Chargemaster Nuts and Bolts

By Cathy Meeter, R.N. BSN CMAS

CDM Director, Sutter Health

Disclaimer

The comments expressed throughout this presentation are my opinions, predicated on my interpretation of regulations/ guidelines and my experiences.

Objectives

1. Define Charge Description Master (CDM) and its primary data elements.
2. Discuss the importance of the CDM in the Revenue Cycle.
3. Delineate who ‘owns’ the CDM and scope of responsibility.
4. Discuss the variability among payer billing guidelines.
5. Discuss key areas that should be reviewed.

What is a Charge Description Master?

The Charge Description Master (CDM) is *primarily* a list of services/procedures, room accommodations, supplies, drugs/biologics, and/or radiopharmaceuticals that may be billed to a patient registered as an inpatient or outpatient on a claim.

What is a Charge Description Master (*continued*)

- The core group of data elements that typically resides within a CDM are:

  -CDM numbers
  -Charge amounts
  -Revenue codes
  -Department numbers
  -GL numbers
  -Modifiers (hard coded)
  -CPT/HCPCS codes
  -Billing and/or charge descriptions

What is a Charge Description Master (*continued*)

- CDM number = unique identifier number assigned to a given line item in the CDM.
- Revenue code – a four digit numeric code established by the National Uniform Billing Committee (NUBC) that categorizes/classifies a line item in the CDM.
- GL (General Ledger) number = a number used for accounting purposes that directs the revenue to the appropriate department.

What is a Charge Description Master (*continued*)

- CPT/HCPCS code
  - Current Procedural Terminology (CPT) codes are maintained by the American Medical Association (AMA). These codes describe services, procedures and drugs. They are updated in January and July of each year.
  - Healthcare Common Procedure Coding System (HCPCS) is maintained by the Centers for Medicare and Medicaid (CMS). These codes describe services, procedures, durable medical equipment (DME), supplies, drugs, biologics, and radiopharmaceuticals. They are updated continually throughout the year.

What is a Charge Description Master (*continued*)

- Billing description = the description that appears on a patient claim. There may be an additional field in the patient accounting system for a charge description. Charge descriptions may have a longer string of characters and may be used for order entry. They should mean the same as the billing description.
- Charge amount = the dollar amount assigned to a CDM line item which will appear on a claim.

What is a Charge Description Master (*continued*)

- Department number = a number assigned to a particular department that denotes the area.
- Modifier – a two digit alpha or numeric character that can be appended to a particular CPT or HCPCS code to provide additional information about that code.
  - Hard coded modifiers can be placed into the CDM and will always be appended to the CPT/HCPCS code for that line item. Examples are the therapy modifiers of GO, GN, GP.
  - Soft coded modifiers should be appended to a CPT/HCPCS code predicated upon review of the medical record. Examples are modifier 59 (distinct service) and 52 (reduced service).

What is a Charge Description Master *(continued)*

- The CDM may also contain/be used for the following:
  - Statistical tracking line items.
    - Used to capture labor for budgetary purposes.
    - No dollars, CPT/HCPCS or revenue code attached.
  - Payment and adjustment codes.
  - Database.
    - For financial, managed care and other analysis.
    - For submission to OSHPD.
  - Private pay services.
  - Other.

How Important is the CDM?

- The CDM is integral to a hospital’s revenue cycle.
  - It is the ‘backbone’ of reimbursement providing many of the necessary data elements for compliant claims submission.
  - AR days can be maximized with accurate CDM data.
    - Decrease/eliminate edits.

Who Owns the CDM?

- It is recommended that a team approach be taken to ‘manage’ the CDM with participants including but not limited to:
  – Billing/Business Office/Patient Financial Services.
  – Health Information Management.
  – Managed Care.
  – Compliance.
  – IT.
  – Department managers/directors from the various service areas that generate charges.
  – Physicians who are responsible for creating and reviewing medical protocols (ad hoc).

CDM Team Responsibilities

- Keep abreast of new/changing regulatory/ contractual issues.
- Assess how the new/changing regulatory/contractual issues impact the CDM.
- Implement necessary updates/changes to the CDM, order entry feeder systems, charge tickets, interfaces and <u>*educate appropriate staff*</u>.
- Evaluate/reassess updates/changes.
- Develop policies and procedures.

Variable Payer Guidelines

- The choices are:
  - Charge and bill all payers the same or
  - Charge and bill non-governmental payers for those services deemed non-billable to Medicare.
    - If you choose the latter option, it is highly recommended that you engage legal counsel to research any potentially adverse impact from this decision in terms of Cost Reporting (determining ratio of beneficiary charges to total charges, issues with apportionment, etc.) **<u>and</u>** contractual language with non-governmental payers.

Beyond the Chargemaster Flat File

- An accurate, up to date chargemaster in and of itself does not guarantee accurate claims submission. It is only a beginning point.
- There are many issues associated with creating, maintaining and utilizing a CDM. The following slides will list areas you should consider reviewing at your facility.

CDM Line Item Size

- Reduce the size of your CDM by periodically removing zero volume/zero revenue line items.
  - Before inactivating a line item, obtain approval from the department first in case the item was recently added or is used infrequently.

Supplies

- Eliminate routine (not billable) supplies and equipment and bundle the cost into the daily R & B or procedure charge.
- Ensure that all non-routine, billable supplies are classified under the appropriate revenue code.
  - This may have reimbursement implications if you have ‘carve outs’ specified in your commercial payer contracts.

Supplies *(continued)*

- Apply HCPCS codes where appropriate on outpatient claims.
  - Medicare will pay for certain outpatient supplies via DMEPOS fee schedule or as a pass- through.
  - Know the rules regarding use of supply HCPCS codes! Examples are:
    - Take home surgical dressings cannot be billed on the day of surgery.
    - Patients must meet the condition of permanence to bill certain items as a prosthetic.
  - You may have contractual language that specifies the need for submitting HCPCS codes for commercial payers.

Supplies *(continued)*

- Criteria to bill a supply:
  - Medically necessary.
  - Single patient use, disposable and represents a cost.
  - Ordered by a physician (as a specific supply or as a procedure) or via an approved hospital protocol.
  - Documented in the medical record or other source that can easily be retrieved to validate that a supply item was used on a particular patient.

Supplies *(continued)*

- Ensure that supplies that are opened but not used are not billed.
- Ensure that supplies contaminated by staff are not billed.
- Stay current with the Medicare Device to Procedure and Procedure to Device edits.
- Discourage the use of 'miscellaneous' supply item descriptors.

Supplies *(continued)*

- Bill separately for each non-routine, billable supply for the following reasons:
  - Records are typically not kept of what supply items are built into a procedure. Over time, people may begin to charge separately for the supplies built into the procedure without removing their cost from the procedure charge.
  - Supply costs may fluctuate which would not allow for easy recalculation of the charge into the procedure.
  - You provide data to Medicare of supplies used with the procedures billed. They use this data to weigh future payments for APCs and DRGs.

Drugs/Biologics/Radiopharms

- Create CDM line items with CPT/HCPCS codes (where they exist) with the appropriate billing unit.
- Ensure the amount administered to the patient gets converted into the appropriate billing units.
- Hemophilia clotting factors will be paid beyond the DRG if reported with the HCPCS code under revenue code 0636.

Drugs/Biologics/Radiopharms
(continued)

- Single use vials
  - May bill for the entire amount of a single use vial if only part of the vial is administered to an outpatient and there is no other patient to which the drug can be administered.
  - Should document the amount administered to the patient and the amount wasted in the medical record.

Observation

- Purpose is to allow the physician time to make a determination as to whether the patient should be admitted as an inpatient or discharged home.
- Bill by the hour using G0378.
- Can charge for direct admit using G0379.
- Physician must document use of risk stratification criteria to support that the patient would benefit from Observation care.

Observation *(continued)*

- Patients cannot be pre-admitted into an Observation status.
- Patients cannot be ordered into Observation status upon their entrance into the PACU (Post Anesthesia Care Unit). They must develop a complication in the normal PACU time (typically 4-6 hours) that warrants Observation status.

Observation *(continued)*

- A specific physician order should be written as “Admit to Observation.” No other verbiage is acceptable.
- Orders written as “Admit to Short Stay” and “Admit to 23 Hours” are unacceptable.

Observation *(continued)*

- Inpatient admissions *typically* cannot be converted to Observation.
  - Condition code 44 = inpatient admission changed to outpatient.
  - Change must be made prior to discharge.
  - Hospital has not submitted a claim to Medicare.
  - A physician concurs with the UR Committee's decision.
  - The physician's concurrence is documented in the patient's medical record.

Observation *(continued)*

- Bill for **all** services rendered to Observation patients. Common procedures are:
  - Infusions
  - Injections
  - Transfusions
- Billing for infusions and injections administered to an Observation patient must take into account charges generated for these services in the ED.

Interventional Radiology

- Most interventional radiology procedures do not have a single CPT/HCPCS code to describe the procedure.
- Ensure that the appropriate surgical component codes are billed in conjunction with the radiology CPT code(s).

Evaluation and Management (E & M) Codes

- E & M codes were created by physicians for physicians. Most of the E & M definitions in the CPT book are not applicable to hospitals. Critical care is the exception (CPT 99291/99292).
- Hospitals may use E & M codes but must create their own objective criteria that reflects resource consumption that is not otherwise represented by another CPT or HCPCS code.

Evaluation and Management (E & M) Codes *(continued)*

- The objective criteria should be documented, available and uniformly applied. Periodic reviews should be conducted to determine if the appropriate E & M code was assigned.
- Definitions for hospitals:
  - New patient = patient does not have a medical record.
  - Established patient = patient has a medical record.

Infusions and Injections

- The AMA has created many new codes with new and confusing concepts/rules over the past several years, i.e. initial, subsequent, sequential, etc.
- Hierarchy for billing:
  - Chemotherapy infusions
  - Chemotherapy injections
  - Therapeutic infusions
  - Therapeutic injections
  - Hydration

Infusions and Injections *(continued)*

- Only one initial service charge should be generated unless the patient has another vascular access site.
- The initial service code applied to the claim does not have to be the initial service provided to the patient.

Infusions and Injections *(continued)*

- A new code was created in 2008 for hospitals (only) to allow charging for IV pushes of the same drug where more than 30 minutes has elapsed.
- For those IV pushes where less than 30 minutes has elapsed, I recommend building each IV push into an E & M code where appropriate, i.e. ED codes, outpatient E & M codes.

Infusions and Injections *(continued)*

- Options for generating charges:
  - Educate staff in all areas that bill for infusion and injection services.
  - Create ‘chart checkers’ or ‘super users’ in areas that bill for infusion and injection services.
  - Have the HIM Department generate the charges or validate the charges that are generated.

Dialysis

- Hospitals that do not have a certified ESRD maintenance facility, can bill for ESRD patients who present to their hospital for emergency treatment and subsequently receive their dialysis treatment while registered as an outpatient.
- Bill for the dialysis service using G0257.

Emergency Room

- Type B emergency departments
  - Not open 24 hours a day, seven days a week.
  - Use HCPCS codes (G0380-G0384) and not the CPT codes (99281-99285).
- Fast Track areas in the ED should be reviewed to see if they fall into a Type B classification.

Emergency Department *(continued)*

- Critical care
  - CMS recently published a Q and A on their website stating that the procedures listed in the CPT book (narrative section) that are considered included in the code for physicians are applicable as well to hospitals.
  - The edits for these codes for hospitals were removed in 2003.
  - CMS states that hospitals should not bill for these services along with critical care even though there are no edits.

Education

- Ongoing education is **<u>key</u>** to having staff remain current with information necessary to appropriately bill for services rendered.
- Code changes and description changes must be communicated to the departments who will be generating the charges.
- Code changes and description changes may need to be altered in/added to the feeder system or the charge ticket may need to be updated.

Final Comments

- The CDM is more than a flat file.
- Collaboration is required with many departments to maintain the CDM, feeder systems, and charge tickets to be able to generate appropriate, compliant claims.
- Ongoing education is vital.
- Senior management support is necessary in creating a culture of accountability.

Wrap Up

Questions?