Charge Description Master

The Heart of a Strong Revenue Integrity Program

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Speaker Overview

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Agenda

1. Charge Master Basics
2. Overview – CDM Maintenance
3. CDM Best Practices
4. Operational Integration
5. Q&A

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Charge Master Basics

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Charge Master Overview

A hospital's charge description master…

(Often shortened to just CDM) is a database of all items, services, and supplies used in patient care with the associated prices.

A typical charge master line item includes the following:

- Department number
- Procedure number (charge item number)
- Procedure description
- HCPCS (CPT, Level II, or Level III) codes
- Revenue code
- Price

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Charge Master Overview

Procedure item number

The procedure item number is what is posted to the patient's account and detailed on the itemized bill.

Procedure item charge

The procedure item charge descriptions on the charge master are what appear on the claim form.

Revenue generated

The revenue generated from each line item flows into the hospital's accounting system for cost and utilization purposes.

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Key Charge Master Challenges Faced by Health Systems

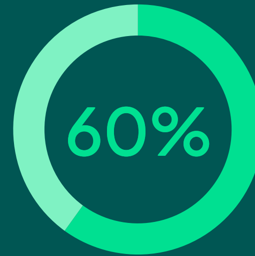
Labor-intensive Process

Limited Staff
Problem keeping up with 1,000s of line-item updates

Compliance Issues
Create payer denials and risk

Pricing Transparency
Difficulty estimating patient responsibility & providing defensible pricing

Charge Master System Coverage



60% items inaccurate or missing:
supplies, Rx, OR time, room charges

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Overview – CDM Maintenance

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Where does CDM maintenance begin?

CDM maintenance is an ongoing process to ensure services are accurately charged, that the hospital is compliant with Medicare regulations, and receives appropriate reimbursement.

Team members should have a thorough understanding of **coverage, payment and reporting issues**

Ancillary staff should participate to ensure that codes and charges reflect services/procedures **actually performed**

Establish a Charge Master Team comprised of members from:

- CDM Coordinator
- Finance/Billing Personnel
- Compliance Officer/Legal/Risk Manager
- Ancillary Directors
- Nursing Administration
- Information Systems
- HIM

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Why is ongoing maintenance necessary?

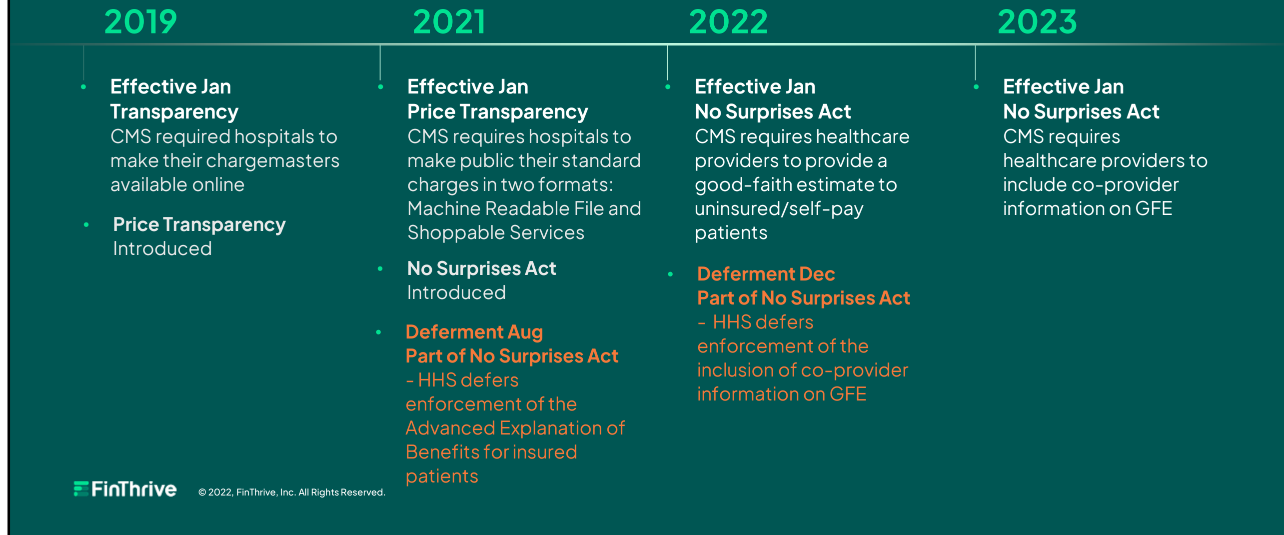
Ongoing CDM maintenance is necessary for:

- New Procedures/Services
- New supplies
- Charge Revisions
- Charge Deletions
- Changes in hospital departments
- CMS updates

CDM maintenance provides accurate and complete data for:

- Correct coding and charging
- Ensures appropriate reimbursement for each procedure code
- Enhances hospital's ability to report correct statistics to governmental agencies

A well designed and maintained CDM can also improve staff (coding, charging, and billing) productivity, reduce claim and line-item denials, while minimizing recoupment and audit risk.



CMS price transparency mandate

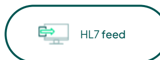
Within the mandate, there are 2 defined provisions that acute-care facilities must fulfill in order to be considered compliant:

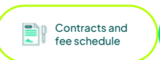
300 shoppable services in either a file or a patient-facing estimator

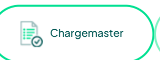
Machine-readable, hospital standard charge file

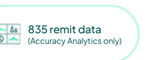
If acute-care facilities are not compliant, significant fines can be imposed, up to $300 per day per facility, up to a maximum of $109,500 annually per facility

Required components for credible, defensible patient payment estimation









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CDM Best Practices

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How do we begin to work toward best practices?

Establish a written protocol:

- The process for submitting revisions, additions, and deletions/deactivations
- The sequence for obtaining CDM change approvals
- Turn-around time for changes to be implemented
- Firmly establish controls on who has authority and system access to update the CDM

Establish process(es) to ensure order entry system or manual charge tickets accurately reflect services provided and that all services in order entry or on charge tickets are reflected in the CDM.

Establish guidelines for the frequency of CDM updates.

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How often should we review and in what ways?

The charge master should be reviewed at minimum quarterly when the CMS updates occur.

Utilize a reference tool for:

- CMS/Fiscal Intermediary updates
- New procedures or services
- New supplies and drugs
- Pricing changes – utilizing peer hospital benchmarks

Each ancillary department should be responsible for conducting a brief monthly review of their department's CDM.

Verify accuracy of CPT/HCPCS and revenue codes.

The CDM should be updated as often as necessary based on the reference tool information

Compare descriptions from CPT codes to the CDM description.

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What should we monitor within our CDM?

Review charge amounts against reimbursement amounts.

Compare order entry/charge tickets with the CDM.

Provide clarification of descriptions/charges/codes and discuss the following with the departmental staff:

- Line items with unlisted codes
- Procedures performed in the unit/department, and what supplies are included
- Non-reportable charges

Monitor claims or perform chart reviews for compliance, reimbursement, code acceptance.

Identify and routinely validate the need for any:

- Charges across the enterprise
- Duplicate charges within a department
- Zero-volume charges
- Zero-dollar charges

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Educate Staff and Communicate Changes

01

Education and training sources:

- CMS regulations, changes and updates
- FI bulletins
- New services/procedures

02

Communicate changes to appropriate personnel:

- Department managers/staff
- Physicians

03

Periodic claims and chart monitoring for billing issues

04

Interim departmental CDM reviews and updates

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Operational Integration

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Build a Strong, Integrated Structure

CDM Management can "live" in different areas based on your organization:

- Compliance
- HIM (under coding or charging)
- Coding (broken out separately from HIM)
- Patient Accounts/Patient Financial Services

When several different structures are acceptable, evaluate based on:

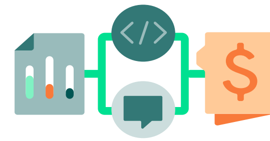
Technology and system infrastructure

- Patient Accounting platform
- Surgical Systems platform
- Radiology Systems platform

Reimbursement Considerations

- Managed Care Contracts

Local practices



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How can departmental (operational) managers help the charging process?

Correct coding problems at the source

- Rejections due to CPT/HCPCS errors should be directed to the appropriate ancillary department or to the HIM department to ensure codes reflect services/procedures performed
- Ask the business office to communicate departmental issues regarding repetitive claim denials

"Own your charges"

- Remain current on all CMS guidelines, FI provider bulletins, and local coverage policies
- Ensure all codes assigned by HIM or hard-coded in the CDM are transferring properly to the claim
- Regularly update the charge master with any coding or billing changes

Accurate and complete documentation

- Ensure accurate and complete documentation in the medical record and use qualified personnel to assign the appropriate codes

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Questions?

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Thank you!

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