Care and Maintenance of Chargemasters (2010 update)

This practice brief has been retired. It is made available for historical purposes only.

Editor's note: This update replaces the July/August 1999 practice brief "The Care and Maintenance of Charge Masters."

The various supplies and services listed on the chargemaster for the average facility drives reimbursement for the vast majority of items listed on UB-04 claims. The chargemaster-also called the charge description master (CDM)-is simply a master price list of supplies, devices, medications, services, procedures, and other items for which a distinct charge to the patient exists. It is a financial management form that contains information about the organization's charges for the healthcare services it provides to patients. The CDM collects information on all the goods and services the organization provides to its patients. Therefore, the responsibility for maintaining the database may fall toseveral individual departments (e.g., laboratory radiology). In addition, some organizations choose to have a central CDM position that interacts with the various departments to ensure that accurate data are maintained in the CDM and address any issues that may arise.

On every front, healthcare is advancing by leaps and bounds. At the same time, organizations and providers struggle to receive appropriate reimbursement for the care they provide. In the midst of MS-DRGs, severity-adjusted DRGs, and annual code updates to both the ICD-9-CM classification and CPT nomenclature systems, the struggle is an ongoing issue for many organizations. As profit margins narrow and the cost of training staff and implementing new reimbursement mechanisms grow, senior management must determine where best to focus limited resources to ensure that the revenue cycle is healthy.

A current and accurate chargemaster is vital to any healthcare provider seeking proper reimbursement and a key indicator in a healthy revenue cycle. The CDM allows the organization to capture charges as they occur, almost in real time. Without a healthy CDM process, the facility would not receive proper reimbursement, and incoming revenue could potentially come to a halt. Among the negative effects that may result from an inaccurate chargemaster are:

- Overpayment or overcharging
- Underpayment or undercharging
- Claims rejections
- Fines
- Penalties

Because a chargemaster 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. For example, if the chargemaster is incorrectly developed with a chest x-ray mapped to a unit of service of 10 instead of one, as the x-ray technician charges for the CPT code associated with a chest x-ray, the patient would be charged for 10 x-rays. In addition, the CDM usually drives more than 70 percent of an organization's revenue cycle dollars because it focuses on outpatient services and supplies. Although these services and supplies may be low in dollar value, they are very often high in terms of volume. As a result, outpatient services can include up to 25,000 line items within the CDM.

Key Elements of a Chargemaster List

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

- Charge description: Also known as "item description" and other names, this title describes the supply, device, medication, service, procedure, or other item provided or performed. There is no set format or vocabulary for this description, but facilities are typically bound by space constraints to only a limited number of characters to describe

each item. Each description should be unique to a facility. Furthermore, each description should be separately identifiable. For example, no two line items should have the exact same description. Keep in mind that the charge description will appear on the patient's detailed bill. Not only do staff members posting charges need to be able to correctly identify which charges to post on a patient's account but patients also should have some understanding of what the charge represents on the detailed bill. When linked to a CPT or HCPCS code, the charge description should match the CPT or HCPCS code descriptor as closely as possible.

- CPT or HCPCS code: The corresponding CPT or HCPCS level II code that identifies the specific service or procedure. Modifiers may or may not be included, depending on the circumstances. However, not all services and procedures listed on the chargemaster 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 leave this field blank in these instances.
- Revenue code: A four-digit code number representing a specific accommodation, ancillary service, or billing calculation required for Medicare billing. The National Uniform Billing Committee and Centers for Medicare and Medicaid Services (CMS) update the list of acceptable revenue codes on an ongoing basis.
- Charge: The charge dollar amount represents the amount charged for the item and the amount that will appear on the patient's detailed bill. Some facilities prefer to use the term "price" instead of "charge."
- Department code: The department code or general ledger number, generally two or three digits, is used for accounting purposes to distribute the revenue to the appropriate department.
- Charge code: An internally assigned unique number that identifies each specific item listed on the chargemaster. This is also referred to as a "charge description number," "item code," or "CDM number."
- Charge status: The charge status or activity date element indicates the most recent activity of an item. This allows a facility to monitor whether a line item has been charged to any patient's bill in a period of time.

CDM example:

Charge Description	CPT/HCPCS Code	Revenue Code	Charge	Department Code	Charge Code	Charge status
Nasal bone x-ray	70160	320	150.00	15	2214111000	12/1/2001
Thyroid Sonogram	76536	320	250.00	15	2110410000	1/1/2003
Echo Encephalogram	76506	320	1,500.00	15	2326222111	7/1/2005

The Chargemaster Committee

Ideally, chargemaster maintenance should not be the exclusive responsibility of one individual. Rather, a committee composed of key facility representatives should share this responsibility jointly. This format will contribute to the accuracy and quality of both the document database and chargemaster review process. For example, the HIM department understands clinical procedure codes, the pharmacy department understands the medications and dosages and their respective codes, and the finance department understands the charge formulas. Proper chargemaster maintenance requires expertise in coding, billing regulations, clinical procedures, and health record documentation. The entire CDM should be reviewed periodically, but at a minimum it should be reviewed annually to coincide with annual code updates and organizational changes. Identification and substantiation of the actual costs of providing healthcare services is an integral part of the CDM update and should also be considered when updating the CDM. For most organizations the finance department assumes responsibility for the annual update to the CDM.

The chargemaster committee should include representation from:

- HIM
- Financial services or the business office
- Information systems
- Corporate compliance
- Department management from various service areas that generate charges including:
    - Radiology
    - Laboratory

  - Respiratory therapy
  - Cardiac catheterization laboratory
  - Physical therapy
  - Emergency department
  - Nursing

- Physicians, as needed

Responsibilities of the chargemaster committee include:

- Developing policies and procedures for the chargemaster review process
- Performing chargemaster review at least annually when new CPT and HCPCS codes are available
- Attending to key elements of the annual chargemaster review, including:
  - Reviewing all CPT and HCPCS codes for accuracy, validity, and relationship to charge description number
  - Reviewing all charge descriptions for accuracy and clinical appropriateness
  - Reviewing all revenue codes for accuracy and linkage to charge description numbers
  - Ensuring that the usage of all CPT, HCPCS, and revenue codes are in compliance with Medicare guidelines or other existing payer contracts
  - Reviewing all charge dollar amounts for appropriateness by payer
  - Reviewing all charge codes for uniqueness and validity
  - Reviewing all department code numbers for uniqueness and validity
  - Performing ongoing chargemaster maintenance as the facility adds or deletes new procedures, updates technology, or changes services provided
  - Ensuring that all necessary maintenance to systems affected by changes to the chargemaster (such as order entry feeder systems, charge tickets, and interfaces) is performed when chargemaster maintenance is performed
  - Performing tests to make sure that changes to the chargemaster result in the desired outcome
  - Educating all clinical department directors on the chargemaster and the effect of the chargemaster on corporate compliance
  - Establishing a procedure to allow clinical department directors to submit chargemaster change requests for new, deleted, or revised procedures or services
  - Ensuring there is no duplication of code assignment by coders and chargemaster-assigned codes in any department (e.g., interventional radiology or cardiology catheterization laboratory)
  - Reviewing all charge ticket and order entry screens for accuracy against the chargemaster and appropriate mapping to CPT or HCPCS codes when required
  - Reviewing and complying with directives in Medicare transmittals, Medicare manual updates, and official coding guidelines
  - Complying with guidelines in the National Correct Coding Initiative, Outpatient Code Editor edits, and any other coding or bundling edits
  - Considering carefully any application that involves one charge description number that expands into more than one CPT or HCPCS code to prevent inadvertent unbundling and unearned reimbursement for services
  - Reviewing and taking action on all remittance advice denials involving HCPCS or CPT coding rules and guidelines or CMS payer rules
  - Educating all staff affected by changes to the chargemaster in a timely fashion

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