

## Supply Chargemaster HCPCS Data and Billing Requirements July, 2009

### The Issue

Health Care Procedural Coding System (HCPCS) Level II codes not only identify procedures and drugs, but also supplies, orthotic and non-implantable devices that may be used during a procedural service. If your facility is not billing medical supplies and devices with the appropriate HCPCS Level II codes, then you may be under-reporting your revenues, services and costs to both Medicare and other payers. These separately billable supply items frequently go unreported or inaccurately reported due to incorrect and/or incomplete facility/supply Charge Description Master (CDM) maintenance.

### The Impact

When supplies, orthotic and non-implantable devices are not being billed with the applicable HCPCS code and the appropriate revenue code, the resulting impact to your facility may be:

- **Missed gross and net revenue** – Reportable supplies should always be billed, even if there are no applicable HCPCS codes and/or there are no separate payments. Some HCPCS Level II supply items may be paid separately by Medicare contractors (i.e. orthotic items). Even though Medicare may not reimburse facilities for some supplies, other payers may reimburse items separately based upon the contractual terms and methodologies for supplies; therefore, charge capture for all supplies utilized during a procedure is necessary to ensure gross and net revenue accuracy.
- **Under-reported costs to payers** – Medicare and other payers collect precise utilization and cost data on the types and total number of supply items used for any given procedure. In addition, they may base future payments on this information. Reporting accuracy becomes a key component to ensure future positive payments for supplies, orthotic and non-implantable devices.
- **CCI edits and held claims** – *Procedure to Device* or *Device to Procedure* - Correct Coding Initiative (CCI) edits will persist and/or claims may be held/suspended or even denied if supplies are not reported accurately. For example, non-supply Level II code G0393 (transluminal balloon angioplasty, percutaneous, arteriovenous fistula or graft; venous) should be billed with device code C1725 (balloon catheter) as well as non-edit devices C1769 (guide-wire) and C1894 (introducer). Accuracy in reporting will ensure timely processing of facility claims.

### The Opportunity

The bottom line is that all billable supplies, orthotic and non-implantable devices should be reported separately with the applicable HCPCS code and/or the appropriate UB-04 revenue code in order to ensure reporting compliance, while also identifying potential reimbursement opportunities. It is essential you verify that your facility chargemaster is complete and contains the appropriate data on a routine basis. Failing to do so not only creates undue compliance risk, but may also cause unnecessary gross and net revenue shortfalls to your organization.

If you have questions regarding coding and reimbursement, or if you would like to discuss specific challenges related to your supply or facility chargemaster, please contact:

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