Ten Steps to Successful Chargemaster Reviews

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Is your chargemaster current, compliant, and comprehensive? In the age of APCs, healthcare facilities would do well to answer these questions regularly. Here's how an HIM professional can help.

On every front, healthcare is advancing by leaps and bounds. At the same time, providers are struggling to get appropriately reimbursed for the care they provide within the myriad of reimbursement rules and regulations, particularly for the Medicare population.

As profit margins narrow and the cost of training staff and implementing new reimbursement mechanisms grows, hospital management will need to determine where best to focus limited resources to ensure that reimbursement is legitimately optimized.

One of the best investments a facility can make on an ongoing basis is to ensure that its charge description master (CDM) or chargemaster-the driver of all facility charges-is current, comprehensive, and compliant with pertinent rules and regulations. This article will take you through the important process of chargemaster review.

Where Do We Start?

Reviewing and updating your facility's current CDM will provide you with the opportunity to ensure that all billable services are accounted for and accurately coded to legitimately maximize reimbursement, in addition to decreasing your general compliance risk. Where do you start?

Chargemasters can include from 10 to 25,000 or more line items, depending on the type of facility. Charging one person or group in a department with the responsibility of reviewing and updating all chargemaster line items will, at best, create a framework for a less than optimal outcome and, at worst, a disaster if a compliance issue is created due to lack of understanding the services being charged in each area. For this reason, the best practice is a collaborative approach, whether you undertake a general high-level review or a comprehensive detailed review of high-risk departments.

Our methodology for conducting a chargemaster review consists of the 10 key steps below. These steps can be expanded or contracted depending on the type of review being conducted and the size and complexity of the organization and its existing chargemaster.

Step 1: Look for the Three Cs

Determine the breadth and depth of the CDM evaluation needed. Should it be a broad high-level review, a focused but detailed review, or a comprehensive review that is both broad and detailed? Each facility needs to determine whether its chargemaster meets the "three Cs" benchmark: is the chargemaster current, comprehensive, and compliant?

Is the CDM current? That is, does it include the accurate, up-to-date codes for all services or the requisite pass-through codes where appropriate for drugs and new technology?

- Have all existing CPT/HCPCS codes been reviewed and updated annually as codes are officially added, revised, and deleted?
- If not, how long has it been since a significant update occurred?
- Are clinical department staff or management aware of the specific codes appended to the services or charges they generate?

- Has the clinical staff had the opportunity to review the accuracy of the codes representing the actual services rendered?

Is the CDM comprehensive? Are all billable services recognized in the chargemaster?

- Do clinical staff understand all of the charges in the CDM for their respective departments? Is there a specific charge for each service provided by each clinical department, or are some charges generically labeled and used to bill for various different services because they seem similar and the department is unaware of requirements for distinct codes per service?
- Have staff requested obsolete service charges be deleted from the CDM when indicated, or is there a potential that many unused charge line items continue to be housed and maintained unnecessarily in the CDM?
- Who decides whether a service is separately charged or is included in another more comprehensive service charged?

Is the CDM compliant? Each facility must determine whether its chargemaster is compliant with the rules, regulations, and guidelines specific to each major payer group (Medicare, Medicaid, and commercial payers) to which it submits claims.

- Have the department-level decision makers been educated on Medicare rules and regulations and official coding guidelines and initiatives, such as the National Correct Coding Initiative (NCCI), prior to requesting charges be added to the CDM?
- If not, who has reviewed the charges for code accuracy and when was the CDM last reviewed for compliance?
- Has the CDM ever been skimmed at a high level for major compliance issues or have high-risk departments been reviewed?
- Who has the final authority to add, revise, or delete charges from the CDM?
- Is there oversight of the chargemaster maintenance process from a compliance perspective as well as from a pricing or reimbursement perspective?
- Have any compliance issues noted during periodic claim or chart audits been traced back to the chargemaster for any necessary CDM code or description changes?

If your facility has kept up to date with federal regulations and has been maintaining the chargemaster on an ongoing basis, a detailed review may not be needed. However, when significant new regulatory changes are passed (e.g., APCs), a more detailed review is usually warranted. If you have conducted a detailed review within the last year, and each department within your facility reviews its chargemaster section at least periodically, only a high-level screening review may be needed for implementation of 2001 codes.

The facility's executive management team will ultimately decide the scope of the review to be undertaken based on reimbursement or potential compliance issues. The cost of the resources required will also be a key factor in determining the review's scope.

A facility may decide that although a comprehensive review is desired, the time and resources necessary to complete it are not available. In this case, a more focused review of a discrete set of departments may be feasible, if performed one or two at a time, in a phased approach. Conversely, if the management and core review team cannot answer key questions to determine review scope, a broad high-level review may be appropriate to screen the CDM first for potential issues.

Step 2: Assemble a Cross-functional Project Team

The next step in reviewing your CDM is to determine who, internally, should participate in the process. In establishing a cross-functional team to conduct the review or participate in the review process, the size of the group will vary. Generally, important members to include are:

- chief financial officer (CFO) or designee
- finance department representative
- billing department representatives
- management representative from each charging department
- health information management (HIM) department coding representatives
- information systems department representative
- chief compliance officer (CCO) or designee (optional)

- legal counsel (optional)

Each representative brings unique skills and insights that are valuable in the review process. It's particularly critical to involve an individual in a key leadership role, such as the CFO, to introduce the project across the institution and gain cooperation, particularly for larger-scale comprehensive reviews. This person can set the tone for the project and its importance, both from a revenue enhancement and a compliance perspective.

The finance, billing, and information systems department representatives will understand how the current billing, charge/order entry, and financial reporting systems work, and what operational changes will need to occur for the final CDM review recommendations to be properly implemented. The HIM department's coding experts will advise on coding guidelines and which CPT and HCPCS codes best represent the services charged, in conjunction with the healthcare regulatory guidance provided by the compliance officer and the billing department representatives.

Clinical and ancillary department managers will bring their knowledge of all items charged and methods by which services are rendered within their departments. Additionally, these managers provide insight for the review team into each department's general understanding of compliance issues and the reimbursement mechanisms that affect its services. They also can determine whether any variations in service provision may require coding modifications, place the department at risk for compliance issues, or create a need for direct HIM coding versus CDM hard coding.

Although most chargemaster reviews are conducted to ensure that codes and charges are appropriate to legitimately maximize reimbursement, compliance issues inevitably surface during the process. Given the variety of issues that can arise and the responsibility to repay any overpayments and take corrective action once an issue is discovered, a facility may wish to conduct the CDM review under attorney-client privilege. Counsel will be able to provide legal advice if necessary and direct further in-depth reviews.

Step 3: Establish a Project Manager

Given that the review process is collaborative and crosses many departments, it is advantageous to select an internal project manager or liaison as point person. The project manager will usually be responsible for:

- scheduling departmental interviews and mapping reviewers to departments based on skills
- coordinating data flow and interviews between reviewers and departments, both initial and follow-up
- providing project updates to executive management and potentially to counsel
- coordinating the implementation of final recommendations

Step 4: Allocate Resources

The core CDM review team may need to expand if the members' requisite skill sets or available time will not be sufficient to achieve the objective, once the scope of the review has been determined. Depending on other initiatives in progress within the institution, timelines, staffing levels, and the existing healthcare regulatory knowledge available internally, external consultants may be required.

Other key resources also will need to be addressed:

- work/interview space
- computer and telecommunication access for nonfacility team members
- coding and healthcare regulatory resources (books, software, electronic or paper regulatory data, LRMP/bulletins from facility's intermediary)

Step 5: Establish Communication Mechanism

Communication between the various review team members is important to the success of the project. Agree on communication mechanisms for daily communications as well as for periodic updates. Set interim meeting dates and times early to avoid scheduling conflicts later. Consult your compliance officer or legal counsel for instructions if compliance issues surface during the review.

Step 6: Assemble the CDM Database

Although the chargemaster file is electronic and should be readily available from the finance/billing system for printing and review, consider how new charge additions or changes in any of the CDM data elements will be captured and implemented.

Ultimately, the changes will need to be input into the master system file. If the review is comprehensive or many changes are anticipated, the facility may decide that it will be more efficient to upload data from a project database than to manually enter written recommendations for changes. For example, it is not unusual for up to 25 percent of the line items in a CDM to require at least one change (code, description, or price), particularly when the CDM has not been reviewed in some time.

In most cases, CDM data will be transferred into an electronic project database for ease of manipulation and search functionality. For example, finance department revenue and usage data for each line item can be merged into the review database to enable reviewers to determine under- and overutilization of charges and potentially quantify expected effects of final coding or pricing changes. Additionally, reviewers could status code each line item change to the database to stratify the types of changes/issues, flag compliance issues by type, prioritize the changes to be implemented, or generate a report for executive management.

Devise a worksheet format to standardize all of the data to be reviewed by line item and the addition/revision data to be captured across reviewers and departments. Database or paper worksheets should include CDM data elements by department.

Step 7: Schedule and Prepare for Departmental Interviews

While the review data is being gathered and formatted into worksheets, complete departmental interview scheduling. This task can be quite time consuming in large facilities, particularly academic medical centers with many separate charging departments. Time spent explaining the project to all participants in advance, along with adequate resources and time to prereview worksheets, will increase both the efficiency and the quality of the actual CDM review interviews.

Some specific interview preparation steps include:

- **assign CDM review responsibility** to one representative for each charging department
- **schedule a project kickoff meeting** for all project participants to discuss the purpose, process, timeline, and expectations of the CDM review
- in preparation for the meeting, **print out the respective chargemaster worksheets by department**. Although data may be entered real-time into an electronic database worksheet during a departmental interview, printed worksheets will be needed for clinical department representatives unless they have access to the database
- after the meeting, **distribute the worksheets**, tracking meeting attendance and worksheet receipt. Any resource materials that will be helpful to the departments as they prepare for their interviews, such as code books, should be available at this time as well

Step 8: Conduct Interviews and Review CDM Line Items per Department

Review each individual line item for:

- appropriateness of the revenue code
- whether or not the line item should be deleted based on current usage volume
- the appropriateness of the CPT/HCPCS code and charge descriptions based on the actual service the line item represents
- whether the line item is a covered charge based on regulations
- pricing consistency for the same service or item within and across other clinical departments

Identify APC "pass-through" items, such as certain catheters and stents, so that any devices or supplies currently bundled into an global procedure charge can be itemized as a separate line item with the appropriate code for additional APC reimbursement.

Step 9: Research CDM-related Issues

Unusual service delivery methods or approaches and new types of equipment and technology will present challenges in describing and coding services accurately. Reviewers may need to contact professional coding resources. Examples include the American Health Information Management Association (AHIMA), the American Medical Association (AMA), and the American Hospital Association (AHA).

HCFA is continually generating new "pass-through" codes, so follow up on all new services, drugs, and technology to ensure that codes can be applied to all items that will generate additional APC reimbursement. You may also need to clarify compliance issues, coverage rules, local medical review policy, and specific payer interpretation of coverage rules.

Step 10: Finalize and Implement Changes to the CDM Database

Once research is completed, pertinent research findings will need to be incorporated into the line item recommendations and communicated to the respective clinical departments. When reviewers finalize CDM recommendations, return draft final worksheets to each charging department for review. Designated department representatives should formally and thoroughly communicate to their staff the changes that will be made to the chargemaster, how to use new charge mechanisms, and the importance of documentation to support all billed charges.

After departmental review and reviewer sign-off, the recommendations may be manually entered or uploaded into the main chargemaster file in the billing system. Each department will need to work with the information systems department to make necessary changes to their charge/order entry system screens, paper encounter forms, or requisitions to reflect CDM changes.

Optional Review Activities

Once the review process is completed, you may wish to perform the optional related activities that complement the review process.

Conduct a Pricing Review

Pricing studies can be conducted concurrently with a CDM review. However, it is usually best to conduct them separately, so the focus stays on from coding and compliance issues. Once the chargemaster is current, comprehensive, and compliant, pricing can be reevaluated.

The exercise of reviewing departmental resource costs and determining a competitive price that is in sync with the overall facility marketing strategy may involve yet a different set of facility staff with more financial, purchasing, and marketing expertise. Adding more team members and different issues will only complicate the CDM review process. Once you have reduced the number of obsolete line items in the CDM, gathered departmental pricing suggestions, and identified pricing inconsistencies during the CDM interview process, you will be prepared to conduct a formal pricing study later.

Refine the CDM Maintenance Process

The chargemaster is a dynamic document or file. Almost as soon as the review and cleanup are completed, new items will be requested to be added, deleted, or perhaps even revised. Maintaining a chargemaster is an ongoing challenge that must be supported by a defined process with written policies and procedures.

Institute controls where appropriate to ensure each line item entered into the CDM is compliant and mapped to the correct code. Pricing will need to be consistent, cover resource cost, and reflect institutional marketing strategies and mark-up policy.

Measure CDM Review Outcomes

Changes to the chargemaster usually result in improved reimbursement and reduced compliance risk. Depending on the extent of charges deleted from the CDM for compliance reasons, the additions of charges not previously captured and the number of code additions or revisions that result in higher or lower reimbursement per service, a department’s bottom line can shift positively or negatively.

The finance department will be interested in monitoring and measuring the overall outcome, which can be accomplished utilizing existing financial analysis reporting mechanisms.

In addition, assess your billing denial rate to track and trend the types of claims that are being rejected. From this analysis, categorize the types of issues and try to trace them back to possible data entry errors made during the input of CDM code changes or incorrect usage of chargemaster line items by department level staff.

Finally, perform chart-to-bill audits on a regular basis to ensure coding accuracy based on medical record documentation and to assess the adequacy of charge capture at the department level.

Conduct Training

The process of reviewing the CDM, researching issues, and obtaining expert advice is a training exercise of sorts in itself, if the facility has included clinical or charging department management and staff in the review process. At the very least, it heightens awareness of reimbursement and compliance issues and sets the stage for building upon that awareness or review-acquired knowledge base.

The challenge is to convey key information to departmental staff responsible for documenting services and generating charges-what to charge, when to charge, how to charge, and what to document to support the charge.

You can approach training through informal or formal department mechanisms depending upon department size, content to be covered, time constraints, and available budget. Training for chargemaster compliance should fit into a larger, enterprise-wide compliance program. It should target staff awareness of regulations, service coverage requirements, and the importance of documentation to support billed charges, particularly in high-risk departments or those with high attrition rates or many new staff. In particular, ensure that what has been presented is retained and that staff bring reimbursement and compliance issues to management for clarification or research on an ongoing basis.

Conduct Targeted Compliance Follow-up Reviews

A comprehensive, enterprise-wide compliance program will include periodic auditing and monitoring via chart-to-bill reviews, in addition to internal audits by the billing department based on claim denial rates or patient complaints. If specific compliance issues surface during the chargemaster review process, a targeted review of the issue is in order, rather than waiting until the suspected issue actually materializes on a claim and appears during periodic compliance monitoring.

In some cases the charge data on a claim may be incorrect, not because the codes in the CDM were inaccurate for the service described, but because a procedural variance is documented in the medical record that warrants the use of a different or more precise code. A chart-to-bill review is the only way to identify this variance and the improper use of a CDM charge line item.

SIDEBAR 1

What is a Chargemaster?

The chargemaster, also known as the charge description master (CDM), is a master price list of all services, supplies, devices, and medications charged for inpatient or outpatient services by a healthcare facility.

Although individual departments will generate charges (electronically using an automated charge/order entry system or manually via paper encounter forms and requisitions), ultimately, a significant amount of billing information for a respective admission or patient encounter is derived from the chargemaster. The price, charge description, and all codes attached to a line item in the CDM file will flow through to the bill, unless manually edited or overwritten by billing department staff or professional coders.

Reimbursement for Medicare and other payers is based on either the diagnosis related group (DRG) payment amount for the inpatient stay or the ambulatory payment classification payment (APC)

amount for outpatient encounters or services. In the case of Medicare reimbursement for outpatient services, CPT or HCPCS codes assigned to charges will be translated into APC groups. Each APC will generate a predetermined payment amount, which is multiplied by the number of units of the charge.

Although many separate APCs may be billed and reimbursed for covered outpatient services on one claim or date of service, most supplies and many of the drugs associated with the services are packaged and thus will not receive a separate APC payment. As a result, capture and coding of all service charges, medical visits, or diagnostic and surgical procedures is critical to facility reimbursement per encounter, because the APC payment theoretically includes payment for drugs and supplies.

The outpatient prospective payment system (OPPS) is expected to control hospital reimbursements for outpatient services. Some services may yield increased reimbursements, while reimbursement for others decreases. However, allowances have been made for certain items that the Health Care Financing Administration (HCFA) believes cannot appropriately be reimbursed as packaged items within the procedural and visit APC payments. Special drugs, such as chemotherapy drugs and devices or supplies that are considered "new technology" items will need to be assigned new "pass-through" codes in order to receive additional reimbursement.

Medicare-reimbursable drugs must be billed in the appropriate dosage amount defined by their respective "J" series HCPCS code and adjusted for the units to reflect the amount of drug administered and be accurately reimbursed. In some cases, these pass-through drugs, devices, and supplies and services will require an assignment of a new series of HCPCS codes that may be currently unfamiliar to a facility's professional coders.

"Accurately Coded Claim," illustrates a chemotherapy administration claim for a Medicare patient receiving ongoing treatment for head and neck cancer.

The chart demonstrates the correct description of services and drugs with the accurate HCPCS codes and units noted on the claim to legitimately maximize the APC payment to the facility.

"Inaccurately Coded Claim," demonstrates a claim generated by a chargemaster that has not been updated for revenue or HCPCS code accuracy or HCPCS code and description dose matching. Thus, the single unit of drug charged will generate only one APC payment per drug instead of the full number of units of APC payment the facility is entitled to collect. Additionally, the CPT/HCPCS code for the significant procedure, chemotherapy administration, while correct for the first hour of chemotherapy for other payers, is not correct for Medicare billing and will not generate an APC payment. A potential exists for the entire claim to be denied because the intravenous (pass-through) drug charge is not paired with a valid significant procedure. The reimbursement impact of inaccurate or nonexistent coding can have a major and negative financial effect on a facility's bottom line.

Like Medicare, third-party payers each have their own respective reimbursement guidelines. They may or may not reimburse a charge without a CPT or HCPCS code but will require at least a revenue code for reimbursement of charge items. Although most state Medicaid programs follow Medicare rules, many have created local codes and coding requirements specific to their state. Regardless of the type of payer, without all of the required charge description and coding elements included on a claim at the point of submission, a facility charge may not be reimbursed in a timely fashion or even at all. Generally speaking, in most facilities, the bulk of the codes assigned to charge line items are automatically generated by the chargemaster (hard coded) instead of being manually applied (directly coded) by coding professionals. This is why the chargemaster is critical to the bottom line of a healthcare organization.

SIDEBAR 2

Accurately Coded Claim

Accurate Coding/Units Updated CDM	Revenue Code	HCPCS	Units	Total Charges	APC	APC Payment
Chemotherapy (Infusion 4 hrs.)	510	Q0084	1	$740.00	117	$89.22
Chemo Drugs (Carboplatin 50 mg IV)	636	J9045	9	$1,300.00	811	$890.10
Chemo Drugs (Fluorouracil 500 mg IV)	636	J9190	2	$13.40	859	$5.50
Drugs (Acetaminophen 325 mg tab)	637	--	2	$7.40	--	$0
IV Solutions (.9% NS 1000 ml)	258	--	2	$125.40	--	$0
Nonsterile Med Supplies (Emesis basin)	270	--	1	$3.50	--	$0
Sterile Med Supplies (IV tubing/cassettes)	272	--	3	$217.50	--	$0
TOTALS	--	--	--	$2,407.20	--	$984.82

SIDEBAR 3

Inaccurately Coded Claim

Accurate Coding/Units Updated CDM	Revenue Code	HCPCS	Units	Total Charges	APC	APC Payment
Chemotherapy (Infusion 4 hrs.)	510	96410	1	$740.00	--	$0
Chemo Drugs (Carboplatin 450 mg IV)	636	J9045	1	$1,300.00	811	$$98.90
Chemo Drugs (Fluorouracil 1 gm)	636	*missing*	1	$13.40	--	$0

Drugs (Acetaminophen 325 mg tab)	250	--	2	$7.40	--	$0
IV Solutions (.9% NS 1000 ml)	258	--	2	$125.40	--	$0
Nonsterile Med Supplies (Emesis basin)	270	--	1	$3.50	--	$0
Sterile Med Supplies (IV tubing/cassettes)	272	--	3	$217.50	--	$0
TOTALS	--	--	--	$2,407.20	--	$98.90

SIDEBAR 4

10 steps to a successful chargemaster review

1. Determine the type of review to be conducted.
2. Assemble a cross-functional review team.
3. Establish a project leader or liaison.
4. Allocate resources to the process.
5. Establish communication mechanism for project team.
6. Assemble the CDM database for review and revision capture.
7. Schedule and prepare for departmental interviews.
8. Conduct interviews and review line items per department.
9. Research CDM-related issues.
10. Finalize changes to the CDM database.

SIDEBAR 5

Web-only exclusive: Visit www.ahima.org for AHIMA's Web-exclusive Medicare Reimbursement Reference Grid, which offers information on how to bill for healthcare facilities and numerous services, plus supporting regulations and resources.

See also the AHIMA Practice Brief "The Care and Maintenance of Charge Masters" (July 1999) available online.

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