Care and Maintenance of Charge Masters (1999)

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Background

The various supplies and services listed on the charge master for the average facility drives reimbursement for approximately 73 percent of the UB-92 claims for outpatient services alone. The charge master -- often called the master charge list or charge description list -- is simply a computer file of charges for each item that may be used to treat the patient, as well as a select group of services.

A current and accurate charge master is vital to any healthcare provider seeking proper reimbursement. Without it, the facility would not receive proper reimbursement. Among the negative impacts that may result from an inaccurate charge master are:

- overpayment
- underpayment
- undercharging for services
- claims rejections
- fines
- penalties

Because a charge master is an automated process that results in billing numerous services for high volumes of patients -- often without human intervention -- there is a high risk that a single coding or mapping error could spawn error after error before it is identified and corrected.

Key Elements of a Charge Master List

The content and layout of a healthcare provider's charge master may vary from one organization to the next. However, one can expect to see the following data elements in the typical charge master file.

- Procedure description: This title describes the procedure to be performed. There is no set format or vocabulary for this description. Each description should be unique to your facility, yet comprehensible to all staff members who need to identify the procedure. Furthermore, each description should be separately identifiable. For example, no two line items should have the exact same description. Grouped under the heading of procedure might be surgery, laboratory, radiology, etc.

- Service description: This title describes the service to be performed. There is no set format or vocabulary for this description. As with procedure description, each service description should be unique to your facility, yet comprehensible to all staff members who need to identify the service. Again, each service description should be separately identifiable -- no two line items should have the exact same description. Grouped under the heading of service might be evaluation and management, observation, emergency room visits, and clinical visits.

- CPT/HCPCS code: The corresponding CPT or HCPCS code that identifies the specific service or procedure. It is important to note that not all services and procedures listed on the charge master will have a corresponding code. Since all supplies and services may not require a code assignment and the use of unlisted or nonspecific codes is not desirable to the organization, it may be better to just leave this field blank in these instances.

- Revenue code: A three-digit code number representing a specific accommodation, ancillary service, or billing calculation required for Medicare billing. National and state uniform billing committees and HCFA update the list of acceptable

revenue codes on an ongoing basis.

- Charge dollar amount: The specific amount charged by the facility for each procedure or service. This is not the actual amount that the facility will be reimbursed by a third-party payer. Instead, the charge dollar amount represents the standard charge for that item. The facility may want to compare the charge amount listed to the Medicare fee schedule to ensure that the charge amount is equal to or higher than the Medicare fee. Some facilities maintain unique charge dollar amount listings by payer.

- Department code number: A unique number assigned to each ancillary department by the facility.

- Charge description number: An internally assigned unique number that identifies each specific procedure or service listed on the charge master.

The Charge Master Committee

Ideally, charge master maintenance should not be the responsibility of one individual. Rather, it should be overseen by a committee composed of key facility representatives that will contribute to the accuracy and quality of both the document database and charge master review process. Proper charge master maintenance requires expertise in coding, billing regulations, clinical procedures, and health record documentation.

The charge master committee should include representation from:

- health information management
- ancillary departments
- the financial services/business office
- information systems

Responsibilities of the charge master committee include:

- develop policies and procedures for the charge master review process

- perform an annual charge master review when new CPT/HCPCS codes are available

- key elements of the annual charge master review, including:

  - review all CPT codes for accuracy, validity, and relationship to charge description number

  - review all procedure and service descriptions for accuracy and clinical appropriateness

  - review all revenue codes for accuracy and linkage to charge description numbers

  - ensure that the usage of all HCPCS, CPT, and revenue codes are in compliance with Medicare guidelines or other existing payer contracts

  - review all charge dollar amounts for appropriateness by payer

  - review all charge description numbers for uniqueness and validity

  - review all department code numbers for uniqueness and validity

- perform ongoing charge master maintenance as the facility adds or deletes new procedures, updates technology, or changes services provided

- establish a procedure to allow clinical department directors to submit charge master change requests for new, deleted, or revised procedures or services

- make sure there is no duplication of code assignment by coders and charge master assigned codes in any department (e.g., GI endoscopy lab or cardiology cath lab)

- review all charge ticket and order entry screens for accuracy against the charge master and appropriate mapping to CPT/HCPCS codes when required

- review and comply with directives in Medicare bulletins, transmittals, Medicare manual updates, and official coding guidelines

- comply with guidelines in the National Correct Coding Initiative or other known coding or bundling edits

- carefully consider any application that involves one charge description number "exploding" into more than one CPT/HCPCS code to prevent inadvertent unbundling and unearned reimbursement for services

- review and take action on all remittance advice denials involving HCPCS/CPT coding or HCFA coding guidelines

Charge Master Resources

- CPT-4 codes and guidelines: Contact the American Medical Association, 515 N. State St., Chicago, IL 60610, (312) 464-5000, http://www.ama-assn.org

- HCPCS codes and guidelines: Contact the US Government Printing Office, Superintendent of Documents, Washington, DC 20402, (202) 783-3232. For training and guidance, contact your regional Medicare fiscal intermediary

- National Correct Coding Initiative: Contact the National Technical Information Service (NTIS), Technology Administration, US Department of Commerce, 5285 Port Royal Rd., Springfield, VA 22161, (703) 605-6000, http://www.ntis.gov

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