



Auditor's Corner

Volume 1, Issue 6
December 2007



Happy Holidays!

“The key to improving charge capture and reducing the revenue loss is to insure that proper charging protocol is being followed initially.”

Quote of the Month

“There’s no thrill in easy sailing when the skies are clear and blue, there’s no joy in merely doing things which any one can do. But there is some satisfaction that is mighty sweet to take, when you reach a destination that you thought you’d never make.”

-Spirella

How to Improve Charge Capture

How to improve charge capture...

One of the common causes of overlooked revenue is related with missed charges. These are charges related to supplies, devices, services and procedures that were rendered but never billed. Missed charges may prevent the hospital from accumulating enough dollar value to hit an outlier, which also results in missed revenue opportunities.

The key to improving charge capture and reducing the revenue loss is to insure that proper charging protocol is being followed initially. There are several ways to identify where charge capture needs to be improved.

Staff Education: Having dedicated and knowledgeable staff will go a long way toward improving charge capture, especially for clinical staff. Nurses are trained to care for patients but no one has really taught them details about charges and why it is so important to document proper charges.

Audit Department: Creating a separate revenue and audit department staffed by an experienced nurse auditor with strong clinical and billing experience to look for charge capture issues on a daily basis. As well as meeting with department managers to determine cause for over and under charges and corrective actions that will

need to be taken by the departments to rectify proper charges.

Concurrent Audits: Hospital should develop a program to perform concurrent audit (complete audit on non-disputed accounts within 30 days of patient discharge). The sample must include both inpatient and outpatient accounts.

Focus Audits: Every so often hospitals should perform audit or charge capture review on revenue generating departments. Such as pharmacy, radiology, OR, ER. Based on each hospital, departments that are going to present the greatest opportunity for missed charges are going to vary.

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Transplant

On March 30, 2007 the Department of Health and Human Services (DHHS) established regulation authorizing the survey and certification of transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for monitoring compliance with the Medicare conditions of participation. All hospital transplant programs covered by the regulation, whether currently approved by CMS or seeking initial approval, must submit a request for approval under the new regulations to CMS by December 26, 2007 (180 days from the effective date of the regulation.) Visit: http://www.cms.hhs.gov/CertificationandCompliance/20_Transplant.asp in order to view Download Section for a list of all transplant programs covered by the regulation and a listing of the minimum information that must be included in all requests to CMS for approval of a transplant program.

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How to Improve Charge Capture (cont. from pg. 1)

Charge Protocol: Maintaining and developing charge protocol and policies in all revenue producing departments in order to insure proper implementation of all corporate charge protocols are in place and are being followed.

Charge Audit Committee: Hospital should designate a formal Chart Audit Committee attended by Chief Financial Officer, Nurse Auditor, Patient Financial Manager, Business Office Manager and Department Directors. This committee which should meet

monthly to review monthly summary of the audit findings by the nurse auditor and address the trend of over and under charges and discuss corrective action that will need to be taken by department managers with excessive errors.

In the end whether the solution involves instituting new procedures, improving staff education, implementing concurrent and focus audits, the benefits are obvious. Accurate charge capture means improving cash flow which translates into increase revenue for the facility.

— Julie Doumad RN, BSN, CMAS

Director of Audit Services

[\(American Healthcare Audit Professionals, Inc.\)](#)



Transplant (cont. from pg. 1)

CMS will review the submitted information and conduct onsite surveys as necessary to determine compliance with the conditions of participation. Programs must be in compliance with the conditions of participation to continue Medicare approval or to receive initial approval for participation. Those programs that were already Medicare approved for participation at the time of the effective date of the regulation will continue to be covered under National Coverage Decisions or ESRD conditions for coverage (as applicable) until they are notified in writing by CMS of their approval or denial under the new regulations.



Medicaid Definition of Covered Case Management Services Clarified

The Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period (IFC) implementing section 6052 of the Deficit Reduction Act of 2005 (DRA) clarifies the Medicaid definition of covered case management and targeted case management (TCM) services. The rule includes measures to address concerns about improper billing of non-Medicaid services to the Medicaid program by some states, while also including significant beneficiary protections that ensure comprehensive and coordinated services to meet the needs of beneficiaries.

Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. “Targeted” case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness.

Widespread improper billing by states of the Medicaid program for services mandated by other programs helped prompt Congress to address the problem in the DRA, which redefined the scope of allowable case management services, strengthened state accountability, and required that CMS issue regulations.

Many accounts of inappropriate Medicaid billing of TCM services have been documented by the Government Accountability Office (GAO). In one investigation of TCM claims, GAO found that inappropriate billing to Medicaid generated an estimated \$12 million in extra federal funds to Georgia and \$68 million in extra federal funds to Massachusetts from 2000-2004.

Across the nation, total spending for TCM services jumped by 76 percent between 1999 and 2003 from \$1.7 billion to \$3 billion. GAO officials believe that some of this increase can be linked to a growing trend among states to hire consultants to assist in administering their Medicaid programs. In some cases, states will pay these consultants a contingency fee based on their performance in maximizing federal Medicaid reimbursement.

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American Healthcare Audit Professionals, Inc.

Toll Free: (888)-816-7758
Local #: (949)-448-8296
Fax #: (949)-203-2298
E-mail: info@ahapinc.com

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- InterQual Criteria Review
- Expert Witness Testimony
- Consulting Services for Attorneys & Healthcare Providers
- Worker's Compensation Reviews



Medicaid Definition... (cont. from pg. 1)

The IFC proposes certain refinements and clarifications to Medicaid's case management benefit that are expected to save the program \$1.2 billion over the next five years. At the same time, the rule ensures that Medicaid case management services include a comprehensive assessment and care plan that would not otherwise be available to beneficiaries. Further, the IFC clarifies that case management services include assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities. The IFC specifies that direct services, such as transporting a beneficiary to an appointment or accompanying a beneficiary to a court appearance are not allowable under the definition of the Medicaid case management or TCM benefit. MAJOR PROVISIONS IN THE FINAL RULE:

- Defines case management
 - o the IFC reiterates the definitions of case management and targeted case management services contained in sections 1905(a)(19) and 1915(g) of the Social Security Act; and
 - o the IFC ensures that case management services will be comprehensive and coordinated, and will include an assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities.
- Specifies and provides examples of excluded activities. The IFC excludes from the definition of case management services, activities that:
 - are an integral component of another Medicaid service;

- include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- constitute the administration of foster care programs;
- constitute the administration of another non-medical program such as guardianship, child welfare or child protective services, parole and probation functions, legal services, and special education (except case management included in an individualized education plan or individualized family services plan); and
- are claimed as necessary for the administration of the State Medicaid Plan.
- Defines the term "targeted case management services" as case management services that can be furnished to an individual, not necessarily to all persons eligible for TCM services
- states may "target" case management services to specific classes of individuals, or to individuals who reside in specified areas of the state.
- Clarifies when a case manager's contacts with individuals who are not eligible for Medicaid, or who are not included in the target population, may qualify as Medicaid case management services
 - contact with family members that are for the purpose of helping a Medicaid-eligible individual access services can be covered by Medicaid.