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Conducting a high value capture assessment

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Missed or miscoded charges and overcharges pose potential compliance risks and can have significant negative impacts on a hospital's finances. It is critical to ensure policies and procedures are enforced throughout the organization and key process owners understand their importance in the compliance and revenue recognition processes. Timely and accurate charge capture, as well as comprehensive revenue reconciliation and governance processes will help ensure compliance, address rework, and ultimately improve net revenue. Focused attention on charge capture functions typically will enhance revenues and margins, and effective internal controls lead to greater charging compliance.

The charge capture, charge master, charge posting, and revenue reconciliation processes are all critical elements of the overall provider revenue cycle. Without standard and reliable processes, poor coding and missed charges can affect healthcare organizations significantly, and overcharging is equally if not more detrimental than undercharging. To help mitigate risks associated with the various charge capture processes, routine reviews should be performed to assess the effectiveness and adequacy of key controls.

Medicare Recovery Audit Contractor (RAC) and Medicare Administrative Contractor (MAC) take-backs, additional documentation requests (ADRs), and forensic audits are all potential compliance risks that can significantly affect a healthcare organization's bottom line. Charge capture errors often lead to overpayments that must be reimbursed to the payer, and errors identified internally or by regulators are often associated with penalties, additional labor costs, and negative publicity.

The Department of Health and Human Service (HHS) Office of Inspector General (OIG) discovered billing noncompliance in 46 of 253 claims at a Missouri Hospital in 2011 and 2012,resulting in approximately $414,000 in overpayments.[1] The root cause for these overpayments related to inadequate internal controls for Medicare billing specifically related to insufficient documentation for billed procedures, incorrectly billed inpatient accounts, and manufacturer credits for replaced medical devices not being reported. The hospital refunded Medicare for 39 of the claims where it agreed an overpayment was made and went through the Medicare appeal process for the remaining seven.

Similarly, an audit of a Utah hospital revealed billing noncompliance in 49 of 232 claims, or approximately $173,000 in overpayments.[2] For the Utah hospital, the root cause for overpayments related to incorrect DRG assignments, as well as insufficient documentation for billed procedures, incorrectly billed inpatient accounts, and unreported manufacturer credits for replaced medical devices. Based on the results identified, this hospital created a corrective action plan to strengthen internal controls.

Based on the sample results, the OIG can and often does extrapolate an overpayment estimate for the audit period and applies that extrapolation to the entire population that could result in a significant amount of lost revenue. The time period used to determine the population often depends on how long it is believed that the

payment error occurred.