



**Valerie A. Rinkle, MPA**



**Valerie A. Rinkle, MPA**

**HCPPro**  
a division of BLR

***The Chargemaster Essentials Toolkit*** is published by HCPro, a division of BLR.

Copyright © 2016 HCPro, a division of BLR

All rights reserved. Printed in the United States of America. 5 4 3 2 1

ISBN: 978-1-68308-086-2

No part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center (978-750-8400). Please notify us immediately if you have received an unauthorized copy.

HCPro provides information resources for the healthcare industry.

HCPro is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

Valerie A. Rinkle, MPA, Author

Andrea Kraynak, CPC, Editor

Erin Callahan, Vice President, Product Development & Content Strategy

Elizabeth Petersen, Executive Vice President, Healthcare

Matt Sharpe, Production Supervisor

Vincent Skyers, Design Services Director

Vicki McMahan, Sr. Graphic Designer

Angel M. Cruz, Layout/Graphic Design

Philip Couch, Cover Designer

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions. Arrangements can be made for quantity discounts. For more information, contact:

HCPro

100 Winners Circle Suite 300

Brentwood, TN 37027

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-785-9212

Email: [customerservice@hcpro.com](mailto:customerservice@hcpro.com)

Visit HCPro online at [www.hcpro.com](http://www.hcpro.com) and [www.hcmarketplace.com](http://www.hcmarketplace.com)

# Contents

<b>About the Author .....</b>	<b>vii</b>
<b>Introduction.....</b>	<b>1</b>
<b>Chapter 1: The Chargemaster Coordinator’s Role Within the Revenue Cycle .....</b>	<b>3</b>
The Chargemaster in the Context of Revenue Integrity.....	3
Key Functions of the Revenue Cycle .....	4
Vital Resources for Chargemaster Management.....	10
<b>Chapter 2: Chargemaster Structure and Principles .....</b>	<b>17</b>
Chargemaster Fields .....	18
Dynamic Versus Static Chargemasters .....	26
Exploding Charges.....	26
Relationship of Chargemaster to HIM Coding .....	27
Relationship Between Chargemaster and Other AR System Files.....	31
Charge Capture Principles and Methodologies .....	33
Pricing Services.....	35
Best Practices for Charges .....	37
The Chargemaster’s Relationship to Cost Reporting .....	38
<b>Chapter 3: Chargemaster Management and Maintenance Strategies.....</b>	<b>43</b>
The Team Approach to Chargemaster Maintenance.....	43
Tracking Charge Description Master Changes for Compliance .....	45
Annual CPT/HCPCS Updates .....	45
Quarterly Updates.....	47
Preparing for a Department-by-Department Review .....	48
Annual Pricing Updates .....	52
Chargemaster Change Reporting Requirements .....	53

<b>Chapter 4: Claims and Claim Submission Fundamentals .....</b>	<b>55</b>
Hospital Claims .....	55
Time Limitations on Filing Claims .....	64
HIPAA Transaction Sets .....	64
Medicare Claims Flow and Processing Systems .....	66
Claim Submission Fundamentals.....	67
Summary .....	76
<b>Chapter 5: Chargemaster Considerations for Routine Services .....</b>	<b>77</b>
General Medical/Surgical Nursing Units.....	77
Nursery Levels .....	78
Specialty Care Units/Intensive Care Units .....	79
Incidental Nursing or Bedside Procedure Charges .....	80
Outpatients in Beds .....	82
<b>Chapter 6: Ancillary Services, Part 1 .....</b>	<b>85</b>
Pharmacy and Radiopharmaceuticals.....	86
Drug Administration Services, Blood Administration, and Oncology.....	92
Supplies, Devices, and Implants.....	95
Laboratory, Pathology, and Blood Products.....	102
Imaging and Therapeutic Radiology.....	112
Perioperative Services.....	120
<b>Chapter 7: Ancillary Services, Part 2.....</b>	<b>127</b>
Respiratory and Pulmonary Services .....	127
Physical, Occupational, and Speech-Language Pathology Therapies.....	132
Emergency, Trauma Services, and Clinic Services .....	138
Cardiology Services .....	145
Labor and Delivery.....	148
Summary .....	151

**Chapter 8: Coding and Claim Edits ..... 153**

    Inpatient Claim Editing Software ..... 154

    Outpatient Claim Editing Software..... 155

    Summary ..... 166

**Chapter 9: Managed Care Contracting Strategies and Price Transparency ..... 167**

    Managed Care Contracts and Payer Scorecards..... 167

    Price Transparency and Patient-Friendly Billing and Collection Practices ..... 171

    Summary ..... 172

**Appendix A: Resources ..... 173**

**Appendix B: List of Downloads ..... 181**



# About the Author

**Valerie A. Rinkle, MPA**, is a lead regulatory specialist and instructor for HCPro's Revenue Integrity and Chargemaster Boot Camp®, as well as an instructor for the Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version. Rinkle is a former hospital revenue cycle director and has more than 30 years of experience in the health-care industry, including more than 12 years of consulting experience in which she has spoken and advised on effective operational solutions for compliance with Medicare coverage, payment, and coding regulations, including chargemaster development, structure, and maintenance.



# Introduction

*The Chargemaster Essentials Toolkit* is designed for those who are responsible for maintaining a hospital's chargemaster. This may be the chargemaster for a single hospital or the consolidated chargemaster for a multihospital system—either way, understanding the role of the chargemaster within the overall context of revenue integrity is critical. Furthermore, this toolkit provides key resources that will enable management of the chargemaster over time.

This toolkit provides information and strategies considered essential for a chargemaster coordinator. It is designed for those both new to their role in chargemaster management and also for those with years of experience.

Professionals who have responsibility for chargemaster management come to the role with varying backgrounds. These backgrounds include coding, finance, reimbursement, patient financial services, and clinical backgrounds (often from ancillary departments such as clinical laboratory, radiology, and surgery). Effective chargemaster management entails the integration of these disciplines, and, given the wide variation in background and experience, attaining the necessary knowledge for all areas can be challenging. Currently, no certification for chargemaster management exists, and formal training may be a challenge to acquire. While this toolkit cannot take the place of either of these, it aspires to be a trusted and effective “go-to” resource.

Chapter 1 offers an overview of the chargemaster within the revenue cycle. This chapter will also describe the importance of an organization's chargemaster in the overall context of revenue integrity and identify vital resources to obtain for chargemaster maintenance. Chapter 2 will define the chargemaster, its function, and principles of the chargemaster itself, including the relationship to the cost report. Chapter 3 will discuss chargemaster maintenance strategies for

management. Because the chargemaster is essential for clean claims, the next chapter, Chapter 4, will review important principles of clean claims and claim submission fundamentals. Chapter 5 drills down on concepts important for routine services and observation. The following two chapters, Chapters 6 and 7, will drill down into ancillary services such as supplies and devices, laboratory, perioperative, emergency department, and other services. This is followed by Chapter 8, which reviews coding and edits, as the chargemaster coordinator is often central to helping resolve the root cause of edits (e.g., determining how to best address them, whether through the chargemaster itself or via processes involving technology and/or staff intervention). This is followed by a concluding chapter, Chapter 9, on payer contracting strategies.

Throughout the toolkit, sample policies and procedures and other resources will be described and made available to “jump start” common chargemaster management activities.

I hope that this resource validates concepts and processes used by experienced chargemaster coordinators, provides a solid foundation for those new to chargemasters, and provides new perspectives that can be used to build the vital relationships with other department staff from which effective collaboration ensues. To me, the ultimate objective of more effective processes designed to ensure accurate and complete payment with the most efficient methods is to support those who provide high-quality care to patients. We are all in healthcare for patients, and it is so important to acknowledge that fact, even when the support feels indirect through administrative and regulatory endeavors.

# **The Chargemaster Coordinator's Role Within the Revenue Cycle**

---

## **The Chargemaster in the Context of Revenue Integrity**

---

The chargemaster is but one tool in the revenue integrity arsenal. A perfectly clean, up-to-date chargemaster—completely accurate from the standpoint of both common procedure terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes, revenue codes, and general ledger linkages—can still result in poor claims. This is because the chargemaster has to be properly used to develop clean claims and to avoid edits that result in slowed accounts receivable (AR).

Therefore, understanding the chargemaster in the overall context of the revenue cycle and the goal of revenue integrity is crucial. With this context, it is then possible to fully appreciate the importance of the chargemaster and the broad role of a chargemaster coordinator, who not only ensures the accuracy of the chargemaster but continually collaborates with others to ensure that the chargemaster is used appropriately to bill for services rendered.

There is no standard definition of revenue integrity in the healthcare industry. One way to think of it is the processes, internal controls, feedback loops, and other procedures along the revenue cycle continuum designed to efficiently and effectively capture complete revenue for all services rendered. This includes having accurate supporting documentation while ensuring revenue is billed to the appropriate party (for covered services) or to the patient (for noncovered services for which he or she received advance notification). Another, briefer definition of revenue integrity is effective, efficient, replicable processes and internal controls resulting in clean claims that are supported by appropriate documentation, authorized and covered, billed to the correct payers and properly paid, and able to withstand audit at any point in time.

The term *chargemaster* is not included in either of these definitions. This may be because the chargemaster is a workhorse behind these functions that helps ensure the outcomes described in these definitions. Increasingly, however, revenue integrity is a stand-alone department, initiative, program, or organizational structure within hospitals and health systems accountable for managing revenue integrity. Chargemaster management responsibility is a key function of these revenue integrity departments. Overall, the basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risk. Effective chargemaster management is a core competency of revenue integrity.

Other core competencies of revenue integrity include understanding principles of eligibility, coverage, and payment. Eligibility means the patient has to be eligible and covered by the third party or insurance for the date of service. The premiums must have been paid and the patient enrolled and acknowledged as a member or beneficiary by the payer. Coverage is an important preservice analysis that requires verification. Coverage requires a specific benefit in the patient's insurance plan that covers the services, such as hospitalization. Beyond a specific benefit, to be covered, the services must be medically necessary. Payment cannot take place until the patient is verified as eligible and the services determined to be covered. A correct claim can then be billed to the payer on behalf of the patient, and payment should be made for the services. Payment methodologies can take various forms, and correct billing and payment is a major goal of chargemaster management.

The functions of the revenue cycle then are the interrelated steps taken when a patient needs a healthcare service. Revenue integrity is achieved through the functions of the revenue cycle, and the chargemaster is at the hub.

## Key Functions of the Revenue Cycle

---

Traditionally, main revenue cycle functions are organized into those functions that are performed in the front (or preservice), the middle (which includes the service performance, documentation, and coding), and back part of the process (which is claims development, claim submission, and other patient financial services such as collections, cash posting, account follow-up, and payment verification). The chargemaster is a middle-revenue cycle function, but it informs almost all of the functions of the revenue cycle.

Handoff points between each of these functions occur in the patient accounting system, in other interfaced systems such as the eligibility-checking software, in department information systems such as radiology and pharmacy, in modules within the patient accounting system itself, and, finally, among staff that perform the functions. Each handoff in the process is an opportunity for error, but, more importantly, an opportunity for improvement and potential automation or leverage of people, process, technology, and analytics.

Often a chargemaster coordinator is asked to be a project manager for initiatives designed to improve revenue integrity. This requires knowledge of the functions of the revenue cycle.

### *Front-end functions*

The front-end functions are often referred to as *patient access*. Patient access includes everything that ensues from the point at which a health service need is identified by the patient and/or his or her clinician. Once the need is identified, for services other than those that can be self-referred (e.g., preventive services), the clinician must make a referral to the performing/furnishing provider. In this book, the hospital is assumed to be the performing provider. Referral management concerns the steps to document and obtain key information regarding the patient and the service to be performed. At times, the referral part of the process is separate from obtaining the full-fledged order. This is the case with scheduling the surgery versus obtaining the orders for the surgery at a later point in time (albeit prior to the date of surgery). At other times, the referral and order are the same.

The time of referral is when information should be obtained to determine whether the insurer covers the services. Coverage is not merely obtaining key diagnostic information about the patient from the ordering/referring clinician. Increasingly, it includes prior conservative, but failed, therapeutic services to then justify that a more extensive or invasive therapeutic service is medically necessary and covered. With electronic health records (EHR), a referring clinician that is on the EHR of the hospital may pull up a referral and click or identify the service, such as an imaging test. The test may be linked in the background to the same imaging test in the chargemaster. This may be the beginning of the revenue cycle process associated with the chargemaster.

Understanding and confirming coverage of the service(s) is one step assumed by the patient when he or she works with the hospital's financial counselors to better understand his or her financial liability. The financial counselor is acting as an advocate for the patient answering coverage, cost, benefit, and other information to determine what the patient is likely to owe out of pocket. Best practice is to obtain this amount in full or to obtain a deposit even before the service is provided. Cost information is determined by the prices in the chargemaster combined with payer information regarding contractual discounts negotiated with the hospital along with year-to-date deductible and copayment information for the patient.

Admitting and registration is where the account number is established in the AR system and includes patient demographic and insurer information. Typically, there is one account number per encounter or visit. At times, encounters can span multiple dates of service, as with an inpatient stay or an emergency department visit that goes overnight. There are some outpatient services that are also required to be billed monthly—specifically, repetitive services such as physical, occupational, and speech-language pathology therapies and cardiac and pulmonary rehabilitation services all under a plan of care that defines the type, frequency, and duration of services. These accounts are often called “series” accounts.

More recently, it has also become increasingly important to know if the specific encounter is part of an overall episode. For example, if the hospital is responsible for bundled payment for a lower extremity joint replacement, the patient's encounter may be related to or part of that episode. AR systems need to evolve to identify not simply the patient's insurers (primary, secondary, etc.) but also whether the encounter is linked to an episode and, if so, which episode. Ultimately, some encounters not part of an episode will be billed to the regular insurances' addresses, but for certain episodes, the claims may need to be billed to a different third-party administrator that is tracking costs of the episode.

This information is all part of verifying eligibility of the patient with the insurers for the date(s) of service and also for managing authorizations. Different services require different types of authorizations. Some services, such as advanced imaging, may require checking appropriate use criteria within the EHR or calling or completing an online authorization to obtain an authorization number. Other services require certification of the inpatient stay, the expected length of stay, the acuity level of the patient, and the location (e.g., whether days are in the special care unit versus the medical/surgical units) or level of care in the neonatal intensive care unit. If the

service is ordered in the EHR, preservice coverage validation that requires the specific order for service may entail computerized provider order entry within the EHR. This, again, is likely linked to the chargemaster service with the price and description of the service.

### *Middle functions*

The middle functions of the revenue cycle include service delivery, documentation, and revenue capture. This process includes accurate patient identification and matching service orders to the patient's medical record. This is a step with possible life-and-death consequences; the information contained in the patient medical record can direct the timely and accurate medical decision-making of the clinicians treating both emergent and elective patients. Once the current encounter is linked to the patient medical record, documentation for the current services can occur. Documentation includes the order, the description of the services by the licensed and credentialed clinicians who execute the order, and the discharge or postservice instructions. This is captured in paper, an electronic medical record (EMR), or a hybrid record (which may include speech and optical character recognition of scanned documents and transcription). Increasingly, it also includes outside records that are acquired by a clinician through a health information exchange and linked to the EMR for the patient. (The information in the outside records should be translated to discreet data when appropriate.)

Case management/utilization review is another important middle function. Case management and utilization review may report to nursing, finance, or quality within the hospital. Utilization review is mandated by the Centers for Medicare & Medicaid Services (CMS) *Conditions of Participation*, and the staff review patients admitted to nursing units of the hospital to ensure their status of inpatient or outpatient meets the criteria of the payer. Often the initial certification of an admission is handled by patient access staff and then transitioned to utilization review or case management staff to provide clinical rationale to the payer to verify the need for the admission, the inpatient or outpatient status, the length of stay, and the acuity (which may require an intensive or special care unit). If the case requires extensive postacute care needs, the payer's case management department may often collaborate with the hospital's department to ensure resources are coordinated on behalf the patient.

Charge capture is the act of selecting the individual services performed and posting them to the patient's account in the AR system. The staff may capture the charge defined in the

chargemaster using the actual chargemaster item number or by selecting the description, using a pick list, or, best of all, completing clinical documentation within the EMR. By performing one of these tasks, the charge is captured and posted to the patient's account with both a date of service and a date of posting. The charge on the account identifies the type of service and when it was performed, and it is a certification of sorts that the service is backed up with the required orders, coverage, medical necessity, and documentation. When that charge is listed on the itemized statement for the patient and summarized on the claim, the charge carries other elements defined in the chargemaster, including the price, description, CPT/HCPCS code, if applicable, revenue code classification, and other payer-specific elements.

If the CPT/HCPCS code is not enumerated in the chargemaster for the charge, then this may need to be added by the certified coders along with diagnoses explaining why the patient received the services. If the account is an inpatient, the coders also add ICD-10-PCS procedure codes in lieu of the CPT/HCPCS codes, because the ICD-10-PCS codes are required for inpatients. This is a key step for chargemaster coordinators to understand. Often, the setup of charges in the chargemaster, along with other master files, determines whether the CPT/HCPCS code is selected from the chargemaster or the coders entering the information in their abstracts. Without a good understanding of the system logic, outpatient claims can result in errors, duplications of codes, and line items or other anomalies that result in errors—errors hopefully caught prebilling so they do not result in inaccurate payment.

There are numerous places in the revenue cycle for edits. Some edits may occur in the front end, but most edits start with coding and are repeated along with other billing edits during the back end of the process. Often, it falls to a chargemaster coordinator to understand the different edits, to understand how they are applied by type of account and/or payer, and to manage those edits logically. At times, edit management traces back to chargemaster setup. At other times, coding edit management requires knowledge of the grouper program and edits deployed at coding versus claim development and billing.

### *Back-end functions*

Back-end functions are usually the domain of patient financial services. This includes claim development from the AR system and claim edit management. Some edits occur in the AR system and prevent the claim from producing until the edits are resolved. Other edits occur after

the claim has developed but prevent the claim from loading in the claim clearinghouse. Still other edits occur after the claim has loaded into the claims clearinghouse and must be corrected before electronic transmission of the claim through the clearinghouse to the payers' systems.

Chargemaster coordinators need to have a strong understanding of claim development and all of these different edits. Indeed, the AR system master files that govern claim development edits may be under the purview of the chargemaster coordinator, as is the chargemaster itself. The edits may be resolved by correcting the chargemaster or the master files. However, the resolution may be more complex, such as establishing a new type of account for a new type of service so the files can be customized to meet payer requirements with minimal manual intervention.

Other staff may bring claims with edits to the chargemaster coordinator for assistance in resolving the edit. The most important and first question to resolve at this juncture is where the edit originated. Is the edit from the time of coding? Is it at the time of claim development? Is it from the clearinghouse or the payer directly? In the case of Medicare claims, this would be from the Direct Data Entry (DDE) system.

A patient financial services staff person may sometimes say the edit is from Medicare but mean the clearinghouse system, not DDE. Before resources are expended to check the edit, the answer to this question must be secured, because this answer determines what resources are used to verify the validity of the edit and the best means to resolve the edit at the root cause. Once a correction is identified and made for current and future claims, a query should be run to identify any past claims or claims in development for correction. Clearinghouses may say that their edits are proprietary. However, the edits cannot violate either CMS or National Uniform Billing Committee (NUBC) guidance, so these edits may have to be changed, and it may be incumbent upon the chargemaster coordinator to put together the documentation to convince the clearinghouse vendor to make those revisions.

Once a claim is billed to the payer and accepted as a clean claim passing their edits, then the claim should be paid following the negotiated contract. If not, the collector follows up to determine why the payment was not made in a timely fashion or pursuant to the contract terms. This entails payment verification. Payment verification may be made via another information system or application that models payment based on inputs from the account and contract. The account information includes chargemaster information.

If the payer does not fully pay the account or denies some or part of the services on the account, then a decision must be made regarding whether to appeal. Appeals are usually divided into two types: technical appeals, which may be handled by patient accounting staff, and clinical appeals. Clinical appeals are often routed to nurse auditors or to case management/utilization review departments, which have the clinical staff able to make a case-specific appeal from the medical record documentation. However, no appeal will overcome a service that is not covered. This is why the coverage analysis is so crucial as an important preservice step in the process.

### *Summary*

The chargemaster is central to many of these interrelated functions, and often the chargemaster coordinator is tasked with resolving issues and leading projects designed to meet new regulatory requirements, implement the billing and coding processes for a new service, or enhance the efficiency and effectiveness of the technology, people, and processes used.

Gathering resources is important to overall success in these tasks, so now it is time to consider and describe the various resources that should be understood and acquired to prepare for chargemaster management.

## **Vital Resources for Chargemaster Management**

---

Chargemaster coordinators may not be aware that they have the weight of law backing them up. To reduce paperwork and streamline business processes across the healthcare industry, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Patient Protection and Affordable Care Act set national standards for claims, code sets, and other revenue cycle transactions, including eligibility verification, claims adjudication, and payment. Each of these national standards is determined by a transaction authority, so the same law that governs privacy and security of patient protected health information includes requirements for administrative simplification of health information. All providers and payers are mandated by law to adhere to these national standards.

The transaction authorities or the Designated Standard Maintenance Organizations (DSMO) publish the standards. For hospital claims, the standards mandate the Uniform Bill (of which the 2004 version is the latest) and its electronic equivalent, the 837I, for institutional claims. The

DSMO for the UB-04 is the NUBC. A subscription to the NUBC for the official *UB-04 Manual* is a necessary resource for the chargemaster coordinator. This defines the revenue codes, requirements for CPT/HCPCS codes per revenue code, and all the fields on a UB-04. This resource often holds the answer to claim or coding edit issues.

Under HIPAA, specific code sets for diagnoses and procedures used in all healthcare transactions, including those under government insurance like Medicare and Medicaid and those under commercial or nongovernment insurance, have been defined as mandatory. Only liability insurances like workers' compensation and motor vehicle accidents are not governed by the HIPAA transaction and code sets and the authorities that define and maintain them.

Code sets classify medical diagnoses, surgical and other therapeutic procedures and treatments, visits, diagnostic tests, equipment and supplies, and drugs. The code sets are used not just for claims, but also for public health.

Code sets outlined in HIPAA regulations include:

- ICD-10 – International Classification of Diseases, 10th edition
- HCPCS – Health Care Common Procedure Coding System
- CPT – Current Procedure Terminology
- CDT – Code on Dental Procedures and Nomenclature
- NDC – National Drug Codes

These code sets are defined and governed by policies and guidance from their respective organizations. For example, the American Medical Association (AMA) is responsible for the *CPT Manual*, 4th Edition. The ICD-10 Coordination and Maintenance Committee is a federal interdepartmental committee composed of representatives from CMS and the Centers for Disease Control and Prevention's National Center for Health Statistics. The committee is responsible for approving coding changes and developing errata, addenda, and other modifications. Requests for coding changes must be submitted and approved by the ICD-10 Coordination and Maintenance Committee.

There is an interrelationship between the DSMO and the code set authorities. The chargemaster coordinator needs the current *CPT Manual* and the one from the year prior at the very least. The chargemaster coordinator must read the *CPT Manual* preface and guidance that discusses how the manual is organized and the coding principles encompassed in the manual. While a chargemaster coordinator is not required to be a credentialed coder, he or she needs a solid grasp of correct CPT coding principles. These principles can be self-taught through reading the *CPT Manual* preface and guidance. When using a specific range of codes in the manual, the chargemaster coordinator should also be sure to read the preparatory paragraphs that pertain to that section. The chargemaster coordinator also needs the *HCPCS Level II Manual* from CMS, as CMS is the authority for HCPCS codes.

A chargemaster coordinator usually does not need an ICD-10-CM or ICD-10-PCS manual, because these codes do not reside in the chargemaster, and the chargemaster coordinator can collaborate with certified coders, typically in the health information management department, who have these resources, and their grouper programs include guidelines and other supporting reference materials. However, it may be helpful to have a *Coder's Desk Reference* or another tool that describes the CPT procedures in layperson's terms. Often, even the long descriptions in the *CPT Manual* are not sufficient to explain the nuances of different but similar codes to the clinical staff who need to understand the distinctions. A desk reference or other tool that describes the procedures in basic terms is very valuable for this purpose.

In addition to these manuals, the chargemaster coordinator should have the most current version of the *National Correct Coding Initiative (NCCI) Manual*. The *NCCI Manual* follows the *CPT Manual* chapters and reiterates numerous correct coding principles and specific common clinical scenarios for which the NCCI has designed edits. Often the *NCCI Manual* provides answers to different edits.

The chargemaster coordinator should have a good understanding of the Medicare manuals. There are two types of manuals: a paper-based manual and the internet-only manuals (IOM). The *Provider Reimbursement Manual* is the only paper-based manual; it contains charging and cost-reporting guidelines and must be downloaded from the paper-based manuals website. The IOM manuals are organized by individual manual and by chapters within each manual. When appropriate, these manuals should be researched for applicable information to the service or issue. Note that CMS often removes or revises manual sections without providing an archive of

prior versions. Chargemaster coordinators should retain their own copy (printed or electronic) of manual sections they rely on for policy decisions.

CMS releases transmittals that update or change these manuals. These transmittals often drive the regulatory requirement to change or update a chargemaster. In transmittals that make changes to manual language, new language is in red text; however, deletions are not noted and revisions should be reviewed carefully. The transmittal number contains letters representing the associated manual (e.g., CP for claims processing or OTN for one-time notification transmittals that are global in nature and not tied to particular manuals). Transmittals are tied to a CMS change request number, which is an internal tracking number that ties together documents associated with a particular policy change. A change request number may have more than one transmittal associated with it if more than one manual is affected by the change request.

CMS may release a transmittal at any time. There are the quarterly Outpatient Prospective Payment System (OPPS) manual updates and any number of ad-hoc updates throughout the year. There are also quarterly updates to the integrated Outpatient Code Editor that detail edit logic and code changes for outpatient claims. The Medicare Code Editor governs inpatient claims. Other updates include changes to coverage policies. Usually, these documents contain details that require updates and changes to one or more fields within the chargemaster. The chargemaster coordinator should sign up for email notification for these transmittals.

CMS also publishes two types of *MLN Matters* articles. Many *MLN Matters* articles are tied to particular transmittals and are intended to provide practical operational information about the transmittal to providers. These articles will be labeled with the letters *MM* followed by the change request number of the transmittal or transmittals associated with it. Special edition articles are not tied to transmittals but rather provide information on topics CMS deems of particular interest. These articles frequently contain information not found in transmittals or manual sections. Special edition articles will be labeled with the letters *SE* followed by two digits representing the year of publication and then two more digits representing the order the article was published in that year. CMS also publishes a quarterly compliance newsletter highlighting different compliance, risk, and audit topics.

The chargemaster coordinator also needs to understand the various payment methodologies used for hospital services. The Medicare Payment Advisory Council (MedPAC) publishes fact sheets

on all of the major CMS payment methods, including hospital Inpatient Prospective Payment System (IPPS) and OPPS. CMS also maintains web pages for each payment system. Specific to the management of the chargemaster is an understanding of the OPPS status indicators defined in Addendum D1 to the OPPS. These status indicators are an important source of information concerning how to set up a particular CPT/HCPCS code in the chargemaster. Addendum B to the OPPS contains each CPT/HCPCS code and its associated status indicator.

Finally, the chargemaster coordinator should understand the relationship between the statutes, the statute-amending legislation, and the implementing regulations that have the weight of law like the transaction sets. The United States Code (USC) contains the statutes for Medicare and Medicaid, and CMS promulgates and implements regulations codified in the *Code of Federal Regulations* (CFR). Statutes are sometimes cited with Social Security Act section numbers rather than their USC section numbers. Social Security Act sections can be found on the Social Security Administration website. New statutes are cited as public laws or by their popular name (i.e., Patient Protection and Affordable Care Act). Public laws can be found at [www.congress.gov](http://www.congress.gov), maintained by the Library of Congress.

The *CFR* is best understood as the law behind the CMS manuals. Regulations—initially published by CMS—are printed in the *Federal Register* by the Government Publishing Office (GPO) and then codified in the *CFR* (also by the GPO). The *CFR* is published in an official version, updated annually, and a regularly updated unofficial electronic version. CMS manuals often quote *CFR* citations. It is useful to refer to the *CFR* section when this occurs.

Understanding these key authorities is important, but often a chargemaster coordinator is working with the manuals or subregulatory guidance. Compliance officers and attorneys are great resources to help when there appears to be a conflict between a manual provision and the underlying *CFR* provision.

Claims are submitted to third-party administrators, which are entities with the software designed to accept, adjudicate, and pay claims. Medicare fee-for-service claims are submitted to Part A/B Medicare Administrative Contractors (MAC). MACs are Medicare claims processing contractors who perform all core claims processing functions and act as the primary point of contact for providers and suppliers for a number of things, including enrollment, coverage, billing, processing, and payment. Prior to Medicare contractor reform, these functions were

performed by fiscal intermediaries for providers and by carriers for physicians and suppliers. MACs publish substantial claims processing, billing, and coding guidance on their websites, including medical review and documentation policies, enrollment information, appeal information, etc. (Note that since hospitals originally performed more Medicare Part A inpatient services, information on hospital services is generally published on the Part A website of the MAC, even though outpatient hospital services are actually covered under Part B.)

In summary, the following resources are recommended for the chargemaster coordinator:

- NUBC *UB-04 Manual* subscription
- *CPT Manual*, published by AMA (for the current and prior year at a minimum)
- *HCPCS Level II Code Manual*
- *Coder Desk Reference* or other resource with layperson descriptions of CPT codes
- Current version of the *NCCI Manual* (downloaded from the CMS website)
- Easily accessed CMS website for paper-based manuals and IOM
- The MAC website for local coverage and billing guidance
- MedPAC fact sheets on CMS payment systems
- CMS web pages for each payment system, particularly the IPPS and OPPS
- OPPS Addendum B and D1 on the CMS website

The chargemaster coordinator should subscribe to CMS email updates through the CMS.gov Email Updates website. Suggested CMS mailing lists include CMS Coverage email updates, MLN Connects™ Provider eNews, and the CMS news releases that include fact sheets on new regulations released. You can also subscribe to the National Institutes of Health email list for *MLN Matters* articles by searching the public lists for “MLNMATTERS-L.” Chargemaster coordinators should also subscribe to their MAC’s email list and, finally, sign up for the Hospital Open Door Forum (ODF) conference calls. CMS periodically conducts these calls that provide valuable information to hospitals. Dial-in information is available by signing up for the ODF listserv or on the Hospital Open Door Forum page on the CMS website.

### *Chargemaster software*

As requirements for CPT coding and billing complexities increase, so does the importance of the chargemaster. As a result, different consulting firms and technology vendors have recognized that software could be developed that would assist a chargemaster coordinator in managing the tens of thousands of line items in a single hospital chargemaster.

There are advantages and disadvantages to the different vendors and software programs. All are designed to contain much of the resource information described above and to notify users of changes by the source authorities, keeping chargemaster coordinators up to date with coding and regulatory changes in much the same way as described earlier in this chapter. Nevertheless, each vendor and software program approaches a chargemaster from a slightly different perspective. For example, some have a gold standard chargemaster. Chargemaster coordinators can compare their hospital's chargemaster to that standard. Others edit each line item and field against possible options and present the line item with questions to the coordinator to assist in identifying the optimal option for the hospital.

Because a chargemaster reflects the structure and type of services of the organization, often numerous valid options within the structure defined by the HIPAA authorities can be selected for a particular line item within a specific department. This is where it is invaluable for the chargemaster coordinator to understand the historical context for the options and the rationale and logic behind selecting one option over another. No software program will be able to answer 100% of these questions and know the correct option for each respective hospital. This is why an understanding of the resources is vital for a chargemaster coordinator. With it, he or she can use the software with confidence and be the most efficient, relying on that knowledge where required.

# The Chargemaster Essentials Toolkit

Valerie A. Rinkle, MPA

Chargemaster coordinators, analysts, and other revenue integrity professionals are responsible for a multitude of tasks related to chargemaster maintenance and strategies. From annual updates and monthly departmental reviews to ongoing compliance efforts, they must stay on top of billing and coding trends and changes, cost reporting, and charge capture, as well as edits, pricing, and revenue codes.

*The Chargemaster Essentials Toolkit* provides readers with the tools to optimize their chargemaster and use it as a powerful tool for ensuring accurate reimbursement and revenue integrity. Readers will also receive helpful downloadable tools such as a sample maintenance calendar, policies, and questionnaires for working with other departments.

This book will help readers:

- Stay on top of ongoing chargemaster education and maintenance
- Learn best practices, strategies, and principles for chargemaster management
- Optimize the chargemaster for both Medicare and managed care contracts
- Understand revenue cycle concepts and terminology crucial to effective chargemaster maintenance

**HCPro**

a division of BLR

100 Winners Circle, Suite 300  
Brentwood, TN 37027  
[www.hcmarketplace.com](http://www.hcmarketplace.com)

CODING

FINANCE

BILLING

DOCUMENTATION

PRICING

TCET

ISBN-13: 978-1-60308-086-2



9 781683 080862