Use of the Charge Master in Revenue Cycle Management

Claims processing activities include the capture of all billable services, claim generation, and claim corrections. Charge capture is a vital component of the revenue cycle. Capturing charges is vital to the financial success of a facility. This where collecting all services, procedure, and supplies provided during the patient care process is done. Each item and service is assigned a CPT number and a price. When services are rendered by the patient a charge sheet is completed with all applicable items noted for billing. Missing even the smallest of items being billed can add up over time, which may affect the facility negatively financially.

Have you ever seen a nurse walk up hall with a bunch of stickers stuck to their top? They then take these stickers and place them on a charge sheet that either gets sent to the billing department or is transferred to a computer system by them or a ward secretary to later send to the billing department electronically. The problem with this is when they have multiple patients at one time and multiple patients’ stickers. Who’s to say they remember to put the right charges on the right patient’s chart? Or maybe they brush up against something and those stickers fall off or stick to something else. This equates back to lost revenue. Don’t be surprised if the Central Supply people are hunting down charts on a regular basis, especially after a weekend. They are trying to make sure that every item in their department has been accounted for.

Coding is a major portion of charge capture. During order entry, electronic or paper-based, a unique identifier for each service is entered. This unique identifier triggers a charge from the charge description master to be posted to the patient’s account. This process is known as hard coding.

Inclusion of new codes must be coordinated with the ancillary departments to ensure that services are properly education can be provided to order/charge entry staff. Many healthcare facilities have contracted with maintenance companies to help keep the CDM up-to-date. In addition to providing up-to-date code sets and regulations, many of these companies provide consultation services that assist facilities in the charge capture process. It is critical that the CDM always be precise.

Prior to the implementation of the Outpatient Prospective Payment System (OPPS) by CMS in 2000 for the use in the Medicare hospital outpatient setting, the CDM was primarily used to house the charge or price for hospital services. Since a retrospective cost-based system was used by CMS prior to that time, only the revenue code and charge were required to complete the reimbursement formula. Therefore, not much attention was paid to the CDM except for the maintenance of the charge or price. With procedure-based payment came a whole new set of billing and coding requirements. Revised and new regulations were introduced to the hospital community.

Several types of visits, such as clinic visits, or services such as lab or radiology, are designed to have procedure codes posted to the claim via the CDM.

During the coding process, medical records are reviewed by the coding staff. All diagnoses and procedures are identified, coded, and then abstracted into the HIM coding system. This system then transfers the diagnosis and procedure codes to the patient accounting system where they are posted to
the patient’s claim prior to submission for payment. This coding process is known as soft coding or HIM coding.

Claims production, pricing, utilization management, and resource consumption are all uses utilized by the charge description master. Many things can be learned by running reports that share information of usage. Each time a unit of service is transferred to a patient claim, the CDM tracks the usage of that service. At any given time the number of services performed or the number of units or rendered services can be calculated. Think back to the E-Systems course and what we learned about databases. The CDM is just a huge database that needs tender loving care often to keep it functioning properly.

There are several components of a charge master description. The charge, or service code, and the description number are used to define an item or service. Charge code number sets are assigned by a designated person; probably someone from IT. Duplicate numbers can never happen. Department codes are also unique. The code is used to identify the area within the healthcare facility providing the service. Numbers or letters can be used to distinguish these. A revenue code also goes on the CDM. Revenue codes are four-digit numeric codes assigned by the National Uniform billing Committee. This means that they are standard from one facility to another. An example of a revenue code would be group 045X, which is the Emergency room, then breaking it down farther 0450, which is general ER, 0451 – EMTALA Emergency Medical Screening Service, 0452 – ER Beyond EMTALA Screening, 0456 – Urgent Care, and 0459 – Other Emergency Room. If someone presents for an EKG their revenue code will start with 073X, with 0732 being specific to telemetry. It’s kind of like its own GPS system.

Then we have to have our good old CPT/HCPCS codes. We already know they are unique and assigned by the American Medical Association and CMS. Remember, we have Level I and Level II HCPCS codes. There’s a good chance a modifier will be used too. Modifiers are codes used by providers and facilities to identify or flag a service that has been modified in some way or to provide more specific information about the procedure or service. Because the use of a modifier can alter the meaning of the code in some way, it is important that modifiers are only applied to CPT and HCPCS codes when documentation within the medical record supports the application of the modifier. It is very rare that these are hard-coded in the CDM. A charge description is an explanatory phrase that has been assigned to describe the procedure, service, or supply. The price is the dollar amount the hospital is charging for the item or service rendered to the patient. The payer ID codes are used to differentiate among payers that may have specific or special billing protocol in place. It is important for the CDM team to review the payer assignment on a regular basis.
Sample CDM

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<tr>
<th>Charge Code</th>
<th>Dept. Code</th>
<th>Revenue code</th>
<th>CPT/HCPCS Code</th>
<th>Modifier</th>
<th>Charge Description</th>
<th>Charge</th>
<th>Charge Status (A/I)</th>
<th>Payer ID</th>
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<tbody>
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<td>99281</td>
<td></td>
<td>Level 1 ED</td>
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<td>123</td>
<td>450</td>
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<td></td>
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</tbody>
</table>

Each facility will have a unique design and philosophy for their CDM. However, each design must incorporate the required billing data elements.

CDM maintenance is an ongoing process at any healthcare facility, physician office, hospital, imaging center, or freestanding laboratory facility. Each year the CDM coordinator should ensure that the proper resources are acquired for CDM maintenance. Code books must be updated yearly to assure you have the newest codes. Medicare Claims Processing Manuals should be available so crucial instructions can be easily located and reviewed. Any regulation changes specific to your state will also need to be available.

A plan needs to be in place for reviewing the CDM on a regular basis. Review of current statistics, CPT/HCPCS codes, revenue code changes and modifier reviews must happen and be updated with the most current information. If outdated information is sent to a payer the claim will be denied. Very many denials and your CFO will be your nightmare. A review of current charges needs to also happen. As medicine evolves things become more expensive to offer. If you get a new piece of equipment to perform state of the art procedures then you will want to pass that cost on to the consumer by way of a charge. Hospital boards often initiate an across the board price hike of 2% or 5% which will help offset cost increases such as raises, or an increase in medicines that the facility is buying.

ICD codes are updated every October 1st and CPT/HCPCS are updated annually every January 1st. Again, it is crucial that your system reflect any current changes to information so you don’t experience a delay in payment because of denial.

Even with policies, procedures, and maintenance plans in place, there will always be issues that arise and need immediate attention. When issues come to the surface, the CDM coordinator must be ready to execute a CDM review to help identify the root cause of the issue. The CDM coordinator should have constant communication with the claims reconciliation unit. The claims reconciliation unit reviews payer
documents to identify if the expected reimbursement matches the actual reimbursement for claims. During data analysis, the reconciliation area may uncover billing, coding, or CDM issues. It is important for the reconciliation, CDM, and coding units to work together to resolve systematic issues.

Compliance, compliance, compliance... In today’s healthcare environment every facility has a compliance plan. It is important for the CDM unit’s policies and procedures to be in alignment with the facility’s compliance plan. There are numerous publications and policy documents that must be reviewed and assessed throughout the year in order to keep the CDM compliant with coding and billing regulations. The CMS Claims Processing Manual is one of the many manuals included in CMS Internet-Only manuals System, which is used by CMS program components, partners, contracts, and other agencies to administer CMS programs. It currently has 38 chapters and provides guidance for producing claims for all healthcare settings. Updates, however, are made throughout the year. Program Transmittals are used by CMS to communicate policies and procedures for the specific prospective payment systems’ program manuals. National and Local Coverage Determinations describe the circumstances under which specific medical supplies, services, or procedures are covered nationwide by Medicare under Title XVIII of the Social Security Act and other Medical regulations and ruling. Local Coverage Determinations provide facilities and physicians with the circumstances under which a service, procedure, or supply is considered medically necessary. There are regional differences in medical necessity and therefore differences in coverage for Medicare supplies, services, and procedures. These all affect payment in the end.

The pharmacy area is a complex component of the CDM because two code sets are used by the facility to track the facility pharmacy items and the dosage must be closely monitored. Pharmacy codes are a little different as the start with a “J,” “Q,” or “S.” The HCPCS Level II Code typically allows for one code per drug and has one set dosage amount. But if, for example, more than the amount described is given then it may need to be reported twice.

When choosing who should be on the charge master committee several key personal must be included; they are: HIM, financial services or the Business Office, corporate compliance, a person from radiology, lab, respiratory therapy, cardiac cath lab, physical therapy, the ER, nursing, as well as someone representing the physicians. Any department that generates revenue should be represented.

As you can see the charge description master is a key piece of the puzzle and keeping it current is essential.

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