A Perfect Charge Description Master Isn't Enough

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What happens when you cross a perfect Charge Description Master (CDM) with imperfect charging processes in your clinical departments?

You lose money. Often lots of it. Conversely, you may get paid too much and run the risk of having to self-report overpayments or even deal with the OIG. Or, you simply are charging for services you shouldn't even if no additional payment is received from Medicare, which can result in an overstatement of charging.

What's the solution? The best way to address this challenge is to integrate outpatient charge capture reviews with the CDM management function.

Your CDM is perfect!

You employ motivated individuals who are highly skilled in coding and have strong interpersonal skills. You are doing everything according to best practices. In addition:

- You use an electronic resource to help ensure the right codes are used and prompt you to check for other charges.

- Your CDM manager meets with each clinical supervisor to make sure every charge requiring a HCPCS code has one that correctly reflects the service provided, is accurate, and is applied and updated in accordance with regulatory guidelines and updates.

- All your revenue codes are correct.

- Your CDM manager works closely with the CDM committee and Compliance Director.

- You have charges in your CDM for everything you can think of and they all make sense.

- Your finance department has policies in place to establish prices.

- Your Business Office no longer assigns CPT codes and modifiers on their own to get charges through the Medicare edits.

- You check to make sure your charges are consistently passing your Medicare edits.

- You assess the accuracy of your outpatient payments.

What's left?

That's all great, but is it enough? Have you done everything you need to do to make sure you are paid correctly? The answer is a resounding "No." The CDM is just one piece in the revenue cycle. CDM management and clinical department charge processes fall into the Middle process, between the Front End (often referred to as Patient Access) and the Back End of the Revenue Cycle, including billing, denials and collections.

What lurks between

Consider the following scenario. You are the hospital CFO. Your hospital handles the billing for the technical and professional components for all radiology services, except for CT Scan where the professional component is billed by the CT Scan physician group. Your Radiology Department Administrator works closely with your CDM manager and tells you everything related to coding and charging is fine. The August radiology statistics indicate that the volume for CT department activity has increased, but revenue dropped significantly. Your department director looks into this. By the time she gets back to you to let you know that she is as puzzled as you, September's statistics are out and you see the same issue. So what

is happening?

- Here is the answer: The Medical Director for Imaging Services has been receiving over-utilization notices from a major payer regarding his physician group's claim submissions for CT Extremity Angiography. To deal with the notices, he instructs the lead CT tech to charge only for a CT Extremity whenever a CT Extremity Angiography is performed. Unfortunately, the lead tech does not inform the hospital's Radiology Administrator of the requested change, and the Radiology Administrator cannot inform the CFO.

- The CT department performs about 500 CT Extremity Angiographies per year at $3,200 per procedure (as opposed to $1,800 for a CT Extremity). As a result, the hospital's annual gross charges decrease by roughly $700,000.

The above scenario is only one of many occurrences in clinical departments that can significantly affect revenue.
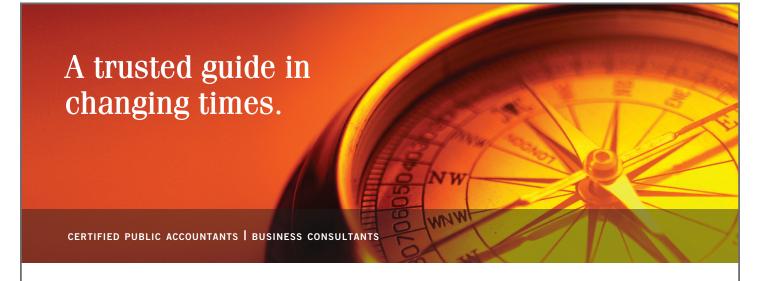
Outpatient charge capture reviews

Best practices to ensure appropriate charging, billing and payment include the performance of charge capture reviews or audits. The CDM management department is usually the most practical resource to do this. Effective review processes should be established and consistently performed. Results should first be reported to the Compliance Director in the event seriously non-compliant events are discovered. Results should then be reported to financial management and the CDM management committee.

What's left – in a nutshell

In today's environment, it is important to realize that an effective charge capture review consists of more than confirming the effectiveness of Patient Access processes; a great CDM; and best practice back end billing and collection processes. Hospital clinical departments are often home to elusive, behind-the-scenes issues that can significantly impact the hospital's bottom line and should be addressed in all charge capture reviews.

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