Chargemaster 101: Understanding the Importance, Purpose and Function of your Charge Data Master

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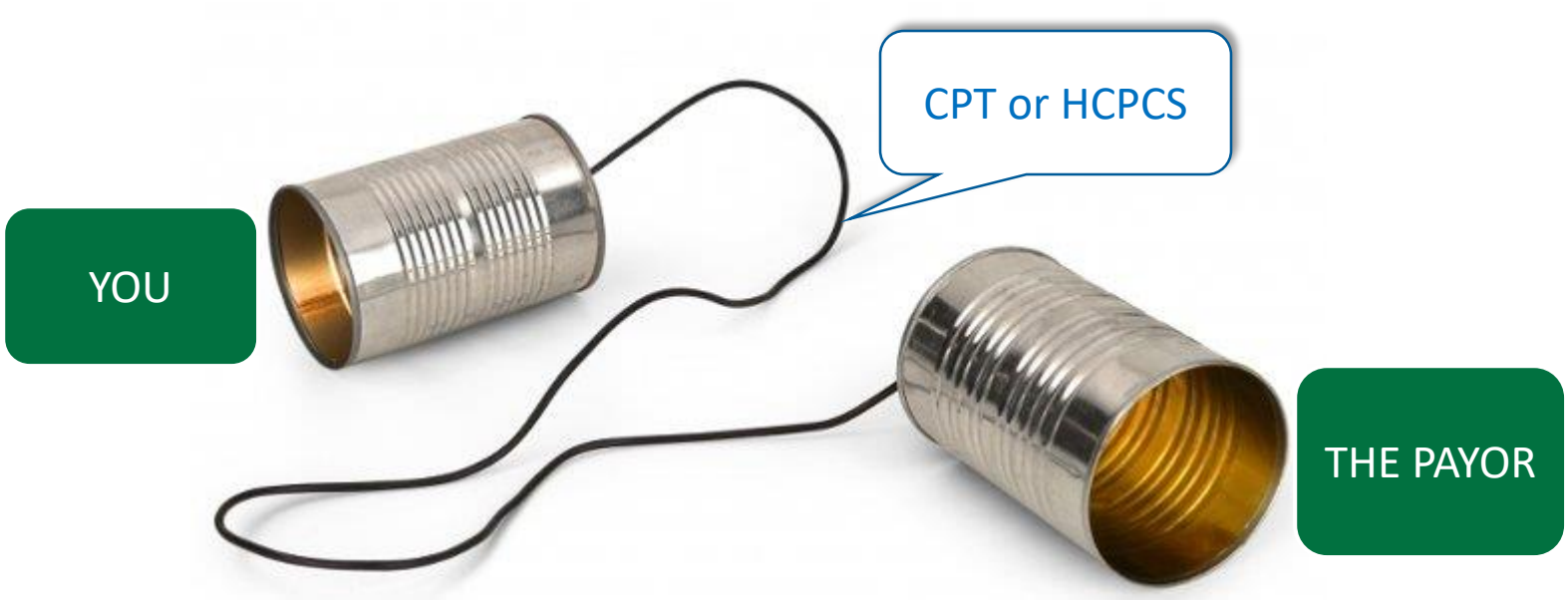
Chargemaster Role

- The Chargemaster is the communication mechanism between your facility and the payors
- All services must be conveyed using the most appropriate 5 character procedure code, either numeric CPT or alphanumeric HCPCS, linked to the appropriate Revenue Code for the service billed.
- Compliant, accurate and complete billing and reimbursement is dependent on the chargemaster



Objective

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- Review the components of the chargemaster
- Understand the individual components and the role of subcategories within the chargemaster
- Examine the chargemaster's impact on billing, reimbursement and compliance
- Outline a process of checks, balances and continuous auditing to ensure a healthy compliant chargemaster

Code Sets Required for Facility Billing

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CODE SET	IDENTIFY	Billing Form	MAINTAINED BY
CPT	Procedures, services, drugs, combo services,	1500 and UB-04	AMA
HCPCS	Procedures, services, drugs, combo services, supplies, DME	1500 and UB-04	CMS, BCBS
Revenue Code	Location, provider, type of procedure	UB-04	NUBC
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	1500 and UB-04	AMA/CMS
ICD Diagnosis Codes	Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM	1500 and UB-04	WHO
Type of Bill	3 digit code representing the place of service, type of service and billing stage	UB-04	NUBC
Place of Service	2 digit code identifying the location of the provider, or type of service	1500	CMS, BCBS

Chargemaster Components

Item Number

- Facility assigned mnemonic that is unique to one service line item

Item Description

- Text Description of the CPT/HCPCS, truncated to the character requirement of the CDM while retaining all pertinent information from the CPT/HCPCS description

Revenue Code

- 3 digit code categorizing the service performed. All CPTs/HCPCS are designated into Revenue Code categories

CPT / HCPCS

- 5 digit number or alpha-numeric code that describes in detail the service provided. CPTS and HCPCS are divided into limiting categories by product, type of service or body part examined.

Modifiers

- 2 Character designation providing additional information for CPT/HCPCS

Charge Amount

- Fee assigned to service line item

Alternate CPT / HCPCS

- Some CPTs and HCPCS overlap, and payors can determine which code is required for processing. Alternate CPT/HCPCS fields allow for one item number to be designated by payor to multiple code selections

Department

- Numeric designation of servicing or expense area within the facility

GL Number

- Numeric designation identifying the department within the General Ledger for accounting purposes

CPT and HCPCS Procedure Codes

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CPT	HCPCS
Current Procedural Terminology, also called, Level I HCPCS	Healthcare Common Procedure Coding System
Assigns 5 digit numeric or alpha-numeric code identifying the service provided	Assigns 5 character alphanumeric code identifying service or material (procedure, drug, supply, supply with procedure combination)
Developed and maintained by the AMA	Developed and maintained by CMS

CPT

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- Divided into subcategories of service type and body part reviewed or treated

Code Range	Description		Code Range	Description
0001F-7025F	Category II Codes		55970-55980	Intersex Surgery
0019T-0261T	Category III Codes		56405-58999	Female Genital System
00100-01999	Anesthesia		59000-59899	Maternity Care/Delivery
10021-10022	General Surgery		60000-60699	Endocrine System
10040-19499	Integumentary System		61000-64999	Nervous System
20005-29999	Musculoskeletal System		65091-68899	Eye and Ocular Adnexa
30000-32999	Respiratory System		69000-69979	Auditory System
33010-37799	Cardiovascular System		69990-69990	Operating Microscope
38100-38999	Hemic/Lymphatic		70010-79999	Radiology
39000-39599	Mediastinum		80047-89398	Pathology and Laboratory
40490-49999	Digestive		90281-99607	Medicine
50010-53899	Urinary System		99201-99499	Evaluation and Management
54000-55920	Male Genital System			

HCPCS

- Divided into subcategories indicating service or material provided

Code Range	Description
A0000-A9999	Transportation, Medical and Surgical Supplies, Miscellaneous, Experimental
B0000-B9999	Enteral and Parenteral Therapy
C0000-C9999	Temporary Hospital Outpatient Prospective Payment System
D0000-D9999	Dental codes
E0000-D9999	Durable Medical Equipment
G0000-G9999	Temporary Procedures and Professional Services
H0000-H9999	Rehabilitative Services
J0000-J8999	Drugs administered other than oral method
J9000-J9999	Chemotherapy Drugs
K0000-K9999	Temporary codes for durable medical equipment regional carriers
L0000-L9999	Orthotic/prosthetic services
M0000-M9999	Medical services
P0000-P9999	Pathology and Laboratory (Blood Products)
Q0000-Q9999	Temporary codes
R0000-R9999	Diagnostic radiology services
S0000-S9999	Private payer codes
T0000-T0000	State Medicaid agency codes
V0000-V0000	Vision/hearing services

Closed Treatment Fractured Toe

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CPT	Description	Short Description
28400	Closed treatment of calcaneal fracture; without manipulation	CLOSED TX CALCANEAL FRACTURE W/O MANIPULATION
28405	Closed treatment of calcaneal fracture; with manipulation	CLOSED TX CALCANEAL FRACTURE; W/MANIPULATION
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	PRQ SKELETAL FIXJ CALCANEAL FRACTURE W/MANJ
28430	Closed treatment of talus fracture; without manipulation	CLOSED TX TALUS FRACTURE W/O MANIPULATION
28435	Closed treatment of talus fracture; with manipulation	CLOSED TX TALUS FRACTURE; W/MANIPULATION
28470	Closed treatment of metatarsal fracture; without manipulation, each	CLOSED TX METATARSAL FRACTURE W/O MANIPULATION
28475	Closed treatment of metatarsal fracture; with manipulation, each	CLOSED TX METATARSAL FRACTURE W MANIPULATION
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	CLTX FX GRT TOE PHLX/PHL W/O M ANJ
28495	Closed treatment of fracture great toe, phalanx or phalanges; with manipulation	CLTX TX FX GRT TOE PHLX/PHLG W/MANJ
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	CLTX FX PHLX/PHLGX OTH THN GRT TOE W/O MANJ
28515	Closed treatment of fracture, phalanx or phalanges, other than great toe; with manipulation, each	CLTX FX PHLX/PHLG OTH THN GRT TOE W/MANJ

Code Selection

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- Departmental leadership, in conjunction with the BO and Medical records should identify all CPTS added into CDM
- CDM should be complete and accurate for services provided within any fiscal year
- No duplicate or redundant entries should be made
- All codes should be examined at least quarterly
  - Deleted codes
  - Utilization
  - Redundant code selection
- Codes with no utilization should be reviewed for possible inactivation
  - Coding
  - Business office/Finance
  - Departmental leadership
- Maintain only what is currently used or likely to be used

Alternate CPT/HCPCS Code Selection

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- Many CPT and HCPCS codes overlap
- Payors may require different codes to represent that same service or supply
- Alternate code options should be specific to one option, or payor
- Alternate code field should be named to ensure accurate and consistent assignment

Alternate CPT/HCPCS Code Selection

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- Create claim logic to assign hierarchy, and only populate alternate codes that differ from main options
  - Payor Specific
  - CPT
  - HCPCS
- Alternate Codes should only be populated to identify a requirement that differs from the primary code selection

Revenue Code Assignment Requirements

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- NUBC guidelines state the Revenue Code assignment should represent the most specific code available to identify:
    - The service performed
    - Where service was performed, and/or
    - By whom
- Medicare guidelines require that the revenue code reflect the cost center where procedure costs are reported on the cost report

Revenue Codes

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- Three digit codes which categorize the type of service or product delivered, describe where the service took place and/or who performed or is billing the service (professional or technical)
- All procedure codes billed in a hospital setting (UB or 837i 5010) must be paired with a revenue code
- Revenue code/procedure code pairing must make sense, must follow National Uniform Billing Committee guidelines, and must be acceptable to payors
- Revenue code HCPCS mismatches are automatic denials in many cases

Example Revenue Code Categories

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Revenue Code	Revenue Category
250-259	Pharmacy
260-269	IV
270-279	Supplies
280-289	Oncology
299-299	DME Equip
300-319	Lab
320-329	Diagnostic Radiology
330-339	Therapeutic Radiology/ Chemo
340-340	Nuclear Medicine
341-349	Nuclear Medicine/ Radiopharmaceuticals
350-359	CT Scan
360-369	OR Services
370-379	Anesthesia
380-399	Blood Administration and Blood Products
400-409	Other Imaging Services

Revenue Code Assignment - Why

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- Proper Revenue Code assignments allow the payors to apply the correct reimbursement schedule
- 43250 - UPPER GI ENDO REMOV TUM FORCP

	2020 Hospital	2020 ASC	2020 Professional	
	Minor Surgery, Endoscopy Suite, ER	ASC	Outpatient Hospital, Endoscopy Suite	Physician Practice
Revenue Code	361, 750, 450	490	982	960
Medicare Reimbursement	$1,557.22	$642.73	$172.17	$401.35

Revenue Code Assignment:46600 - DIAGNOSTIC ANOSCOPY

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Outpatient Hospital Revenue Codes		Professional Revenue Codes
360	Operating Room Services – General	960
361	Operating Room Services – Minor Surgery	969
450	Emergency Room – General	975
510	Clinic – General classification	981
514	Clinic – OB /GYN Clinic	982
515	Clinic – Pediatric Clinic	983
516	Clinic – Urgent Care Clinic	521
517	Clinic – Family Practice Clinic	520
519	Clinic – Other Clinic	
750	Gastrointestinal (GI) Services	
490	**ASC**	

Assigning Revenue Code

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- Business Office receives request from departmental leadership to add a CPT/HCPCS to the chargemaster. All requests should, at a minimum, include:
  - Identification of servicing department
  - The servicing provider (Hospital, ASC, Professional, type of clinic)
  - The most appropriate revenue code associated with CPT/HCPCS requested
  - When addition is approved, assign unique item number relating to procedure code and revenue code

Sample Tracking Log

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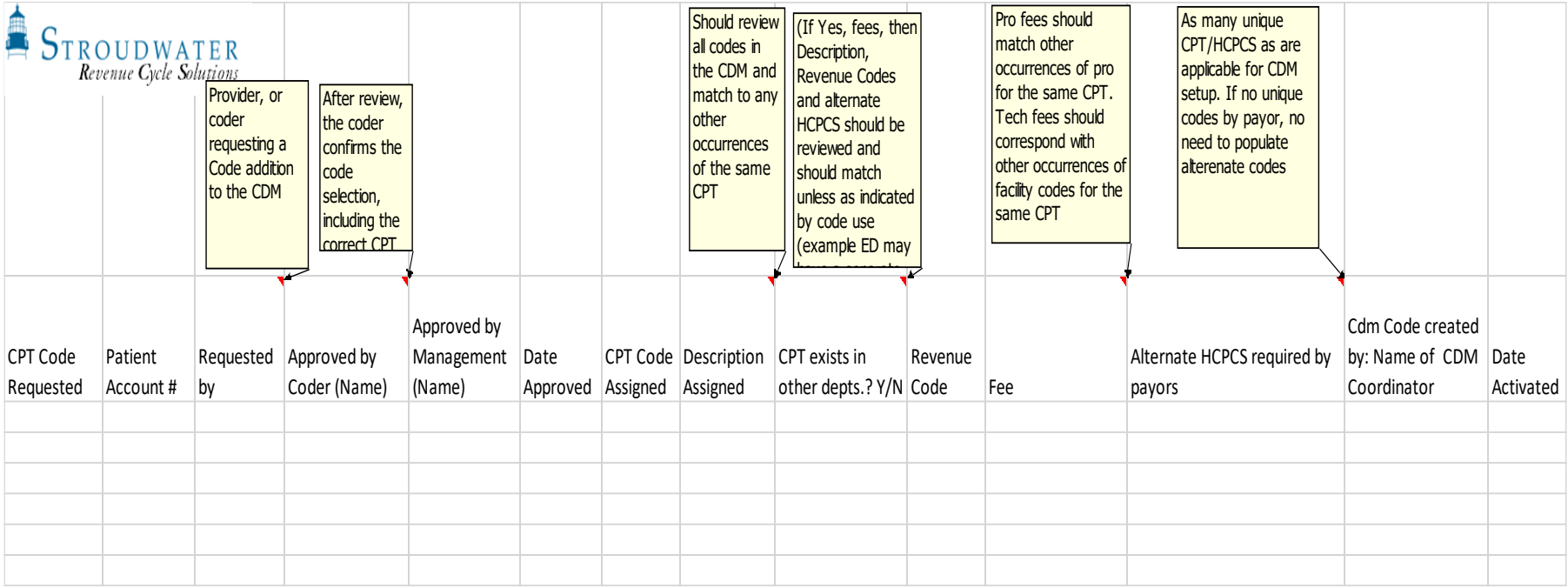

Item Number

- The item number should be unique. No line items may have the same item number
- If possible, the item number should contain the department number followed by the CPT. HCPCS can be assigned numeric item numbers
- A unique item number is the only piece of CDM information necessary to tie all revenue and financial reports together

Item Number

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- Ideally, the item number should represent both the department and the primary procedure code
- First 3 or 4 characters represent department number
- Next 5 represent primary procedure code (CPT or HCPCS)
- A uniform process of item number assignment allows for check and balance reviews in the Business Office process

Description

- AMA updates codes annually
  - Changes may include descriptions and code definition
- The Item Description should contain the most pertinent information contained in the CPT/HCPCS explanation
- The descriptions should be uniform for all occurrences of one CPT/HCPCS within a chargemaster
- CDMs are character limiting – usually under 40 characters, and complete code descriptions can be very long
- AMA produces 28 character and 48 character descriptions
- May changes annually

COMPLETE CODE HISTORY - 28515

▼To Bottom

Change Effective Date	Status	Change Summary
01/01/2000	Changed	Officially recognized, Full, medium and short description, Changed
01/01/1994	Changed	Officially recognized, Full description, Changed
01/01/1993	New	Officially recognized, Other, New

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CPT and HCPCS Selection and Maintenance

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- The chargemaster must maintain all CPTs and HCPCS used within the facility, and provide accurate differentiation between codes for proper identification
- Example: Upper GI endoscopy from esophagus to jejunum

CPT	Previous Description	Current Description	Updated Description	APC	MCR Reimb
43247	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	EGD FLEXIBLE FOREIGN BODY REMOVAL	5301	$785.83
43250	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	EGD FLEX REMOVAL LESION(S) BY HOTBIOPSY FORCEPS	5302	$1557.22
43257	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease	EGD DELIVER THERMAL ENERGY SPHNCTR/CARDIA GERD	5303	$2998.75

Vague or Incomplete Examples From CDMs Examined

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- 43250
  - UPPER GI ENDOSCOPY
    - Description fits over 40 CPTs
  - UP GI/ESOP/STOM/DUOD/JEJUN
    - Description fits 22 CPTS
  - UP GI RMV TUM LES POLYP
    - Description fits 4 CPTs
  - EGD FLEX REMOVAL LESION(S) BY HOTUGI ENDO; W/REMV TUMOR/POLYP/LES- BIOPSYBX FORCEPS
  - EGD CAUTERY TUMORUGI ENDO; W/REMV POLYP

Complete and Accurate Descriptions

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- 43247 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body
  - EGD REMOVE FOREIGN BODY
- 43251 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
  - EGD REMOVE LESION SNARE

Why is Description Important?

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- Strategic Pricing
- Allows for quick and accurate code selection by the servicing provider
- Allows for check and balance at all levels of the Revenue Cycle
  - Providers gain understanding of documentation requirements
  - Coders can review and assess quickly if provided with proper naming conventions
  - Revenue posters can QA as they enter charges
  - If denied, follow up and appeals team can quickly validate services were billed appropriately
  - Customer service will have a more complete picture to respond to customer issues

Charge Amount

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- Charge amount - the fee associated with the Code selection/Revenue Code combination
- Fees should:
  - Be uniform for all modalities within a service line
  - Be defensible based on cost and community
  - Utilize a consistent multiplier, reasonable for the department
  - Take into consideration transparency in billing practices

Setting Charge Amount

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- Determine the appropriate service component
  - Professional
  - Hospital
  - Alternate Fee Schedule
- Review all fee schedules and contracts that pertain to the service under consideration
- Compare that to the acceptable multiplier within the department, and to any information available for competitor pricing
- Assign fee
- Review all occurrences of the code within the service component in the CDM (pro to pro, tech to tech, etc.,)
- Update all for consistency

Summary

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- Assigned CPTs should represent the most accurate code defining service performed
- Alternate codes should only be populated if they vary from the primary code activated for the item number. Where appropriate, they should identify the code required by the payor assigned to the dedicated alternate code
- Revenue code assignment should be the most appropriate code for the service as represented in the cost report
- Item Number should be unique to one line item in the chargemaster, ideally should contain the department and procedure information
- Item Descriptions should contain the most pertinent information to identify the service, distinguish from similar services and allow redundant QA processes
- Pricing should be fair, defensible and consistent throughout a department or service line

Questions?

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Thank You

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- Stroudwater Revenue Cycle Solutions was established to help our clients navigate through uncertain times and financial stress. Increased denials, expanding regulatory guidelines and billing complexities have combined to challenge the financial footing of all providers.
- Our goal is to provide resources, advice and solutions that make sense and allow you to take action.
- We focus on foundational aspects which contribute to consistent gross revenue, facilitate representative net reimbursement and mitigate compliance concerns. Stroudwater Revenue Cycle Solutions helps our clients to build processes which ensure ownership and accountability within your revenue cycle while exceeding customer demands.
- **Contact us to see how we can help.**

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