitals and physicians are facing yet another risk to their financial health. Recovery Audit Contractors (RAC), Medicaid Integrity Programs (MIP) and commercial recoupment audits loom with greater presence than ever before. Each hospital needs to address its own internal charging practices aggressively and ensure it has done everything possible to achieve revenue integrity and reduce recoupment exposure. Charge Description Masters can either help or hinder a hospital's hunt for revenue efficiency. Who holds responsibility for them, how they are managed, and attention to regulatory requirements details dictate a successful or unsuccessful revenue system. This article identifies many specifics that auditors and compliance professionals need to understand.

Introduction

The continued focus on improper payments from the Medicare Trust Fund by the Office of the Inspector General (OIG) and Department of Justice (DOJ) makes it important to understand the key means for identifying and managing risks. The RAC audits and other recoupment audits focus on patterns of behavior. The Charge Description Master (CDM) is one tool used by facilities to ensure compliant billing, but it can also serve as a strategic tool for self-analysis.

The CDM can serve as your 'friend' in charging and billing accurately, or it can become a 'foe' when it creates patterns of inaccurate charging behavior. Some of those patterns are errors within the CDM that cause potential billing and reimbursement errors. For instance, the lack of a charge line ensures that the charge will be lost. Additionally, the CDM can also help to identify items that are a potential risk in the Hospital Compliance Guidance.

The CDM as 'Friend'

When the CDM is set up appropriately, it allows for proper charging of evaluation & management (E/M) (visits), procedures, supplies, and pharmaceuticals. It can provide consistent coding for procedures that are performed identically each time. Examples of such services are chest X-rays, EKGs, aerosol treatments or those with CPT codes in the range of 70,xxx–90,xxx. The CDM also supports HCPCS codes for supplies, pharmaceuticals and orthotics. The CDM can be a mechanism for managing revenue and can also provide a key decision support function for Relative Value Unit (RVU) comparisons and volume utilization.

The CDM as 'Foe'

On the other hand, if the CDM is poorly maintained, it will lead to charging errors that require repetitive back-end work. CDMs differ from manual charging and billing performed by coding professionals in that once charged, the service will be automatically coded by the CDM and no human is present to prevent an inaccurate charge from going on the claim. An example of this is charging the incorrect item, or charging the item to the wrong patient account. In these cases, no one is comparing it to documentation to ensure accuracy. Therefore, key assumptions are that all documentation is present, and if not present on audit will result in an over- or underpayment finding.

It is important to note that the Office of Inspector General has named the CDM as a potential compliance concern [Federal Register, Vol 70, No 19, p. 4861].

Risks and Challenges

Here is a list of risks and challenges that exist for the CDM:

- Ownership & accountability for CDM maintenance
- Documentation: hard coding vs. soft coding
- Collision coding
- Charging for evaluation and management/critical care services
- Zero volume line items
- Pharmacy—units of service
- Use of modifiers in the CDM
- Prosthetic/orthotic devices vs. DME
- Revenue code application
- Use of CDM for statistics

Ownership & Accountability for CDM Maintenance

One of the biggest issues is who 'owns' the CDM. Potential ownership models include finance, compliance, and revenue cycle or revenue integrity.

If the finance department owns it, the drawback is that it is incentivized to bill for services to enhance gross revenue figures. As a result, it may feel pressured to increase charges to ensure that every penny of a percent of a charge claim benefits the bottom line. The potential problem is that the Finance department's requirements for ensuring a healthy bottom line could overshadow compliance requirements.

Conversely, if compliance owns the CDM process, its input can be beneficial but it can also be looked upon as the "fox watching the hen house." It may be that the department cannot remain objective and mitigate risk if it is causative of that risk.

In most cases, the revenue cycle or revenue integrity department is generally thought of as the 'best practice' model for owning the CDM. This is because it has expertise in charging, coding, billing and compliance so you get the best of all worlds. The department typically also has a good working relationship with all other areas of the hospital.

No matter what group is selected to own or manage the CDM, ultimately each respective revenue-producing department has to be accountable for its own CDM accuracy. This is because each department alone understands what it does, and when, and the documentation present to support the charges. Therefore, there is a shared responsibility between the performing departments and CDM management staff.

Documentation: Hard Coding vs. Soft Coding

A vast majority of the CDM line items are hard coded. This predicates the assumption that documentation exists to support the charge and that it is present prior to charge entry. The inherent risk here is that all documentation must be present prior to bill submission to a federal payer, and on a retrospective audit it may not be present or may not be sufficient to support the charge. Once an order is placed in the facility ordering system, no person will touch it until it appears on the claim. This can create a 'pattern of behavior' if there is an error in the original data input, which may result in being at risk in a retrospective audit. It also has the inherent problem that there is no check and balance to prevent submitted code errors.

> *If the CDM is poorly maintained, it will lead to charging errors that require repetitive back-end work.*

With hard coding, there is a lack of the safety net that soft coding by the Health Information Management (HIM) department provides. Soft coding requires human skill to review the medical record and abstract a procedure code so there is inherently less risk since a professional is basing the procedure code on documentation in existence.

Collision Coding

Collision coding occurs, for example, when both the CDM and HIM are entering procedure codes for GI and Cath Lab procedures and Evaluation and Management (E/M) services. This will commonly result in multiple same or conflicting CPT codes on the claim for the same service and creates a pattern of under or overcharging. It can also delay claim submission and disrupt cash flow because of the amount of work required to rectify the issue.

E/M and Critical Care Services

The challenge in these situations occur not within the CDM but in having policies and procedures that speak to the eleven guidance points [Federal Register/ Vol. 72, No. 227/p. 66805] set forth by CMS within the Outpatient Prospective Payment System (OPPS) guidelines for CPT-4 codes:

99201—99205 (New Patient)

99211—99215 (Established Patient)

99281—99285 (ED)

There is a requirement that policies and procedures outline what constitutes critical care, as well as what activates the start time and causes the stop time to occur. And so the challenge is how to represent included services within Critical Care codes 99291–99292 in the CDM. The facility should ensure that they are not included on a claim during the period in which critical care was being performed. It should also be aware that it cannot bill certain items between the start and stop times of critical care, although it could bill these before and after critical care is active.

CPT states that certain services are included within the master critical care CPT (99291–99292):

- Interpretation Cardiac Output 93561, 93562
- Chest X-Ray 71010, 71015, 71020
- Pulse Oximetry 94760, 94761, 94762
- Gastric Intubation 43752, 91105
- Ventilatory Management 94002-94004, 94660, 94662
- Vascular Access 36000, 36410, 36415, 36591
- Others as stated on p.19 (AMA 2009 CPT)

This poses a challenge because certain services do not fall within the ED CDM,

so there has to be a manual process for charging/billing during critical care. The facility may need to set up critical care 'orders' that do not charge, and then after review of the record generally the Medical Records department will add the charges (or this could be delegated to another entity). However, this also poses a risk for under or over charging.

Zero Volume Line Items

Another area of risk within a CDM that lends itself to charge capture issues daily is the inclusion of outdated, deleted or zero volume CDM line items. When these are active and still able to be used for charge capture, front-end staff have more opportunity to make an incorrect charge selection and thereby a charging/billing error. The CDM should be limited to active charges to decrease potential charge selection errors.

Minimize risk by removing outdated, deleted or zero volume line items from the CDM. Remember you will never have documentation to support a service charged in error.

Pharmacy—Units of Service

The alphanumeric HCPCS codes used for pharmacy or "J" codes have dosages in the description. However, when dispensing drugs, it is imperative that the medication or IV 'label' is correct on the medication. Improper labeling can cause errors between charging and dispensing with the incorrect number of units being charged. The CDM and multipliers are responsible for charging billing for pharmaceuticals.

The RAC Evaluation Report in June of 2008 for Outpatient Pharmacy found that 1.1 million dollars of drugs in the state of New York were improperly coded. Two drugs that were singled out with improper reporting issues were Oxaliplatin and Darbopoetin.

The report also found CDM unit of service errors for the drug Neulasta on automated review, and that the over-reporting of these units of service was Medically Unnecessary.

Nationally, RACs have identified pharmacy as 'low hanging fruit' because they can perform automated reviews and locate the patterns of charging errors. Pharmacy is one department that is entirely hard coded within the CDM; therefore it can easily create a pattern of charging behaviors, which is caught on automated review. The good news is that pharmacy represents a preventable risk area by using software to perform automated reviews and ensure that the code, description, and billing units match.

Use of Modifiers in the CDM

Hard-coded modifiers represent a risk unless the modifier and associated procedure is performed identically every time. For instance:

- Ankle X-ray 2 view—right ankle
- 73600 RT

Anatomical modifiers of RT and LT and Bilateral (50) are examples of modifiers that are the same every time.

> One of the biggest issues is who 'owns' the CDM.

The Medicare Physician Fee Schedule (MPFS) and the Medicare Physician RVU files dictate the modifiers RT, LT and 50 for Medicare purposes. Within the RVU file is the Bilateral at Surgery Column, which can be found at http://www.cms.hhs.gov/PhysicianFeeSched/. In the column, you will note the following information:

- Indicator—1 and 3 then RT, LT or 50 may apply
- Indicators 0, 2 and 9 never have RT, LT or 50
- Paired organ systems or opposing structures

Modifier 25 is a high area of risk. For many years, it has been a focal target for multiple agencies including Medicare Administrative Contractors (MAC), Medicare and Medicaid Integrity, CERTs and commercial payers recoupment. The use of the modifier indicates that a 'separately identifiable' event occurred. Currently, post payment reviews performed by MACs and quality organizations in the Midwest are focusing on this, as there is seldom documentation to support 'separately identifiable resource utilization' above and beyond the procedure performed. Here is an example:

- A patient presents to the Emergency department following a car accident. The patient has arrived, confused and bewildered, with a laceration. The physician examines the patient and performs a midlevel (99283) evaluation by documenting all orthopedic, neurological and laceration procedures within the elements required to determine the level of service. The physician charges an Evaluation and Management and then subsequently performs an intermediate laceration repair to a 3cm laceration. It is important to note that the physician has identified a separately identifiable service from the E/M and went "above and beyond" in the documentation and service to qualify for the modifier 25.
- Coders code for the MD 99283-25 and 12032
- The coder assigns a 99282-25 for the facility and 12032

However, auditors reviewing the facility medical record note that the nurse performed a brief assessment, took vital signs, cleaned the wound and then applied a dressing to the site and provided home-going instructions. Auditors concluded that a separate E&M service was *not separately identifiable* and the monies were recouped. Guidance is clear that modifier 25 must have documentation that it was separately identifiable and went above and beyond what is customary for pre- and post-procedural care. Were they wrong? Are you at risk for this?

Regulatory Guidance for use of Modifier 25:

Transmittal A-01-80—http://www.cms.hhs.gov/Transmittals/dow nloads/A0180.pdf

Medlearn Matters MM5025 (Physician Guidance)—http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5025.pdf

Transmittal A-00-40—http://www.cms.hhs.gov/transmittals/downloads/A0040.PDF

OIG Report on Modifier 25—http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

In a 2005 OIG review it was stated:

"Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. Medicare should not have allowed payment for these claims because the E/M services were not significant, separately identifiable, *and above and beyond the usual preoperative and postoperative care associated with the procedure*; or because the claims failed to meet basic Medicare documentation requirements."

To mitigate your compliance risk, only anatomic modifiers (RT, LT, 50) or professional designation (GP, GN, GO) should be hard coded within the CDM. And no modifiers that require additional supportive documentation, or are in nature variable (such as modifiers 25, 59, 73, or 74), should be contained within the CDM.

Prosthetic/Orthotic Devices versus DME

Most CDM professionals struggle with the inclusion of certain items in the CDM. Are they supplies, prosthetic/orthotic (P/O) devices or DME? General supplies carry an ancillary revenue code of 027X. Ancillary supplies should never be used for things that are integral to the inpatient room and board such as charges for specialty beds, telemetry, etc.

The P/O devices represent separately reimbursable supplies for Medicare and should be represented utilizing revenue code 0274. They are characterized by the use of "L" HCPCS codes and are frequently missing from the CDM. If present within the CDM, they are generally found to have incorrect revenue codes or to be missing the "L" HCPCS code that is required. The P/O devices are not considered DME if they require a license in order to provide and charge.

Medicare Claims Processing 100-04, Chapter 20, § 10

"…and hospitals bill the FI for prosthetic/orthotic devices, supplies, and covered outpatient DME and oxygen (refer to §40). The HHAs may bill Durable Medical Equipment (DME) to the RHHI, or may meet the requirements of a DME supplier and bill the DME MAC. This is the HHA's decision. Fiscal Intermediaries (FIs) other than RHHIs will receive claims only for the class "Prosthetic and Orthotic Devices."

The "L" HCPCS codes should be obtained directly from the vendor and compared to the HCPCS coding guidance to ensure accuracy. Your CDM should contain P/O devices especially in Physical and Occupational Therapy, the Emergency departments, and some specialty clinics.

> With hard coding, there is a lack of the safety net that soft coding provides.

P/O devices must accompany the correct CPT codes and NCCI edits must be followed. The risk is that missing these items will result in lost charges.

Splinting, Casting, and Strapping services represented by the CPT 29XXX series should not be charged in addition to the "L" codes as they include the fitting and adjustment.

Common P/O Devices include:

- L1830 Knee orthotic (KO), immobilizer, canvas longitudinal, prefabricated (includes fitting and adjustment)
- L0120 Cervical, flexible, nonadjustable (foam collar)
- L0172 Cervical, collar, semi-rigid thermoplastic foam, 2 piece—Philadelphia collar
- L1901 Ankle orthotic, elastic, prefabricated—e.g., neoprene, Lycra (includes fitting and adjustment)
- L1930 Ankle-foot orthotic (AFO), plastic or other material, prefabricated (includes fitting and adjustment)

DME is commonly found within the HCPCS series labeled as "E". The list of items includes crutches, walkers, and canes. The provision of these items and billing of Medicare and/or a Medicare beneficiary requires a DME license or certificate to dispense. These DME items are frequently found in the CDM with supply revenue codes and are charged as if they are supplies. This should be considered a high-risk area when you have any DME items within your CDM.

Revenue Code Application

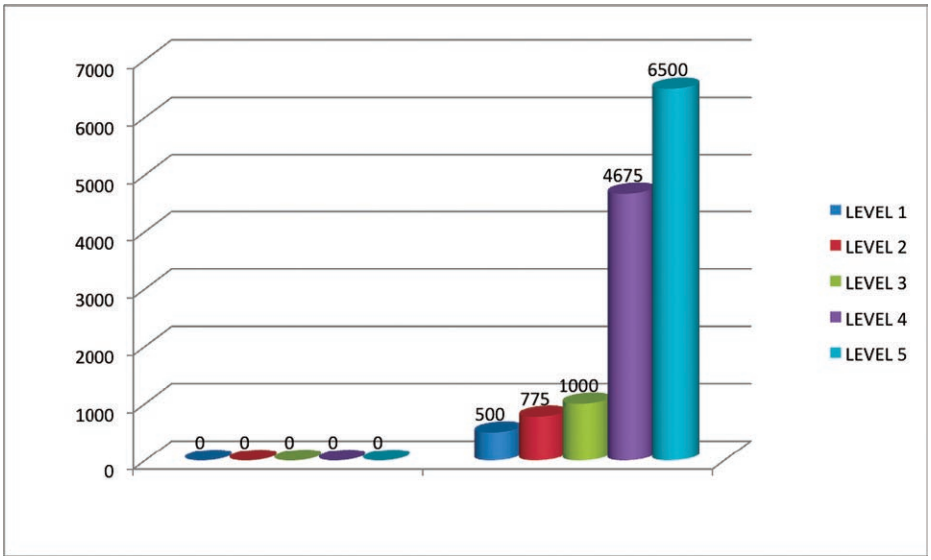
Revenue codes are four digits defined by National Uniform Billing Committee (NUBC). For Medicare OPPS there is a crosswalk to the cost centers for the cost report which can be viewed at http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage. Revenue codes are also important to ensure accurate reimbursement.

The following quote explains the importance of revenue code to cost-to-charge ratio and provides further detail concerning appropriate revenue code assignment:

"This mapping indicates if and how charges on a claim are mapped to a cost center for the purpose of converting charges to cost. Every active revenue code is listed on the spreadsheet. If the revenue code is not used in OPPS median calculation, "N" appears in Column C, titled "Used in OPPS". If the revenue code is used in OPPS median calculation, "Y" appears in Column C. One or more cost centers are listed for every revenue code that is used in OPPS median calculations, starting with most specific, and ending with most general. CMS maps the revenue code to the most specific cost center with a provider-specific CCR. If the hospital does not have a CCR for any of the listed cost centers, the overall hospital CCR is the default."

The following revenue codes, when billed under OPPS without HCPCS codes, are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819 and 0942.

Figure 1: XYZ Emergency Department 2008



Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. Return to provider (RTP) any claims that contain revenue codes that require a HCPCS code when no HCPCS code is shown on the line. [A-03-035, CMS Transmittals, May 2, 2003].

Revenue codes that package when assigned with an HCPCS that are separately payable can cause reimbursement errors. Inappropriate assignment of revenue codes can dilute your cost-to-charge ratio. Example: Using 0361 (minor surgery) for procedures that are truly small and done in a treatment room, which is better represented by revenue code 0761.

Use of CDM for Statistics

Many finance personnel use the CDM for purposes of budgeting, FTE acuity, and variable staffing statistics. This can take away from the primary purpose of the CDM in charging and billing, however. An example of this is using the CDM for purposes other than accurate charge capture, such as using CPT codes (such as E/M for respiratory assessments) to capture "work statistics."

The problem with the use of the CDM for statistics is that they frequently and inadvertently are charged and billed for reimbursement. There is usually no substantiating documentation of services rendered. It can encourage staff to perform services that are not required just to "validate their jobs." This is being seen more over the last three to five years since operating margins are decreasing. This is high risk, since it amounts to charging for services without medical necessity for the purpose of gross revenue production and statistics, without meeting billing/coding regulatory requirements or medical necessity.

Determine Your RAC Risk Areas

- Pull volume and usage statistics from the CDM
- Organize these from highest volume to lowest volumes
- Focus on your top 50 procedures
- Always include the E/M codes whether in your top 50 or not
- 99201-99215, 99281-99292

Focus on your E/M services. Look for volumes that demonstrate shifts to the right or left compared to national values.

Example (XYZ Emergency Dept 2008):

99281—500 visits

99282—775 visits

99283—1,000 visits

99284—4,675 visits

99285—6,500 visits

Let's note the following items about the XYZ hospital and E/M services:

- Skewed to the right
- No bell curve
- As compared to national average more levels 4 and 5
- Can catch this in "automated RAC" evaluation
- Might see this also in a specialty hospital where specific visit types exceed the average for the nation

Review the Risk Areas

Example: Wound Care

Look at wound care procedure volumes. Then look at the E/M visit volumes. Do they come close in numbers? If the answer is yes, then the department may be assigning E/M services with a planned procedure. If the answer is no, then there is limited risk.

Also, compare the total visits to the facility's wound care clinic to the volumes in the CDM. Do they match? Does any one procedure or group of procedures constitute the majority of the examinations? Are nurses performing CPT codes that are for sharp debridement? Are therapists performing vacs that need to be under a therapy plan of care?

Tools to Prepare

CDM Volumes—Get the zero volumes out of the CDM

Abstraction Reports—Useful in determining procedures performed with soft coding

Department Review—Have departments look at CDM volumes with the audit staff and identify any that look out of alignment with clinical practice patterns

Data Mining

Use your CDM for data mining. It is the most likely cause of 'pattern of behavior' errors, such as units of service. Also, be leery of 'explode codes.' These can create patterns of behavior for charging convenience of the front-end staff that ultimately create billing errors and recoupment in the final analysis.

Conclusion

The chargemaster represents an incredibly valuable asset to help ensure that your healthcare facility is optimizing its operations and reaching toward the revenue integrity ideal of 'billing

and being reimbursed for every penny earned and not a penny more.' However, a poorly maintained CDM can also represent your worst liability, creating patterns of inaccurate billing and reimbursement that can put your facility at increased risk and thereby affect the bottom line adversely. Use your CDM to data mine and conduct self-analyses before one of the many recoupment audit programs finds the errors instead. Such an event will impact your financial health through recoupment, fines, and penalties. **NP**

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You're the only one who can make the difference. Whatever your dream is, go for it.
~Earvin Magic Johnson