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White paper

Chargemaster maintenance ensures financial viability of hospitals

The quickly expanding role of the charge description master (CDM) has made maintaining it critical to financial success and a hospital's continued compliance with regulations. The chargemaster fulfills many needs. It is a revenue generator, a productivity tracker, a base for negotiating payer contracts, a tool for keeping abreast of competitors' services and, increasingly, a way to interact with patients through price estimation tools. The CDM is at the center of the revenue cycle, driving regulatory compliance, operational efficiency and accurate reimbursement for services rendered.

Gone are the days when a hospital could update its CDM once a year, typically with the annual coding updates effective every January. Even quarterly updates put facilities at increased risk of noncompliance with Medicare regulations, inaccurate or incomplete coding, increased claim edits and denials, and potential loss of revenue. Coding updates (additions, modifications, deletions), instructions and clarifications on proper reporting are released throughout the year, often at irregular and frequent intervals. For this reason, monthly or even semi-monthly updates to CDMs are ideal. Not only do they accommodate changes to codes and prices as they occur, but such frequent updates enable CDM personnel to make timely corrections, whether due to payer, government or hospital error.

The CDM is a list of the facility's billable services and items – from procedures and tests to drugs and supplies – and the CPT®/HCPCS (if applicable) and revenue codes necessary to submit claims to payers. The chargemaster associates each entry with a price and includes charges for items, such as room and board, observation stays and clinical services provided in facilities such as the emergency department and specialty clinics.

Accurate charge capture, which is a regulatory mandate and is vital to creating claims, requires that CDM personnel closely coordinate with the clinical departments providing the services. The chargemaster must contain all of the services, supplies and pharmaceuticals that departments provide to patients. The clinical documentation systems must have all the items in the chargemaster correctly crosswalked so that charge capture correctly reports the goods and services provided.

The CDM is at the **center of the revenue cycle**, driving regulatory compliance, operational efficiency and optimal reimbursement for services rendered.

Because comprehensive chargemasters can have tens of thousands of items, maintaining them manually requires an enormous amount of time, research and vigilance. In a manual environment, often the issues that arise from inaccuracies in the CDM are discovered after claims submission, and they are often not reported to CDM personnel to update the chargemaster to prevent recurrence. Since CDMs are used to generate all patient charges, small errors add up quickly in the form of compliance risk, rework related to edits and denials, and potential lost revenue.

For this reason, many providers use automated systems to maintain their chargemasters. Automation enables a facility to be proactive about updates and catch errors before claims are submitted, minimizing rework caused by the CDM. Considering the complexities of the various systems used to generate the final claim, a well-maintained chargemaster adds an element of much-needed stability, enabling the CDM to be eliminated as a factor, allowing targeted identification and correction of claim edits.

Whether done manually or through an automated system, CDM maintenance will ensure the following:

The CDM complies with all regulatory requirements. First and foremost, the role of the CDM is to minimize risk of noncompliance and government audits. Proper reporting is a CMS mandate.

Charges are captured for all procedures and services, ensuring proper reimbursement. The CDM is used to create an itemized statement of services and supplies provided, along with their charges, on inpatient and outpatient claims. Ongoing review with clinical staff providing the goods and services guarantees that all applicable charges are represented in the chargemaster and are available in the various charge mechanisms used in a facility (EHR, charge sheet, etc.).

Claim edits and denials due to coding errors are minimized. Up-to-date and complete codes with accurate descriptions, along with routine staff education and communication, mean less rework when it comes to claim edits and denial appeals.

Analysis of data compiled from the CDMs is based on accurate information. Facilities and practices can confidently rely on the CDM data to monitor the cost of care and compile cost accounting data for their financial systems.

To perform these tasks well, each element of the CDM must be current, accurate and complete. Each charge line item contains several pieces of information:

- Unique item number designated by the facility or practice
- HCPCS Level (CPT®) or Level II code
- Short description of the code
- Revenue code indicating the type/location of service
- Charge or fee
- Additional codes that could be used for specific payers
- General ledger number (department generating the charge)
- Applicable modifiers

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Action plan

Make sure codes are current and complete

It is clear to see that codes are essential to the integrity of the CDM. Even one missing or inaccurate code can have a profound impact on revenue when the omission or error is reflected on multiple bills over time. For example, an add-on procedure code may be available when the primary procedure code is not, or a separately reimbursable pharmaceutical might be reported with an incorrect HCPCS code that is not eligible for separate payment.

The first thing to do is to check that all billable goods and services provided are available to department staff (via the EHR documentation, paper charge tickets, batch charge entry, etc.) and map to the correct items on the chargemaster. For example, are unilateral procedures on the charge mechanism incorrectly mapping to bilateral codes on the CDM? Are infusions containing medication being charged as hydration?

Also, ask department staff about all the services they provide to determine whether some items are not represented in the various charge mechanisms. Perhaps these systems or documents need to be updated with additional codes or staff educated about what can and cannot be charged. Each department must have a charge policy that reflects current regulations and is readily accessible for the staff to reference.

The next step is to make certain that all the codes on the CDM accurately reflect the service they are associated with and are current. Also verify that no services and accompanying codes are missing from the chargemaster and that modifiers are included, when warranted. Keep an eye out for any line items without codes or with unlisted codes that should have specific codes assigned.

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Ensure only appropriate pharmaceuticals and supplies are charged

According to guidelines from the Centers for Medicare & Medicaid Services (CMS), pharmacy and supply items not considered to be separately billable generally fall into one of the following categories: personal comfort items, routine items, reusable equipment or incremental (bundled) services. Pharmaceuticals and supplies can be billed only when they are medically necessary, used for a specific patient, are not routinely part of a procedure or service, and are documented in the medical record.

Set defensible, reasonable prices, and review and adjust them regularly with patients, commercial and CMS fee schedules in mind

Price transparency is in the forefront of regulators' minds and is receiving nationwide attention from the press. Consumer watchdog agencies regularly highlight instances of seemingly exorbitant hospital charges, such as a $20 aspirin tablet, creating negative public sentiment. Pricing items too low can adversely affect reimbursement, while pricing items too high can result in patient dissatisfaction or disproportionate contractual writeoffs, and/or trigger various payer audits. CMS provides very little guidance on pricing besides stating that it should be reflective of resources used to perform the service. Do not forget to consider both direct and indirect costs.

Defensible pricing is becoming increasingly important to maintain patient and payer trust. Pricing should be thoroughly reviewed at least annually, including consideration of its relationship to work efforts, adherence to supply and pharmaceutical markup schedules, and defensibility.

Verify that more complex versions of a procedure have higher charges than those for the basic procedure. For example, a procedure with a biopsy should have a higher price than the same procedure without one. Procedures that can be performed on both the right and left sides should also have the same charge.

Keep an eye on units

It is important to work with clinical departments to understand which services and supplies are provided in particular units. For example, some drugs are administered in a high dosage while the code specifies a small dosage. In that case, multiple units of the code must be charged. A small slip-up in units reported can add up to significant over- or underpayments and potential fines or penalties.

Write billing descriptions that are patient-friendly

When possible, put billing descriptions into layman's terms so that patients can better understand their bills and compare services. Patients who understand CDMs are better able to research shoppable services and grasp the extent of their financial responsibilities. Hospitals that fine-tune their CDMs to account for market and regulatory pressures on charges can power their financial health through the next decade. If the past 10 years are any indication of the future, facilities can expect the heat from payers' and consumers' focus on costs and charges to intensify. A defensible CDM will keep hospitals from getting burned.

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