Charging vs. Coding: Untangling the Relationship for ICD-10

By Jeff Pilato, MHA, RTR, CPC-H

While the transition to ICD-10-CM/PCS has the potential to put revenue at risk, adding staff to the revenue cycle is rarely an option in today's cost-cutting environment. There are no extra hands to review charges, double-check bills, or safeguard claims. To mitigate risk, preventive measures should be put into place at every juncture within the revenue cycle to ensure bills are correct and claims are paid.

Re-evaluating and updating the charge description master (CDM) is one preventive measure healthcare providers should take in preparation for ICD-10-and health information management (HIM) professionals can help lead the way. There are several indirect links between ICD-10 and the CDM that HIM professionals need to know and leverage at their organizations.

Chargemasters Explained

At the core of the revenue cycle, the hospital CDM is extensive. It contains thousands of individual charges and procedures across all hospital departments-usually up to 45,000 or more separate line items. Each charge code is then associated with a revenue code linking to revenue categories used in the hospital's accounting and billing systems. Every chargeable item in the hospital must be part of the CDM in order for a hospital to track and bill a patient, payer, or another healthcare provider. This includes all services and supplies for all patient types.

For each chargeable procedure, item, or service, the CDM includes a unique item number, technical description, CPT/HCPCS and revenue codes, the assigned price, and several other elements. Multiple subsystems interface with the CDM including radiology, laboratory, respiratory, pharmacy, central supply, and billing. The CDM's primary functions are to:

- Produce an itemized statement
- Assign charges on the inpatient claim
- Assign charges, codes, and descriptions on the outpatient claim
- Track statistics
- Monitor the cost of care for patients
- Provide cost accounting data to financial systems

The CDM is also used for a host of other internal reports. The majority of charge and billing issues are not the result of an inaccurate CDM but rather the disconnected nature of the charging process. ICD-10 will likely magnify CDM errors that already exist.

The Heavy Cost of Mismatches

The implications for having inappropriate charges and mismatches affect a hospital's earnings before interest, depreciation and amortization (EBIDA), cost-to-charge ratios, and outlier payments. For example, assume the organization reports to Medicare 1,000 colonoscopies in one year-500 with biopsy and 500 without. Also assume that within the organization's chargemaster, the charge for "with biopsy" is $800. However, the charge for colonoscopy "without biopsy" is only $500.

A simple error in charging, perhaps due to a limited or antiquated chargemaster vocabulary, could result in $150,000 in lost annual charges. This type of mismatch could impact the EBIDA, cost-to-charge ratios, outlier payments, and a host of other financial reports.

Three Areas of Disconnect

There are three areas of disconnect between charging and coding. The first and most common disconnect occurs with inpatient procedures because there is no direct link in the CDM between its CPT codes and the ICD-9-CM/ICD-10-PCS procedure codes assigned by coders. Inpatient procedures are coded using ICD-9-CM or ICD-10-PCS codes, but they are charged using the CPT code descriptions in the CDM.

After a procedure or service is completed, the clinical team, nurses, or technologists enter the procedure or service rendered into the hospital information system (HIS) and any special items utilized. These clinical points of data entry are applied to the chargemaster, which in turn applies the correct charge to the patient's bill. So the "charge" entered by the clinical staff at the time of delivering care has no direct connection to the ICD-10-PCS procedure "codes" assigned in HIM.

The next disconnect occurs in the reimbursement department. The reimbursement department is often responsible for making sure the charges are correct. However, very few reimbursement or financial departments have mechanisms in place to check for inaccurate charges. Auditing for inaccurate charges is a complex process. This step is usually the responsibility of the clinical department. However, clinical departments only perform half of the review; they do not match charges to coded procedures.

Furthermore, reimbursement staff may not understand codes, nor do they need to. They simply review a list of daily charges to ensure that all services were charged. Finally, CPT procedure descriptions in the chargemaster can be very different from ICD-10-PCS code descriptions. For this reason, auditing inpatient charges is a difficult and labor intensive process. For example, a percutaneous transhepatic cholangiogram for biliary drainage with low osmolar contrast agent and radiological supervision and interpretation (S&I) is performed to treat an obstruction of the common bile duct. The CDM charges would include four separate CPT code components:

- 47500 – Injection for Percutaneous Transhepatic Cholangiogram
- 74320 – Cholangiography, Percutaneous transhepatic, S&I
- 47510 – Intro of Percutaneous Transhepatic catheter for biliary drainage
- 75980 – Percutaneous transhepatic biliary drainage with contrast monitoring, S&I

Under ICD-10-PCS, only two codes-with very different descriptions-would be assigned;.

- BF101ZZ – Fluoroscopy of Bile Ducts using Low Osmolar Contrast
- 0F9930Z – Drainage of Bile Duct, with Drainage Device, Percutaneous approach

The complexities of accurate charging and coding make thorough and precise clinical documentation extremely important-another justification for a strong clinical documentation improvement program. This is especially important as descriptions become even more complex, as is the case with some ICD-9-CM combination codes and future ICD-10-PCS procedure codes.

Specific Areas of Concern

Complex inpatient procedures are a specific area of concern often resulting in a charging-coding mismatch. These include interventional radiology and cardiology. Combination and add-on procedures also lead to charging-coding mismatches. Multi-component procedures with one or more surgical and/or technical components fall into the high risk category. And finally, services where the ICD-9-CM or ICD-10-PCS description is considerably different from the CPT description may put organizations at risk.

Preparing a Chargemaster for ICD-10

There is no single, set method to update a chargemaster in preparation for ICD-10. However, there are some practical ways HIM professionals can begin to allocate time and resources to this challenging process. A solid implementation plan including these preventive measures helps ensure a successful transition to ICD-10.

The first step is to identify the top 10 to 50 ICD-10-PCS procedure codes performed by one's facility and compare the ICD-9 and ICD-10 descriptions to the CDM CPT code description for the same procedures. HIM professionals should have a meaningful discussion with their revenue team about the risks associated with incorrect or inconsistent charges.

Teams tasked with auditing charges should follow these steps to get started:

- Perform a chart-to-charge audit on the top procedures and identify charge entry omissions
- Share the findings with clinical staff
- Create a charge policy to help enforce consistency
- Educate staff by using examples
- Assign one charge specialist to audit charges regularly

HIM professionals possess broad-based knowledge of medical terminology, CPT, and ICD-9/ICD-10 coding to oversee this effort. They can ensure consistency between the chargemaster and ICD-10-PCS code descriptions, while also verifying the accuracy of charges supported by the clinical documentation.

Sample of Chargemaster Screen

ITEM NUMBER	DEPT NUMBER	DESCRIPTION	PRICE	HCPCS CODE	REVENUE CODE	MEDICAID CODE	GL NUMBER
791002	761	CORONARY ARTERY DILATION	$1,550.00	92982	481	92982TC	0800.4601
791000	761	INJECTION, CARDIAC CATH	$ 220.00	93540	481	93540TC	0800.4601
761001	761	NURSING FAC CARE, SUBSEQ	$ 75.00	99307	636	7610	0800.4601
761002	761	HOME VISIT, NEW PATIENT	$ 80.00	99341	636	7610	0800.4601
761003	761	REPAIR EYELID DEFECT	$ 110.00	67915	636	7610	0800.4601
810003	761	REPAIR EYELID DEFECT	$ 550.00	67916	272	7610	0800.4601
810004	761	REMOVAL OF KIDNEY STONE	$ 390.00	50080	272	7610	0800.4601
810050	761	DECALCIFY TISSUE	$2,065.00	88311	272	7610	0800.4601
810061	761	CHROMOSOME COUNT, ADDITIONAL	$ 275.00	88285	272	7610	0800.4601
810072	761	ASSAY OF FREE THYROXINE	$ 159.00	84439	622	7610	0800.4601
810080	761	ASSAY OF THYROID ACTIVITY	$7,064.00	84442	272	7610	0800.4601
791004	761	ASSAY THYROID STIM HORMONE	$ 650.00	84443	272	7610	0800.4601

Talk Now, Not Later

The launch point for clarifying reimbursement and untangling the charge/code relationship lies in further understanding of the chargemaster alongside application of HIM skills, knowledge, and coding connections. HIM professionals have the ability to fill

in the gaps in the code-chargemaster relationship by performing audits to ensure codes assigned by HIM professionals match the charges assigned by the CDM.

Educating HIM professionals on the disconnect discussed above and working to resolve issues in chargemaster update efforts will improve revenue and charging-coding collaboration. Now is the time to develop strong working relationships between HIM professionals and the staff members responsible for reconciling charges within the organization. This relationship will open the opportunity to discuss potential issues now-well ahead of the ICD-10 deadline.

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