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Charge Description Master: Use It to Optimize Revenue

Secure hospital revenue integrity by implementing best practices for compliant charge capture.

When billing hospital services, it's important to know the fundamental elements of the Charge Description Master (CDM). Here's guidance to ensure your CDM is correct and compliant to keep your hospital's financial livelihood strong.

Recognize CDM Functionality

CDM, commonly referred to as the "Charge Master" or "CDM," is the heart of a hospital's cash flow. This system master file is the catalogue of every chargeable item that a hospital offers. Every patient revenue dollar that flows through an organization is generated through this file. Hospitals that take great care to ensure their CDM is correct are able to optimize their revenue cycle for enhanced patient experience and improved financial sustainability.

An improperly set up and maintained CDM can cost an organization millions of dollars in lost revenue or compliance penalties. Medicare and the Office of Inspector General consider accepting overpayments from health insurance companies or the government to be fraud, which can result in substantial penalties.

Proper CDM setup and maintenance is especially important as the healthcare system faces declining reimbursements and rising scrutiny of charging accuracy, pricing transparency, and justification. These factors have put hospitals in difficult positions to generate revenue. Hospitals have had to take a hard look at their revenue cycle best practices and seek opportunities for improvement, starting with the CDM.

Improve Coding Accuracy

Medical coders play a critical role in a hospital's revenue cycle. By gaining an appreciation for the function of the CDM, you can improve your coding accuracy and, in turn, optimize your hospital's revenue cycle and improve patient experience by mitigating billing errors. This starts by fostering a culture of accountability and communication between CDM managers, coders, and clinical staff to ensure the CDM is properly set up and maintained.

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Break Down the CDM Components

CDMs can vary from hospital to hospital. Generally, there are several basic elements:

Description of Service: The Healthcare Financial Management Association's (HFMA) Patient Friendly Billing Project recommends that all patient financial communications be clear, concise, and correct. Many modern billing systems can have multiple description lines, the most common are a technical description and a billing description. The technical

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description is typically what is used internally, and the billing description is typically what appears on a patient's itemized bill.

Most organizations have the same description on all lines, but there may be situations where different descriptions make it easier for patients to understand their bill. For example, CPT® code 95808 *Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist* is for polysomnography. Although this is an acceptable description for internal use, from a patient perspective it may make sense to use "sleep study" as the external description for the itemized claim.

CPT®/HCPCS Level II Codes: Most of the charge master is comprised of services where the code will not change. When the service is not likely to change, then the codes are directly programmed as part of the charge. If the CPT® code is variable, then generally the charge is a "shell" charge and coders assign those codes.

Modifier Codes: Modifier codes can also be programmed as part of the charge; but be careful when placing a modifier in the CDM. Modifiers should only be added when a specific situation calls for modifier use 100 percent of the time.

For example, a single-view wrist X-ray does not have a specific code, while a two-view wrist X-ray is reported using CPT® 73100 *Radiologic examination, wrist; 2 views*. As such, it's appropriate to report 73100 with modifier 52 *Reduced services* when only one view is taken, to communicate to the payer that full payment should not be received for this charge.

Revenue Codes: Designated by the National Uniform Billing Committee, revenue codes inform the payer where the service took place. For example, an infusion given in the emergency room is reported with revenue code 0450 *Emergency Room – General.* This differentiates it from an infusion given in an infusion clinic, which is reported with revenue code 0260 *IV Therapy - General*. Medicare also uses these codes to group revenue for cost reporting.

Identify Chargeable Supplies

Supplies often fall into a "gray area" in terms of what is considered chargeable. Many supplies are considered non-chargeable because they are part of a hospital's "floor stock," which means they are included in an inpatient's room and board charge or are included in the payment for the outpatient procedure/service.

Hospitals can improve their revenue capture of chargeable supplies by developing guidance based on the following questions:

- Is the item medically necessary and specifically ordered by a physician?
- Is the item used specifically for and by the patient?
- Is the item not commonly furnished as part of a medical procedure or treatment?
- Is the item not commonly available for patient use in the medical department or setting?
- Is it documented within the medical record that the item was used?

From a compliance perspective, this last question (documentation of supplies used within medical records) is very important. Auditors often cite hospitals for insufficient documentation of supplies used, especially for operating room procedures.

Hospitals should not rely on physicians to dictate all of the supplies as part of their procedure notes; rather, nurses should be trained to document all supplies used on an inventory sheet with attestation and capture revenue this way.

Check the Price

One area that varies widely from hospital to hospital (unlike any other industry) and that confuses patients the most is pricing. Pick any three hospitals within a 30-mile radius of each other and you can bet the price of the same procedure at each hospital varies — sometimes, greatly.

Medicare does not dictate how an organization should establish their pricing, but it does offer the following guidance in the Medicare Paper Based Manual (section 2202.4) to ensure a reasonable relationship between cost and price:

> Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

For compliance best practice, hospitals should price services for reimbursement maximization only.

- **Service prices should be defendable** - for example, be sure the price can be explained to a consumer.

- **Service prices should be consistent** - for example, left and right should have the same price.
- **Service prices should be logical** - for example, a computed tomography (CT) scan without contrast should be priced less than a CT scan with and without contrast.

Consideration should be given to commercial fee schedules to assess if the organization is leaving money on the table.

Maintain the CDM for Accurate Payments

CDM maintenance, whether centralized or decentralized, needs to be consistent and often. Many hospitals centralize oversight of the charge master with a CDM analyst/manager. These positions are important but are not enough on their own. Clinical departments must be accountable for their charges because the CDM analyst/manager, although responsible for ensuring consistency within the CDM, is not a practitioner and does not know the actual practice at the patient's bedside.

An often-overlooked area of CDM maintenance is external ancillary systems, which are not directly part of the CDM but do interface with the patient accounting system (e.g., lab, radiology, and pharmacy). This extra complexity is why maintaining the CDM should be a shared responsibility between the CDM analyst/manager and the clinical department.

Although modern patient accounting systems are more integrated than 10 years ago, periodic reviews should include mapping out these external ancillary systems within the CDM. Hospitals can inadvertently charge the wrong service if said service is not mapped correctly throughout the system. Clinical departments should review their charges annually, at a minimum.

Ensure Proper Charge Entry

Charges can be processed in many ways: Typically, charges are automated or connected with clinical documentation. Clinicians may not be aware that, as they document in the record, charges are being generated. As such, it's essential for the CDM to be set up to facilitate proper billing.

Example:

A nurse in an oncology clinic administers bevacizumab to a patient. The patient needs 950 mg. Bevacizumab (HCPCS Level II code J9035 *Injection, bevacizumab, 10 mg*) needs to be billed in 10 mg increments. If this charge is not set up to report in 10 mg increments, the hospital is at risk of receiving a significantly incorrect payment.

The national reimbursement rate for Medicare is $76.66 per unit. For a 950 mg dose (excluding reporting waste), 95 units should be reported, for a Medicare payment of $7,282.70. Incorrectly reporting the bevacizumab per milligram would result in 950 units and an overpayment of $72,827. Incorrectly reporting the drug per dose, as one unit, would result in an underpayment of $76.66.

It's important for departments to have a full understanding and ownership of their charges, including reconciling charges on a consistent basis. One way to ensure that consistent and ongoing charge reconciliation is happening is to periodically complete charge audits on clinical departments.

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Maintaining the charge master is more than entering a charge in a systems' master file. Other aspects to consider include:

- Charges that are too high, too low, or inconsistent
- Improper revenue codes for where the service has been completed
- Incorrect CPT®/HCPCS Level II codes for the actual bedside service
- Inappropriate pharmacy units
- Obsolete charges
- Zero volume charges
- Inadequate or inappropriate charge descriptions
- Use of miscellaneous charge codes
- Application of markup policies for drugs and supplies

Ensure Compliance and Proper Charge Capture

Creating a culture in an organization where maintaining the charge master is a team effort is critical to ensuring proper compliance and charge capture, especially as high deductible plans force pricing transparency and billing scrutiny.

Teaming up with compliance can be an effective way to expedite a CDM accountability culture. Organizations with a defendable pricing structure and effective revenue integrity/charge capture programs will secure their revenue now and in the future. The end goal is to ensure your organization is paid every dollar due: no more, no less. HBM

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Resource

Medicare Paper-based Manual, Section 2202.4: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html