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Operating Room Implications for CDM

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Agenda

Today we will cover:

- Review Charge Capture Process in OR
- Preference Cards and the CDM
- Mapping a key element to success
- Identify high-cost items of leakage
- Use of software to ensure all opportunities are reconciled

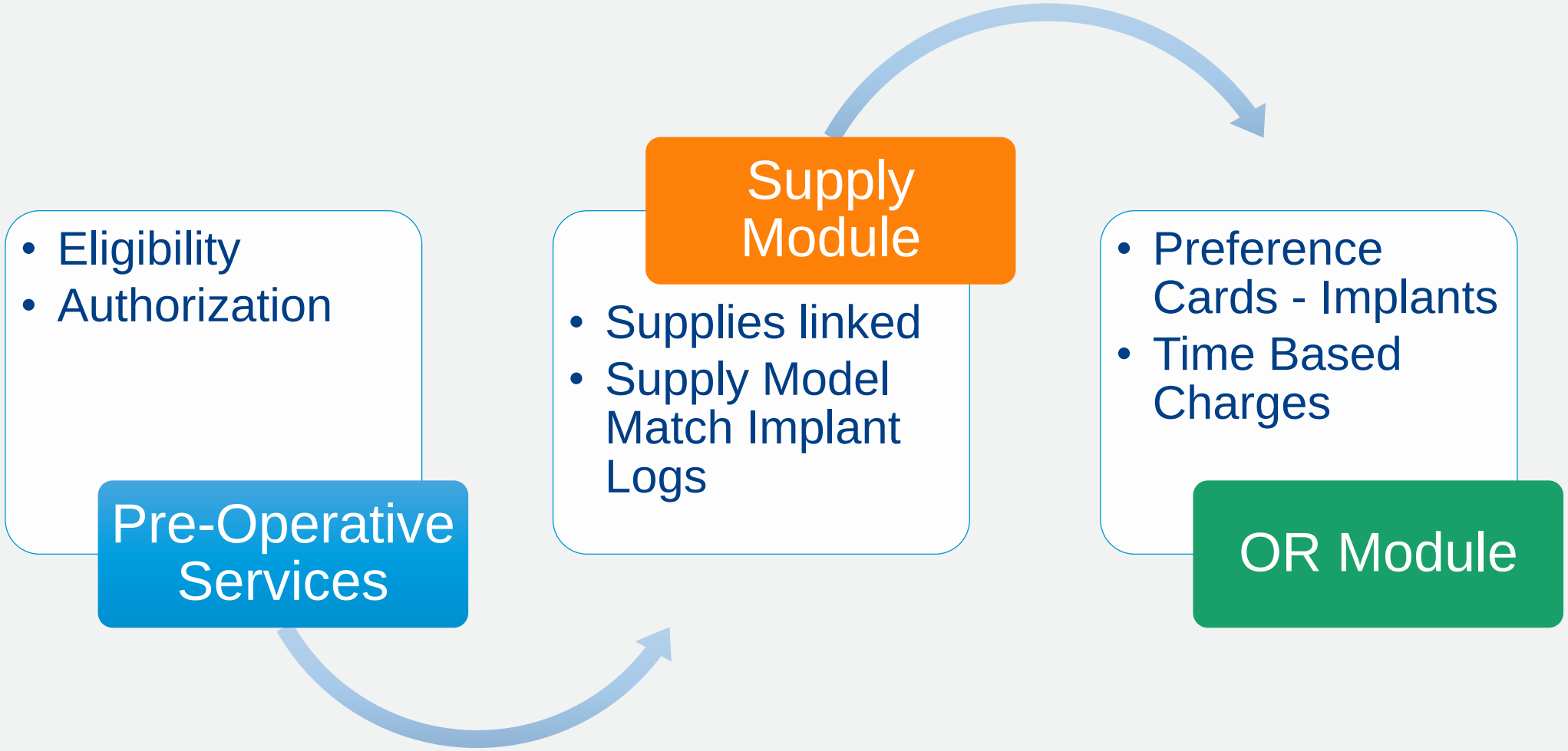
Objectives

Today we will cover:

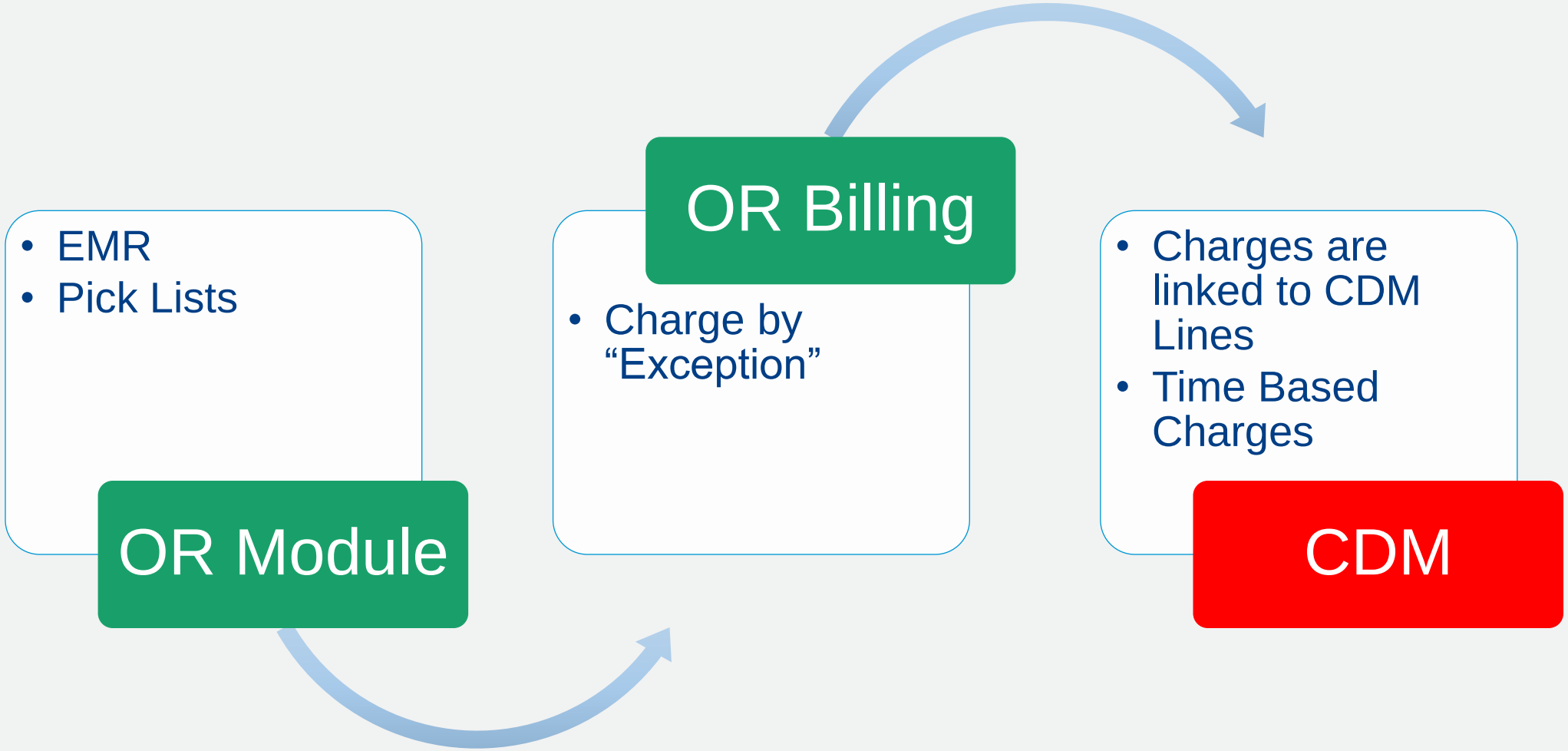
- Understand the overall OR charge capture process
- Be able to identify mapping considerations
- Be able to state why preference cards play such an important role
- Understanding supply coding implications

Overview of Charge Capture

Charge Capture Flow in OR



Charge Capture OR to CDM



Surgical Scheduling is Key

Setting the Stage for Success Begins in Surgical Scheduling & Pre-Op

- **Key elements that can cause a claim to fail payor edits are:**
  - Lack of eligibility
  - Lack of authorization for a service or incomplete authorization
    - Authorization must be for the most extensive procedure
    - Must be specific to the date being performed
    - Needs to be confirmed PRIOR to getting the patient in the room
  - Failed demographics
    - Can result in claim error or failure to process at payor
    - Revenue Cycle Intelligence quotes in their article these can be as high as 25% (1 in 4)

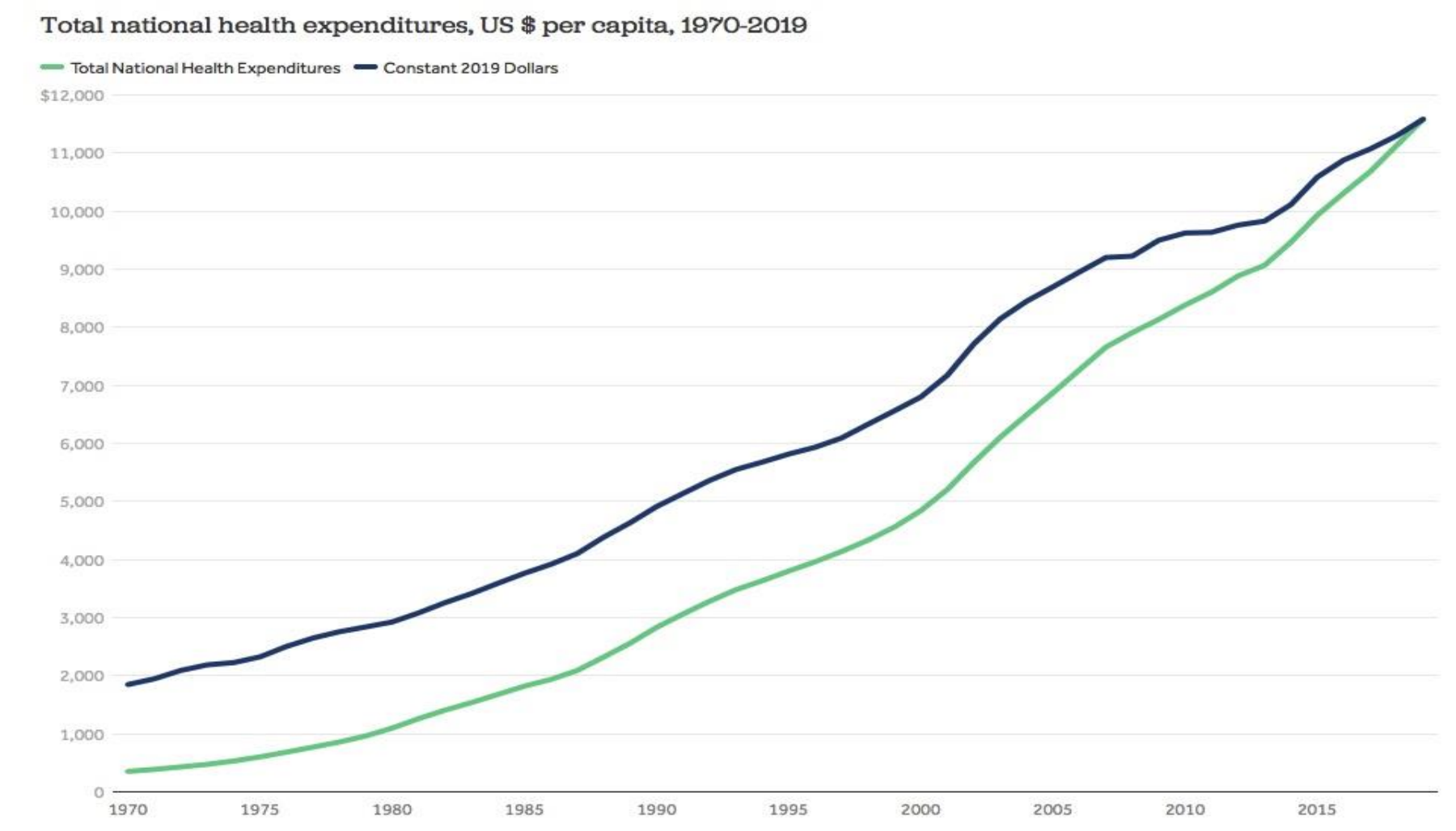
Keys to Success

- OR desk should confirm that an authorization has been obtained and recorded in the record PRIOR to the procedure
- If no authorization is required then no action need be taken
- If authorization is required that should be reviewed in pre-op to determine if it is current, for the date of the surgery and for the procedure(s) stated on the schedule to be performed

Cost Management Becomes Priority

Why Cost is a Focus Post Pandemic

https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_3



US Costs Vs. World

https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-spendingcomparison_gdp-per-capita-and-health-consumption-spending-per-capita-2019

“Charge” Description Master vs. “Cost” Description Master

- With spending at an all time high
- Post pandemic influences
- Seeing a move of charge to value
- Price Transparency initiatives
- The “charge” description master now serves to move more toward “cost” description master
- Many facilities are employing cost accounting software to be able to provide the resource cost of a service
- Costs can be then reflected on the CDM individual lines

Charge Capture in 2021

- **Charge capture in 2021**
  - Make sure root causes of leakage are remediated
  - Try to control costs associated with patient care
  - Many of the charges are not reimbursable but the cost still exists diminishing the bottom line
  - Facilities are looking at controlling practice patterns and supply chain to ensure costs are addressed
  - The new definition
    - Charges – Cost = Revenue
    - Charges reviewed for lost charges
    - Cost reviewed for overutilization and practice patterns

OPPS Packaging Focuses on Cost

- Packaging also encourages hospitals to effectively negotiate with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care delivery. **Similarly, packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources**. Packaging payments into larger payment bundles promotes the predictability and accuracy of payment for services over time.
  - [OPPS Final Rule Federal Register/Vol. 84, No. 218/Tuesday, November 12, 2019/Rules and Regulations 61173]

OR Charge Capture

What Can You Charge For

- **In a facility there are five major buckets that you can charge for:**
  1. **Procedures** (generally 10,000 – 69,999 CPT codes)
  2. **Services** (lab, radiology, medical procedures and E & M – CPT 70,000 – 99,xxx)
  3. **Pharmacy** (generally 250, 255, 636 – J codes and 637 revenue codes)
  4. **Supplies** (generally a HCPCS code or revenue code 27x)
     - In addition for inpatients room and board as designated by room type revenue code
- **In all cases the CDM must contain a line item to charge for the item or even with a CPT code on the claim you might miss revenue earned (especially for commercial payors)**

Focus on Supply

- Supplies represent a large percentage of the institution cost to provide services
- Seldom separately reimbursed
- Preference card(s) that are not accurate, current or contain the correct supply information will translate to lost charges or overcharges
- Supply items not in the CDM but on the preference card can lead to systemic failures

Preference Card Literature Review

- The healthcare supply chain is of critical importance in managing costs, as supplies make up almost 20 percent of U.S. hospital expenses.
- Moreover, as Cardinal Health found previously, the supply chain loses $5 billion in high-value medical devices annually for healthcare systems
  - *Cardinal Health Supply Chain Survey Data conducted Oct-Nov 2016 by SERMO*
- Since 2017 these costs continue to rise and the complexity of the electronic supply chain is growing with it allowing for a greater margin of inaccurate charges

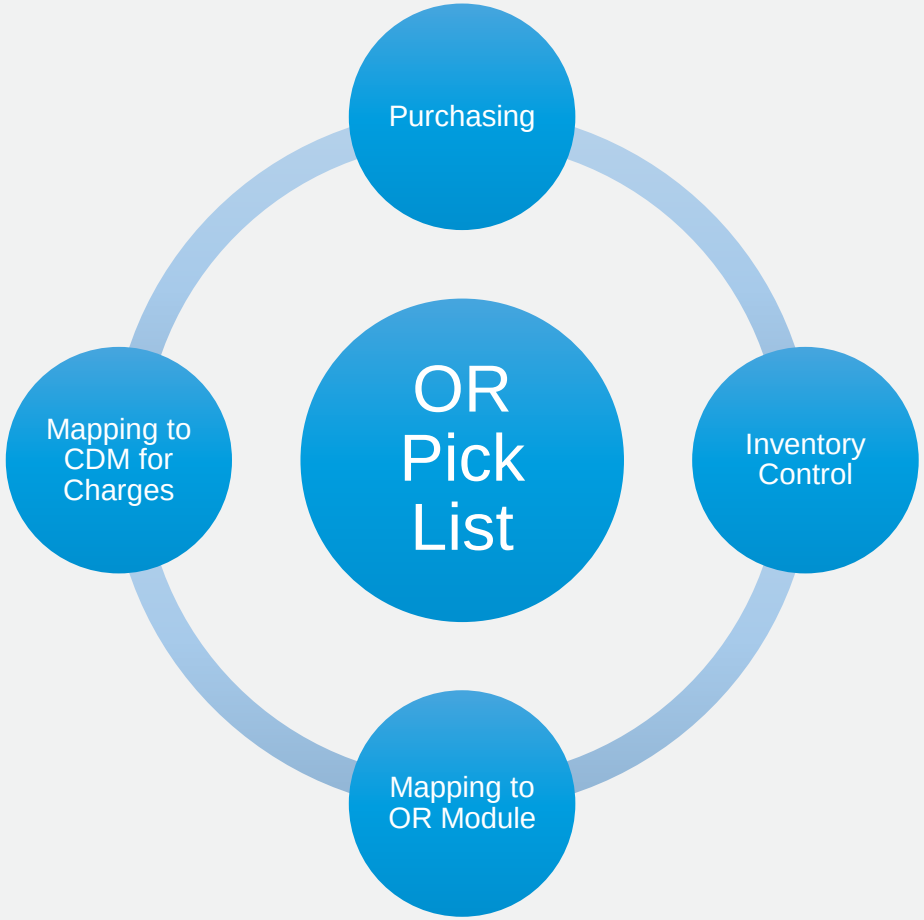
Preference Card Literature Review

- "...studies have found that an estimated $5 billion per year is wasted on supplies due to inaccurate and outdated preference cards
- Preference cards generally contain 20-40% more supplies than are actually required for a given case
- Typically, there is a reported waste of $50 to $150 per case of opened, but unused disposable supplies; however, one study found an estimated average disposable supply waste of $968 per neurosurgery case"
- https://www.operativeflow.com/blog/2020/1/21/inaccurate-preference-cards-amp-disposable-supplies-a-5-billion-per-year-problem

Supply Chain Mapping

- **Supply chain changes daily with**
  - Item
  - Make & Model
  - UNSPC
- **OR spends considerable time managing the supply chain within the OR**
  - Much of which is manual
- **It is essential that the supply utilized is in fact the supply coded and charged**

OR Supply Chain Coding and Billing



Mapping Between Modules Critical

- **Mapping between the supply chain and the OR must be meticulous**
- **More and more Bar Coding and/or RFID identification of the supply is part of the newer supply chain systems**
  - Example are RFID enabled supply cabinets
  - Bar coded individual packs and disposables
  - Goal to minimize theft and loss from opened but not utilized items
- **Using these methods to “connect” the item to the the preference card item is the first mapping critical step**

From Pick List / OR Module to CDM

- This step is essential to ensure the proper “charge” is placed on the claim at the proper charge amount
- Due to the volume of items and item model and vendors changing this is generally handled within the “supply chain”
- ***Concern: Supply chain may not have HCPCS coding experience***
- CDM will need “experts” who may come from supply chain that have the ability to research and find the most correct code

From Pick List / OR Module to CDM

- **CDM team should have personnel who can manage both the procedural coding, level charging and supply coding**
- **Many claim edits match the supply HCPCS code to the procedure and vice versa**
  - These edits will “stop the claim” before it goes out to ensure that the charges are accurate
  - Most of these edits trigger because the supply code is inaccurate and therefore an inaccurate claim
    - Example: Dual Chamber Pacemaker Insertion and the device is coded as a single chamber pacemaker.

OR and the CDM

Charge Master

- **The OR CDM and requisite internal mapping between modules represents one of the facilities largest challenge**
- **CDM must be current and accurate and will require a team:**
  - Surgical scheduling
  - Finance / Reimbursement
  - CDM team
  - Supply Chain
  - IT (representative of each module that will link to CDM)

Charges

- **Charge lines within the CDM must be set up for:**
  - OR Levels or Procedure Codes (individual)
  - Anaesthesia charges
  - Supplies
  - PACU
- **OR levels are created according to a mechanism**
  - Number of nurses in the room
  - Equipment included
  - RVU weight
  - Other

Anaesthesia

- **This area of the CDM is straightforward**
- **Revenue code 0370**
- **Place a charge on the CDM line**
- **There is no requirement for a HCPCS / CPT code for hospital billing for Medicare**
  - Note other payers may differ but the majority follow Medicare
- **Pharmaceuticals can be charged under revenue code 0250 (general pharmacy), 0636 (drugs of detail) or 0370 (anaesthesia)**

Anaesthesia

- **Inhalation agents have characteristically created a charge conundrum**
  - The bottle of sevoflurane, isoflurane etc. should be charged to the anaesthesia department and the cost passes on the charge
- **Charges are generally “per minute” and should be based on the time that anaesthesia personnel began any care and when they sign the patient into PACU**
  - Generally will not be the same as OR time in and out.

CDM Management for OR Level

- **OR levels will include:**
  - Individual CDM line
    - Description
    - Revenue Code (4 digits)
    - Charge
    - No CPT / HCPCS code
  - CDM line for the OR level allows for the CPT / HCPCS code to be applied by the coding professionals
  - Will merge the coded service(s) with the line for the charge at time of claim creation

Time Based

- **OR levels are time based**
- **It is very important to front end load the cost of the resources to be able to set the room up and get the case going**
  - Generally first 15 minute charge
  - Highly weighted in terms of patient charge
- **Additional time can be either in minutes (easily created by the system) or in any other increment deemed sensible**

Procedural Based CDM

- **Procedural based CDM for the OR will:**
  - Have an individual CDM line, CPT code/HCPCS Code, revenue code an patient charge.
  - Utilized by HIM who will determine the best code(s) from the operative report
  - HIM will select the CDM line that matches the procedure code determined from the record
- **This method will provide a charge specific to the CPT code rather than a level charge – NOT TIME BASED**
- **This will require that CDM be created with the full involvement of HIM and Finance**

Supply

- **As discussed previously supply creates unique requirements**
  - Pick list must reconcile with the supply chain
  - Pick lists should be reviewed with the surgeon to alleviate any potential items that are not necessary at the time of the case
  - Pick list create a source of costs for supplies not utilized
  - Pick list should then be reconciled to ensure that each item matches the CDM line assigned to it
  - CDM must contain current data to create the HCPCS code most specific to the item

High Cost Items

- **OR is the one department where high cost supplies and devices reside**
  - Cardiovascular
    - Pacemakers
  - Orthopaedics
    - Joint Implants
    - Screws / Plates
  - Neurosurgery
    - Neurostimulators
- **Devices charged should be in the implant log and reconcile to HCPCS codes charged**

Device Look Up by Make and Model

Model Number	UPN	GTIN	Device Name	Manufacturer	Manufacturer Subdivision	CPT/HCPCS
338171			Belos DR-T Cardioverter-defilbrillator, dual chamber (implantable)	Biotronik		C1721
344129			Belos DR-T Cardioverter-defilbrillator, dual chamber (implantable)	Biotronik		C1721
342873			Belos VR Cardioverter-defilbrillator, single chamber (implantable)	Biotronik		C1722
342874			Belos VR-T Cardioverter-defilbrillator, single chamber (implantable)	Biotronik		C1722
344131			Belos VR-T Cardioverter-defilbrillator, single chamber	Biotronik		C1722

Knee Joint by Make and Model

00-5790-020-00	M/G PRECOAT UNI KNEE FEM,MED-LT/LAT-RT, 42MM A/P	Zimmer Biomet	C1776
00-5790-022-00	M/G PRECOAT UNI KNEE FEM,MED-LT/LAT-RT, 44MM A/P	Zimmer Biomet	C1776
00-5790-024-00	M/G PRECOAT UNI KNEE FEM,MED-LT/LAT-RT, 47MM A/P	Zimmer Biomet	C1776
00-5790-026-00	M/G PRECOAT UNI KNEE FEM,MED-LT/LAT-RT, 50MM A/P	Zimmer Biomet	C1776
00-5790-028-00	M/G PRECOAT UNI KNEE FEM,MED-LT/LAT-RT, 52MM	Zimmer Biomet	C1776

PACU

- **PACU tends to be generally represented by a time based methodology, similar to OR**
- **CDM will have time based lines using revenue code 0710 and a charge. PACU does not generally have a HCPCS code as it is a packaged service with the OR**
- **PACU can also serve as a medical unit to perform procedures that require sedation safely**
  - Ex: Electroconvulsive Therapy (ECT)
  - Minor surgical procedures

PACU

- **It is essential that CDM meets with the PACU team and ensures that all procedures, not just recovery services are reconciled with the CDM**
- **CDM team should consult HIM to obtain an abstract of anything performed in PACU**
- **PACU also lends itself to a time based minor procedure level that would allow for the charge for the service.**
  - It is important to use 0761 or 0361 for these services as 0710 is a packaged revenue centre.

Summation

Summary

- Cost post pandemic will become a key concern
- First priority for reimbursement will be to achieve the eligibility and authorization requirements of the payer
- Complex interactions between patient access, EMR, Supply Chain, OR module, Chargemaster and Billing can create many opportunities for mapping failures

Summary

- Supply chain and CDM must work as one team and many facilities now include a CDM person within the supply team
- Supply represents the biggest risk of incurring a cost without corresponding charge leading to significant charge leakage
- CDM is essential in putting the charges through accurately so that there is no delay in reimbursement
- Edits should be in place to ensure that every OR charge has corresponding Anaesthesia and PACU charge

Questions?

Thank you!