Charge Master and Charge Capture:
Risks, Opportunities & Best Practices

hfma™
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Agenda

- Charge Description Master (CDM)
  - What is the CDM and why is it important?
  - CDM risks and opportunities
  - Keys to successful CDM management
- Charge Capture
  - Importance and complexity of charge capture processes
  - Charge capture risks and opportunities
  - Connecting the CDM and charge capture
  - Best practices for ensuring accurate charge

What is the Charge Description Master (CDM)?

- A comprehensive list of procedures, supplies, devices, drugs, and other items for which a distinct patient charge exists
- CDM may also include statistical tracking line items, payment and adjustment codes, other data
- Master file is maintained within the hospital information system(s) and is interfaced with other applications to support the charging of items and services

Importance of the CDM

- Some describe the CDM as “the life blood of the revenue cycle”, or the “backbone” or “central revenue cycle mechanism”
- Whatever the term used to describe it, the CDM is fundamental to revenue generation and the charge capture process
- Maintenance of the CDM is critical to the financial success of any institution

Who is Responsible for CDM Management?

- Every hospital is different – much depends on the size and resources of the facility

Examples:

- Large health system – CDM Manager, team of CDM analysts
- Mid-sized hospital – CDM Coordinator
- Small facilities – Responsibility of PFS director, along with EVERYTHING ELSE?

- Important: Access to make updates to the CDM should be tightly controlled

CDM Risks

- Charging for wrong items/services
- Not charging for items/services
- Reporting incorrect number of units
- Denials or claims rejections – many reasons
- Fines or penalties
- Automation – a single error may be duplicated hundreds or thousands of times before being identified

Basic Risk Areas and How to Avoid Them

- Simple everyday charge master maintenance tasks, if done incorrectly, can lead to major risks

- On the following slides, we will discuss some common risk areas and how to avoid them

Charge Descriptions

- Accurate charge descriptions are important
- Often limited by space constraints
- Descriptions should match the definition of the corresponding CPT/HCPCS code assigned in the CDM
- Slight inaccuracies or vagueness can lead to incorrect charges being reported, which may lead to dramatic differences in reimbursement

Charge Descriptions

- Standardized descriptions
  - Use standardized verbiage that appropriately describe items/services and are understood by all that use the charge (e.g., specimen source, number of views, unit of measure, etc.)
- Abbreviations – make sure they are clear
  - Example: “Diphenhydramine 1 ml SYR” – Does this mean syrup? Syringe? Each would be billed differently (injectable drug versus self-administered drug)
- Timed codes
  - Biller per hour? Per 15 minutes? Does description specify?

Revenue Codes

- Four-digit numeric codes established by the National Uniform Billing Committee (NUBC) that categorize/classify line items in the CDM
- Example: 0420 – Physical Therapy, 0301 – Lab Chemistry, 0250 – Pharmacy
- How do you choose revenue code assignments?

Revenue Codes

- From CMS (Medicare Claims Processing Manual, Chapter 4, Section 20.5):

  Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

Why are Revenue Codes Important?

- Cost reporting
  - Revenue codes are cross-walked to certain cost centers on the cost report
- Claim edits
  - Some CPT/HCPCS codes must be reported with a specific revenue code in order to get reimbursed by certain payers (e.g., Medicare requires revenue code 0770 for some preventive services)
- Reimbursement
  - Some payers base payment on revenue code assignment rather than CPT/HCPCS codes (fee schedule, case rate, per diem?)

Modifiers

- Two-digit alpha or numeric character that can be appended to a particular CPT or HCPCS code to provide additional information about that code
- Modifiers may be “hard coded” in the CDM or can be “soft coded” by HIM or other staff
- Who should assign modifiers? HIM? Departmental staff? Billers?
- Some modifiers can be safely added in the CDM. Examples:
  - Laterality (LT, RT, 50)
  - Informational (GP, GO, GN)
  - Payer required (GY)

Modifiers

- Other modifiers can be very risky to have hard-coded in the CDM and are not recommended. Examples:
  - Separate and distinct services (25, 59)
  - Repeat lab tests (91)
  - Discontinued procedures (73, 74)
- These modifiers describe *clinical situations* and require a certain level of expertise when determining when it is appropriate to assign
- These modifiers may circumvent NCCI edits, or impact reimbursement amounts

Modifiers

- Have a set policy in place documenting which modifiers are included in the CDM and which are not
- Ensure that staff adding modifiers understand the significance of the modifiers and requirements for their use
- Only hard-code modifiers when the situation they are describing is true **100% of the time**

Modifiers

- **Very important** – keep up with the ever-growing and changing list of modifiers required to report data and/or trigger reimbursement policies for Medicare

- JW modifier for drug waste
- PO/PN modifiers for off-campus provider-based departments
- JG/TB modifiers for 340B-acquired drugs
- FY modifier for computed radiography
- CT modifier for imaging equipment that doesn't meet NEMA standards

Pharmacy

- Major risk area in CDM due to constant changes
- Who assigns HCPCS codes? Often, Pharmacy staff have more involvement in their CDM.
- When new drugs are added to formulary, are HCPCS codes always looked up?
- Many drugs have specific HCPCS codes, many of which are separately reimbursed by Medicare and other payers
- No HCPCS code = no reimbursement
- Drug may not have HCPCS code when first created – who monitors updates?
- How are non-formulary drugs handled?

Pharmacy – Self-Administered Drugs

- Self administered drugs – not covered by Medicare Part B
- How are these identified in the CDM?
- If assigned to revenue code 250, may be getting billed to Medicare "masked" as a covered drug – compliance issue
- Should be assigned to revenue code 637 (many hospitals use 259)
- Mechanism should be in place to either bill to Medicare Part B as non-covered, or to write off the charges

Pharmacy – Drug Unit Multipliers

- Drugs are billed in units defined by HCPCS descriptions
  - Example: J1745 “injection, infliximab, 10 mg”
  - 100 mg vial would be billed as 10 units of J1745
- Who assigns multipliers?
- Where are they housed? CDM? Formulary?
- Are these reviewed when codes change?

Supplies

- Does person creating charges for supplies understand the definition of billable patient supplies?

1. Medically necessary and furnished at the direction of a physician or other practitioner
   - Does not include personal convenience items (e.g, slippers, personal care items)
2. Single use/disposable
   - Cannot charge for reusable supplies
3. Patient identifiable
   - Medical record documentation must support the use of the item
   - Does not include routine items such as drapes, pads, cotton balls, urinals, bed pans, gauze, etc.

- Is there a policy for charging for supplies?

Pricing

- Is there a standard methodology that is used consistently?
- Do prices for the same services vary from department to department?
- Are prices appropriately tiered based on the complexity of the services?
- Are prices reviewed against payer fee schedules?
- Annual price increases?
- Be mindful of current trends in hospital pricing - price transparency, defensible pricing, etc.

Obsolete Items

- Departments should regularly review their charges and should inactivate charges that are no longer needed

- Keeping obsolete items in the CDM:

1. Leaves the possibility open for incorrect charges to be selected
2. Makes the CDM larger, more cluttered, and more difficult to analyze

- Review all items with no volume for 12-18 months with departments and consider for inactivation

Charge Explosions/Panels

- Charging for related services can be assisted with the use of charge explosions or panels
  - Charging a single line item which “explodes” out to multiple line items
- Commonly seen in Radiology, Lab
- Be very careful that explosions are only utilized when every component is performed
- Clearly identify which charges are explosions
- Be mindful of how annual code changes can impact existing explosion set-ups – explosion builds are frequently forgotten/ignored

Alternate Code Assignments

- In some scenarios different payers require different codes to be reported for the same service
- Example: Medicare requires G0463 instead of 99201-99215 for outpatient visits
- Not every alternate code is reported the same manner as the default code (e.g., different units, etc.) – in some cases claim logic is needed to report correct billing units, or an entirely separate charge may be needed
- Ensure that alternate coding assignments are accurate in the CDM and fully understood when assigned

Charge Master Reviews

- Best practice – complete review every 2 years
- Involve clinical departments!
  - Share findings
  - Review processes and procedures
- It is more than just confirming valid CPT/HCPCS codes
  - Volume analysis, identification of missing charges, pricing, etc.
- Don’t forget to implement changes!
  - A comprehensive CDM review sitting on the shelf collecting dust helps nothing!

Keys to Successful CDM Management

- The first key to CDM success is OWNERSHIP
- Does the person, or people, responsible for the CDM "own" the file?
- Or is CDM management a secondary task or responsibility that is done "on the side" or "when there is time"?
- CDM management must be a priority
- The CDM owner should be deeply knowledgeable of the file and should be accountable for all changes made to it

Keys to Successful CDM Management

- The second key to CDM success is COLLABORATION

- The CDM contains elements that are both financial and clinical in nature.

- Finance cannot maintain the file without the assistance of clinical departments, and vice versa.

  - Example: Complicated changes to lab drug screen codes for 2015 - 2017

Keys to Successful CDM Management

- Are clinical department heads aware of what is in their CDM file?
- Do they keep up with changes?
- Is there continuous communication between clinical departments and the “owner” of the CDM?

Additional CDM Players

- In addition to the clinical departments, other parties greatly impacted by the CDM include:
  - Business office/PFS
  - HIM
  - IT
  - Compliance
  - Finance
- Each of these areas should have a line of communication with the person or people responsible for the CDM.

Does a Clean CDM Guarantee Revenue Maximization and Risk Reduction?

NO!

The CDM is One Major Piece of the Puzzle

- The CDM is a major component of the revenue cycle and its importance cannot be understated
- However, the positives of a clean CDM can be negated due to poor charge capture
- A charge may be perfectly represented in the CDM file, but….
- If it isn’t captured, it isn’t paid!

What is Charge Capture

- Ensuring that each patient encounter is charged completely and compliantly for all services, supplies, and pharmaceuticals used

- Very complex process

  - Multiple types of patient encounters
  - Many different departments and locations
  - Unique coverage and billing requirements
  - Variety of information systems

Who Captures Charges

- During a single patient encounter, many different hospital departments and associated personnel contribute to providing and charging for services and supplies
- Do all parties understand the complexities of charge capture?
  - Nurses?
  - Ancillary staff?
  - Coders?
  - Billers?
- One major reason for charge capture failures is that many personnel are not properly trained or provided with the necessary resources

Charge Capture Risks

- Missing charges
  - Not charging for all items/services being delivered
- Incorrect charges
  - Charging for items/services that were not the actual items/service being delivered
- Late charges
  - Delays in posting charges leading to held claims, rebills, write-offs
- Reduced productivity
  - Spending far too much time fixing charging issues on the back end

Methods of Charge Capture

- Order entry (ordered/resulted)
- Upon EHR documentation
- Manual entry by specified staff (and backup person if staff is out?)
- HIM/coding (are there backlogs/delays?)
- Patient accounts? (hopefully not!)

What Methods are Used at Your Facility?

- Does each clinical department head have a complete understanding of how they are charging for what is being done in their areas?
- What is the worst response that we often here when we ask a clinical department head “how do you charge for _____ ?

I DON’T KNOW

- How can you be sure that you are getting paid for everything that you are doing if you don’t even know how you are charging for it?

Are you Charging for Everything You Can?

- Interview departmental staff to determine all services that are being performed
- Confirm that all chargeable items/services are identified in the CDM
- Review code ranges in CPT book
- Review new CPT codes
- Chart reviews/audits may identify services being performed that aren’t being captured

Identifying Charge Capture Errors

- Daily charge reconciliation

  →Confirm that appropriate charges are being posted to every account

- Revenue and usage reports

  →Look for trends that might identify issues

- Late charge reports

  →Excessive late charges due to charge capture breakdowns

- Chart reviews

  →Identify deficiencies that might otherwise go unnoticed

Connecting the CDM and Charge Capture

- Regardless of how charges are being captured - where are the charges coming from?

- How are charge capture methods in clinical areas linked to the CDM?

  - Order entry? Electronic procedure menus interfaced with CDM? Charge sheets?

- Do items/services being described in various charge capture methods link to matching items in the CDM?

Connecting the CDM and Charge Capture

- Verify that a 1:1 relationship exists between items on charge sheets, order entry dictionaries, and the CDM
    - Charge sheets get outdated!
    - Is there a process for regular review?
    - Revision date should be included on document.
- Review of “mapping” is just as important as review of CDM or charge capture processes

Ensuring Accurate Charge Capture

- Provide departments with the education and tools that they need to manage their charges
  - Written policies and procedures
  - Training regarding billing rules and guidelines
  - Paper or electronic resources (e.g., CPT books, online reference sites, CDM management tools)
- Promote charge reconciliation
- Review Revenue and Usage reports
- Perform regular audits
  - Compare physician orders, to chart documentation, to itemized charges, to claim form – identify deficiencies or missing charges

Concord Hospital Tips & Lessons Learned

- Invest in your CDM person/team
- Invest in tools to help your team stay up-to-date on coding and regulatory updates
- Maintain strong relationships with your clinical teams
- Insert yourself/your team in conversations and planning around new clinical items and services
- Implement a formal request process for new charges
- Track all CDM changes
- Implement and document standard work around CDM maintenance and charge capture processes

Conclusion

- Clean and complete CDM and accurate charge capture are critical to the financial success of any hospital
- This cannot be a secondary responsibility, but rather must be an area of focused effort and attention
- Requires the right people with the right knowledge and the necessary resources needed to get the job done right
- There is more than one piece to the puzzle. Breakdowns in any area can lead to risks.
- One size does not fit all – every facility is different. Each hospital needs to develop processes that work depending on the size, the resources and the people at your facility.

Questions?

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