CHARGEMASTERS

Strategies to ensure accurate reimbursement and compliance

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CHAPTER
ONE

Introduction to the chargemaster

Introduction

Welcome to the wonderful world of chargemasters. As we shall discuss throughout this book, developing and maintaining hospital chargemasters is a technically challenging and personally rewarding process. Because the chargemaster is integral to the financial viability of the hospital and is an essential part of numerous compliance concerns, the importance of the chargemaster is well-established.

We will address the following questions in this book:

- What is the chargemaster?
- How does the chargemaster fit into the billing process?
- Is the chargemaster part of the revenue cycle?
- How does the chargemaster affect other parts of the coding, billing, and reimbursement process?
- Who takes care of the chargemaster?
- Do facilities need chargemaster policies and procedures (P&P)?
- How does the chargemaster relate to the cost report?
- Should current procedural terminology (CPT) codes be in the chargemaster?

In addition, we will discuss many other concepts throughout this book. For example, there are many P&Ps that facilities must develop in conjunction with the chargemaster. Some of these P&Ps also involve other aspects of the coding, billing, and reimbursement process. The full development of a comprehensive set of coding, billing, and chargemaster P&Ps is a major undertaking even for small or medium-sized hospitals.

Also remember that we are addressing the chargemaster as a universal concept among hospitals. Hospitals vary in the way they structure and implement the chargemaster as part of the billing system.[1]

The chargemaster is part of a dynamic area that constantly changes–especially in the larger picture of healthcare provision and associated areas of coding, billing, and reimbursement. Thus, facilities must assess every concept, idea, process, or procedure that we discuss in the appropriate context.

Key concepts for the chargemaster

What is the chargemaster?

The chargemaster is typically a file that lists all of a hospital's services and items, along with their charges. Although unlikely today, the chargemaster could be part of a manual system that generates bills (i.e., itemized statements) and associated claims. In today's world of computers, the chargemaster is typically a file located in the hospital's billing or accounts receivable (A/R) system. Because there are many hospital computer-billing systems, the exact form, layout, and capabilities of the chargemaster may differ.

Throughout this book, we will discuss the required data elements and the optional data fields for the chargemaster. Every chargemaster must have the following fundamental data elements:

- Chargemaster line-item numbers
- Line-item descriptions
- Revenue codes
- CPT/healthcare common procedure coding system (HCPCS) codes
- Charges

Note that although we listed the CPT/HCPCS codes above, the inclusion of such a code for a particular line item is not always necessary. Some line items must contain CPT or HCPCS codes, while others do not have such codes. Additionally, the chargemaster may be able to associate different CPT/HCPCS codes per line item based on different third-party payer requirements.[2]

What function or role does the chargemaster perform?

The chargemaster is an integral part of the revenue/reimbursement cycle. More specifically, the chargemaster provides key information for generating the itemized statement and the claim form.

Regardless of a given computer system implementation, the chargemaster must contain certain information to generate the itemized statement and the associated claim form. The chargemaster includes information about how to

- generate itemized statements and claims
- maintain the chargemaster
- develop organizational tools

Facilities can also use the chargemaster to develop statistical information concerning services. In some

cases, a given line item may have no charge attached because the facility uses that line item to count materials or services for statistical purposes. Chargemaster personnel must decide whether to allow this type of use. (*Note*: See Chapter 15 for alternative uses of the chargemaster.)

Who takes care of the chargemaster?

The person/group assigned to develop the chargemaster varies based on the size of the hospital/healthcare system. In a small, rural hospital, the tasks associated with setting up and maintaining the chargemaster may only be a part-time job. In a mid-sized hospital, a full-time chargemaster coordinator may be appropriate. For large hospitals and healthcare systems, a small group of personnel are often devoted to maintaining the chargemaster. (*Note*: We will refer to the chargemaster coordinator or chargemaster personnel as the individual/group providing organizational support for the chargemaster.)

Establishing and maintaining a chargemaster may go beyond a single individual or a small department. In many cases, a chargemaster team involves staff from all administrative areas in the hospital that have a close relationship to the chargemaster. For example, the patient financial accounting or claims transaction area has a significant interest in the chargemaster. Likewise, compliance personnel and those from health information management also have a keen interest in the chargemaster and the overall coding, billing, and reimbursement process. Because the chargemaster is a significant part of the hospital's A/R computer system, someone from information systems or information technology should also monitor its status.

Another question is "Who actually owns the chargemaster?" This is an important organizational distinction. For many hospitals, the various departments and service areas have ownership/final responsibility for the chargemaster's completeness and accuracy, and the chargemaster coordinator is the guide and informational resource for the facility. In many cases, the service area personnel do not know the technical information regarding the chargemaster, but they know all of the activities, supplies, drugs, and other services provided in their area. Thus, the chargemaster coordinator must work with all the service areas to develop a consistent and compliant chargemaster.

What policies and procedures relate to the chargemaster?

Facilities use P&Ps to document their decisions regarding the chargemaster's development and maintenance. Because the chargemaster is part of the reimbursement cycle, the associated P&Ps must be closely integrated with coding and billing P&Ps.

For example, under ambulatory payment classifications (APC), Medicare pays separately for various injections, so facilities must appropriately code and bill these injections. The coding of injections typically goes through the chargemaster, and many departments or service areas may charge, and thus code, for these services. Many issues thus arise surrounding injections. For example, what exactly is the difference

between an intravenous (IV) injection and IV therapy? If staff inject the same drug three different times, does that justify three separate injection codes? What is the relationship between conscious sedation and IV injections?

These are the types of questions facilities must address in a comprehensive coding, billing, and chargemaster P&P for coding and billing various types of injections. Many other P&Ps are also necessary to develop and maintain the chargemaster.

Note also that for those who audit itemized statements and claims, there must be standardized ways to use the chargemaster. Without these P&Ps, it is difficult for auditors to judge whether everything works appropriately.

The process for developing and gaining the approval of P&Ps may not be straightforward. Facilities should use a systematic process that includes training affected employees and auditing for compliance with the given P&P. For chargemaster coordinators, such implementation, training, and auditing functions may involve new skill sets that are not typically associated with chargemaster work.

How does the chargemaster relate to the revenue cycle?

The chargemaster is integral to the revenue cycle. It enables hospitals to create charges for their services. Thus, the optimization of the revenue cycle must include the chargemaster and all of its associated interfaces, including charging, coding, and the cost report.

We may also refer to the “reimbursement cycle,” which is a variation of the revenue cycle. The revenue cycle typically takes a financial perspective of the overall service, billing, and payment process for all types of services, patients, and payment mechanisms. The reimbursement cycle focuses on the claims-filing process and the associated payments from various third-party payers.

How should we set our charges?

Setting hospital charges is a major issue with which chargemaster coordinators constantly struggle. Setting charges is an integral part of establishing and maintaining the chargemaster. From a statutory compliance perspective, the Medicare charging rule comes into play. We will discuss this rule in more detail, but a simplified description involves two aspects:

1. A hospital cannot charge Medicare patients more than the hospital charges other patients
2. The hospital’s charges must be consistent and based on costs

Many hospitals use a single set of charges for the same line item for all patients in the chargemaster. This makes it appear that the hospital charges Medicare and non-Medicare patients the same way. However, the Office of Inspector General has indicated that when a hospital accepts discounted payments from a given private third-party payer, the discounted payments are considered to be the hospital's charges.

The second statement above relates to the cost report. The Centers for Medicare & Medicaid Services' (CMS) *Program Integrity Manual* provides language that allows different charges for Medicare and non-Medicare patients if the overall charges are grossed up in the Medicare cost-reporting process. The increasing number of self-pay patients has exacerbated this issue. Providers often discount services for these patients, which raises the issue of considering discounts to be reduced charges.

We will discuss these compliance issues in more detail later in this book. Given this overriding compliance environment, how should hospitals set charges? An immediate answer is to use a simple multiplier times the cost of a given line item for a service, supply, drug, etc. This raises two immediate questions:

1. What constitutes costs?
2. How do we know the costs for a given line item in the chargemaster?

Answering the second question can be easy—ask the financial personnel at your hospital who are in charge of the cost-accounting system. But this statement is a little facetious in that many hospitals—particularly smaller to mid-sized—do not have cost-accounting systems. Thus, the answer to this question may actually be a significant challenge.

The first question is, in some respects, even more difficult. The issue of what constitutes costs can fill an entire accounting book. We will not tackle this question in detail in this book. However, we will discuss concepts, such as acquisition costs and fully loaded costs, along with some techniques for performing ad hoc analyses relative to cost determination.

Other third-party payers

Up to this point, we have considered only Medicare as a third-party payer. However, hospitals have contractual agreements with many other third-party payers. There are also some constraints related to the charges that facilities can develop for these payers. If there are not constraints on setting the prices, there will certainly be constraints on adjusting charges over time. Many third-party payers base payment on a percentage of charges, and they will be sensitive to hospitals increasing their charges.

CASE SCENARIO 1.1: APEX MEDICAL CENTER CHARGE ALGORITHM

The fictitious Apex Medical Center has decided to establish charges by multiplying the costs of any given line item by 1.7. Apex has a comprehensive cost-accounting system, so it knows the actual cost for each line item.

Question: If Apex consistently uses this simplified charge algorithm, what would its overall cost-to-charge ratio (CCR) be?

Although this example is simplified and not based upon a realistic set of circumstances, the basic idea is that:

Charges = 1.7 x Costs

Using algebra, we divide both sides of the equation by "charges" to obtain:

1 = 1.7 x (Costs/Charges).

Now divide both sides by 1.7 and switch the equation around to obtain:

Costs/Charges = 1/1.7 = 0.59.

"Costs/Charges" is actually the CCR, so CCR=0.59.

Note: The CCR is an integral part of the Medicare cost report. It is briefly addressed later in this chapter. Also see Chapters 8 and 9 for more information about establishing charges or pricing of certain items and services.

Setting charges is a major issue that closely relates to cost accounting and the Medicare cost report. Additionally, there may be contractual constraints on setting/changing charges.

How does the chargemaster relate to compliance?

The chargemaster is intimately involved with different hospital compliance concerns and thus may be a direct or indirect target of compliance audits. Compliance issues generally fall into two broad categories: statutory and contractual.

Statutory obligations

The statutory concerns are the most serious because failure to meet these requirements can go beyond civil monetary penalties to criminal penalties and possible jail sentences. The statutory concerns are primarily with the Medicare and Medicaid programs, and other government healthcare payment systems. Medicare has many rules and regulations that constantly evolve. The following are typical sources of Medicare statutory requirements (in order of increasing detail):

- The Social Security Act
- The United States Code
- The Code of Federal Regulations
- The *Federal Register* (FR)
- Medicare manuals, including national coverage determinations
- Medicare contractor information, including local coverage determinations

Medicare contractors serve as fiscal intermediaries for hospital billing and as carriers for physician billing. Medicare also uses specialized contractors, such as durable medical equipment regional carriers.

Contractual obligations

Contractual obligations arise from relationships that hospitals have with various private (i.e., nongovernmental) third-party payers. Hospitals usually contract with the third-party payers to which they file a significant number of claims. These contracts often include requirements relative to how the chargemaster can be structured and, most important, how charges can be structured and changed. Larger third-party payers may audit the chargemaster and associated coding and billing processes.

For example, a given third-party payer may have a contract with a hospital whereby it pays 85% of the hospital's charges for services. That payer may be interested in how the facility formats the chargemaster and associated charging processes. It may also be interested in limiting the hospital's ability to arbitrarily raise charges.

Chargemaster coordinators/personnel are keenly interested in the statutory provisions, primarily the Medicare rules and regulations, and the private third-party payer contractual obligations. Although everyone has access to the Medicare rules and regulations, chargemaster personnel should also have access to the various third-party payer contracts and be involved in negotiations with third-party payers. The chargemaster coordinator must also be aware of any third-party payer manuals that delineate the coding and billing processes.

Facilities must constantly review compliance concerns and identify future compliance concerns. By systematically addressing these potential risk areas, facilities can avoid statutory or contractual violations.

How does the chargemaster relate to the Medicare cost report?

There can be a close relationship between the chargemaster and the Medicare cost report. Probably the most immediate relationship is that of the CCRs, which facilities develop as part of the overall cost-reporting process. CMS uses the hospital-specific CCRs to translate the charges on the claim forms into costs. CMS uses these costs in different ways. For example, CCRs are used to

- calculate whether an outlier should be paid
- calculate the costs for certain items
- identify costs based on charges to determine relative weights

Pass-through charges

Medicare pays for some items on a pass-through basis (i.e., it pays the cost of the item based on the hospital charges). Although pass-through items can vary, as of June 2005, Medicare pays for brachytherapy sources through the APC system on a pass-through basis. Thus, if a hospital's cost for a certain brachytherapy source is $1,500, then the hospital should set the charge for the source in such a way that CMS will translate it back into the correct cost.

Assume the hospital's CCR is 0.6 (i.e., the costs are 60% of the charges). To recoup the cost of $1,500, the hospital must charge $2,500 because 0.6 multiplied by $2,500 equals $1,500. This process raises the following questions for chargemaster coordinators:

- What if the hospital charges more than $2,500?

- What if the hospital charges less than $2,500?

- If a hospital charges Medicare patients $2,500 to gain proper reimbursement, must it charge all patients this amount?

A moment's reflection shows that these questions can become significant. If the hospital charges more than $2,500, then it will recoup more than the $1,500 in costs. But what exactly is the cost—is it the acquisition cost, or does it include administrative overhead? Perhaps the hospital should add 10% to make the charge $1,650. Is this a compliance issue?

If the hospital charges less than $2,500, then it will not recoup the cost, which doesn't make sense because Medicare is supposed to pay based on cost.

The question about charging non-Medicare patients the same as Medicare patients is a restatement of the so-called Medicare charging rule mentioned earlier in this chapter. Other private third-party payers may also pay your hospital a percentage of charges. Certainly, a third-party payer paying you 85% of your charges would not want to pay you 85% of the $2,500 charge. So what should your hospital do in a case like this?

Relative weights

Medicare uses CCRs to determine the relative weights in diagnosis-related groups for the inpatient payment system and for APC outpatient payments. Medicare uses a complex statistical procedure (using the CCRs and the hospital charges) to generate the relative weights. However, if the CCRs developed from the cost report are incorrect, then the payments can be skewed.

For example, such an error occurred related to payment for blood and blood products under the APC payment system between 2000 and 2004. Hospitals did not report the charges for blood and blood products in association with the proper costs, which then generated skewed CCRs. In 2005, CMS recognized this problem and increased payments for blood and blood products based on interim calculations. CMS hopes that once it identifies situations such as this, hospitals will appropriately report charges and associated costs on the cost report, which will result in accurate payments.[3]

Thus, the Medicare cost report has a distinct relationship to the chargemaster, and chargemaster personnel should work with cost-reporting personnel concerning any unusual ways in which the chargemaster is set up and utilized. Pay particular attention to any unusual third-party payer requirements, particularly those involving revenue codes and charges.

Chargemaster interfaces

Many of the questions that we have started to address in this chapter involve what can be classified as interfaces to the chargemaster. Consider the following interfaces:

- Coding
- Billing
- Claims generation
- Cost report

- Charge capture
- Cost accounting
- Pricing or setting charges
- Statistical reporting

Each of these areas represents situations in which hospitals must make significant decisions concerning the form and format of the chargemaster, along with the associated flow of information within the reimbursement cycle. Hospitals may also need to address other more subtle interfaces. For example, many hospitals have “back-end computers” or “claims scrubbers” that apply edits to claims before the hospital files them. In some cases, these back-end computer systems may actually change the claim before the hospital files it. The logic in these back-end computers may affect the structure of the chargemaster.

Although we will certainly look at the chargemaster itself, the proper structuring of the interfaces is absolutely crucial. In this book, we will go beyond the chargemaster to look at various associated processes necessary to optimize the reimbursement cycle.

Coding interface

The coding interface is particularly important to the chargemaster. In many cases, various codes must appear on the final claim form, particularly for outpatient claims, which Medicare pays based on the codes present, such as with the APC payment system. Generally, various CPT-4[4] codes, which the American Medical Association develops and maintains, drive the payment process. Chargemaster coordinators decide how to place the various codes on the claim forms. In some cases, the codes will be in the chargemaster itself and will be driven by the charge entry process. This is called “static coding” because the codes are statically placed in the chargemaster. For example, radiology and laboratory services use static coding.

However, professional coding staff may also develop the CPT codes and input them into an abstracting system, which then interacts with the hospital’s billing system. These codes are then aligned with the charges entered for the services described by the CPT codes. This is called “dynamic coding,” because coding staff develop the codes dynamically.

In some cases, the hospital may be able to override a default code in the chargemaster through use of a dynamically developed code, if necessary and appropriate. Whichever approach a hospital takes, the coding interface with the chargemaster is one of the most difficult areas for chargemaster coordinators.

Chargemaster architecture decisions

Chargemaster coordinators are a combination of architects and engineers. There are many design, maintenance, process flow, interface, and compliance issues that require careful study and solutions.

Form follows function

A key principle for this book is the concept that "form follows function" (i.e., the chargemaster should be established to capture whatever services/items are dispensed in a given service area). Because of different constraints, hospitals may only be able to implement this concept partially. For example, in the surgery area of the chargemaster, there may be extensive presurgery activities provided by more than one department or service area. However, no revenue code allows for a separate line item in the chargemaster for presurgery activities.[5] Another example might be nursing services on the medical-surgical floors of the hospital. Typically, these routine nursing services are bundled into the room charge.

Laboratory services

Coordinators must also make other architectural decisions. For example, in many facilities, the laboratory department provides most of the laboratory services, and the chargemaster addresses the various laboratory tests. However, nursing staff may provide some laboratory tests, such as the Clinical Laboratory Improvement Act–waived point-of-care tests, in areas such as the emergency department (ED) and observation. It is not always clear whether these tests should be in the laboratory section of the chargemaster or in the performing department's section of the chargemaster.

Categorization of supplies

The categorization of supplies is also an important compliance issue. Later in this book, we will address decisions concerning overhead supplies versus billable supplies versus bundled supplies versus noncovered supplies. CMS has developed the concept of a supply or drug being an *integral part* of a procedure or service (i.e., if the given supply or drug is always used as part of some procedure or service, then there should not be a separate line in the chargemaster and it should not be billed separately).[6] The charge for the supply or drug should be included in the line item for the procedure or service associated with the supply or drug.

Charging v. billing for services

This leads to the important concept of being able to *charge* for a given item, but not being able to *bill* for the item (i.e., the charge for the given item or service must be included or bundled into another line item that can be billed separately). Obviously, the application of compliance constraints of this sort has a significant impact on the architecture and engineering design of the chargemaster.

Chargemaster reviews

The chargemaster is constantly evolving. With various coding and revenue code changes, new service areas, coding and billing directives, and compliance interpretations, facilities must regularly modify, review, and assess the chargemaster.

There are different levels of review and ways to review the chargemaster. Because the chargemaster represents various functions involved in the billing process, many hospitals develop a chargemaster team to address issues such as reviews. The membership of such a team may vary from hospital to hospital, but it typically includes personnel from financial services, patient financial accounting, health information management, information technology, and compliance. Typically, the chargemaster coordinator serves as the team leader.

Reviews can be comprehensive or focused, and hospitals can perform them using in-house personnel or external consultants. Thus, facilities can choose from a variety of reviews. Additionally, special chargemaster software can help facilities conduct various reviews.

For example, a chargemaster review of the ED may involve only the technical component billing or both technical and professional component billing if the chargemaster drives the generation of professional claims. Facilities should also consider evaluation and management levels, medical procedures, and surgical procedures, as well as the coding and charge-capture interfaces. Typically, hospitals will also use a sample of claims to identify the flow of claims and verify accuracy.

The ED review is characteristic of choosing a specific service area or type of service. Another example might be to investigate observation services, which may involve several service areas. A review may also focus on a particular aspect of the chargemaster, such as pricing. Hospitals can use pricing reviews to ensure that charges meet compliance constraints and verify that charges optimize reimbursement under various third-party-payer payment mechanisms.

A comprehensive chargemaster review will address all sections, service areas, and the various chargemaster interfaces. External consultants together with the chargemaster team typically conduct comprehensive reviews.

Conclusion

We have discussed some of the many questions surrounding chargemasters in this chapter. We will take some of these concepts and expand our discussions throughout this book, while incrementally increasing the depth and level of detail in our discussions. Remember the fundamental concept that the chargemaster is just a part of the larger overall process of the reimbursement cycle. As such, there are many interfaces with the chargemaster that we will explore in coming chapters.

Notes

1. As we will see, the variations in chargemaster design create significant challenges for the government and private third-party payers to effectively audit and compare hospital chargemasters.
2. In theory, this type of situation should violate the Health Insurance Portability and Accountability Act of 1996's Transaction Standard/Standard Code Set Rule because providers and payers should use standard codes, such as CPT or HCPCS, the same way.
3. For a further discussion of this issue, see the August 16, 2004 FR (69 FR 50521-50525).
4. As this book goes to press, the development and release of CPT-5 is imminent.
5. In this case, we are considering the "presurgery activities" to be those provided just before the surgery. A related concept is the "presurgery clinic," which involves nursing and diagnostic testing performed several days before the surgery.
6. This begs the question of a supply or drug that might be an integral part of certain procedures, but not an integral part of other procedures. Thus, a line item might be allowed for the given supply or drug, but under certain circumstances the charges should be bundled into another line item.

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