CHARGE DESCRIPTION
MASTER (CDM)

Facility Best Practices and How to Sustain

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TODAY’S AGENDA

• Understand what a CDM is
• What is the role of the CDM
• How other systems impact and influence the CDM
• Understanding the importance of Charge Audits
• Know how often the CDM should be maintained and reviewed
• Understand who is responsible for the accuracy of the CDM
DEFINITION AND PURPOSE

The Charge Description Master: Commonly simply referred to as the CDM

- AHIMA’s Definition: The Charge Description Master (CDM), sometimes called the Chargemaster or Procedure Code Dictionary, is the database of all billable items that go on patients’ accounts. It contains all the descriptions, revenue codes, department associations, alternate CPT®/HCPCS codes for different payors. A file representing a comprehensive list of services, items and supplies that are billable.

- The CDM is the backbone of the revenue cycle to generate the organizations revenue.
CDM BASICS

• Elements of the CDM
  – Description(s) of the service
  – Hard coded CPT® codes
  – Hard coded modifiers
  – Revenue code
  – Revenue center

• Explode Sets
DESCRIPTION OF SERVICES

• Some patient accounting systems will allow for multiple descriptions
  – Billable description - this is generally the description that the patient will see on the itemized bill
  – Technical - this is generally the description used for internal purposes, this should be the clinical description

  – Example: polysomnography (CPT® 95808) - Call the service a sleep study on what will drop to the itemized bill and the technical terms on the internal description
CPT® CODES

• AAPC definition
  – CPT® codes are the United States’ standard for how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management (E/M) services. All healthcare providers, payors, and facilities use CPT® codes.

• 5 numeric code developed by the AMA
HCPCS CODES

• AAPC Definition
  – HCPCS is an acronym for Healthcare Common Procedure Coding System (HCPCS).
    Standardized code sets are necessary for Medicare and other health insurance
    providers to provide healthcare claims that are managed consistently and in an orderly
    manner
  – Commonly referred to as HCPCS Level II. Technically HCPCS Level I codes are CPT®
    codes
  – Alpha Numeric Codes. 1 Letter followed by 4 numbers
  – Medicare uses these for specific things they want to track
  – Other insurance companies have their own codes (rarer)
  – Some drugs and supplies also have unique codes
MODIFIERS

• Modifiers should be hard coded into the CDM ONLY when that modifier is going to be needed 100% of the time.

  – Example: A 1 view Wrist X-Ray: CPT®: 73100 would be in the CDM as 73100-52 to demonstrate the reduced service
REVENUE CODES

• 3 digit code used to categorize charges into different lines on a UB-04 (claim)
• Also used by Medicare and other insurance companies to analyze charge data
OTHER POSSIBLE ELEMENTS

• Department where the charge resides
• Reporting groups
• General ledger components
• Other user fields
  – If there is a user field available, for supplies the recommendation is to map the item number so that a cross walk can be created for pricing updates
TYPES OF CHARGES

- Flat rate charges: Majority of CDM
  - Diagnostic and therapeutic
- Time based
  - Surgical/Recovery time, Observation
- Supplies: Gray area what is considered chargeable
- Pharmaceuticals
- Statistical: Zero dollar charges for tracking purposes only
- Exploding charges: CDM that automatically generates other CDMs
ROUTINE VS. NONROUTINE SUPPLIES

• Routine Supplies - not separately billable
  – Items are considered floor stock and should not be individually charged
  – Considered to be part of the procedure or Room and Board
  – Organization should have a policy on what they consider nonchargeable and routine
    ▪ Supplies that are customarily used or considered an “integral part” during the course of treatment are considered routine
    ▪ Considerations
      o Should there be a cost dollar threshold? $5, $10, $20 dollars? Financial analysis should be done to see what makes sense. Charging for inexpensive items could cost more than not charging for them
      o Items like IV tubing, gauze, gloves, needles, bed pans, patient convenience items should NOT be charged
ROUTINE VS. NONROUTINE SUPPLIES (CONT)

• Nonroutine Supplies- billable to the patient
  – Can you answer “yes” to the following questions
    1. Is the item medically necessary and specifically ordered by a physician?
    2. Is the item used specifically for and by the patient?
    3. Is the item not commonly furnished as part of a medical procedure or treatment?
    4. Is the item not commonly available for patient use in the medical department or setting?
    5. Is the item documented within the medical record that it was used?
HARD CODING VS. SOFT CODING

- Hard Coding: CPT® codes are housed directly in the CDM as part of the charge.
  - These are CPT® codes that get entered directly on an outpatient claim and can go out the door without coding intervention.

- Soft Coding: Coding will enter the CPT® code generally through an abstraction process
HARD CODED CDM ITEMS

• Only enter a CPT® code on a CDM if that code is to be used 100% of the time

• The majority of the CDM is hard coded
  – Diagnostic Services: Lab, Radiology, Neurosciences
  – Therapeutic Services: Radiation Treatments, Infusions, Pulmonary, Rehab
  – Pharmaceuticals
SOFT CODING

• If there is a possibility of the CPT® code changing, that charge should go to coding for review or selection
• Items that are coded in this manor are attached to a “shell” charge from the CDM
• Common areas that are generally soft coded: Operating Room, Endoscopy, Emergency, minor procedure areas such as a Pain Clinic
• Generally CPT® codes in the 10021-69990 lend themselves to optimal soft coding as there can be variation in how procedures are performed
PRICING

• Is your price defendable?
• Is your price consistent?
  – Does a left hip cost the same as a right hip x-ray?
• Is your price logical?
  – How does the price of CT Scan without contrast compare to a CT scan with contrast
• How does the price compare to fee schedules?
  – Are you leaving money on the table?
PRICING (CONT)

• Are prices related to costs?
  – Medicare paper based manual section 2202.4: Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

• Organizations should have a policy as to how prices are set
ANCILLARY SYSTEMS
CDM MAPPING

• When charges are being entered from ancillary systems, they have to be maintained in BOTH systems
• Communication is key between the ancillary department, applications analyst who maintains the software and the person/team who oversees the CDM
• Charges can very easily be missed when communication breaks down
CHARGE ENTRY

• There are MANY ways that charges can be entered into a patient’s record.
• Often charges are entered in an automated fashion
• Orders into ancillary systems often create charges

KEY POINT!
• Clinical users often do not realize as they are documenting that charges are (OR ARE NOT) being created in the background!
PHARMACY CHARGE ENTRY

• Does your organization “charge on chart” or “charge on dispense?”

• Organizations that charge on “dispense” have a risk of overcharging the patient. Meaning the patient may have received the medication but it was never charted
PHARMACY UNITS

• Often one of the biggest areas of risk
• Pharmacy units can make zero clinical sense
• More often than not, the quantity that the pharmacy is entering is NOT what needs to go on the claim
  – This conversion can happen in the pharmacy system or CDM depending on system limitations.
PHARMACY WASTE

• Medicare allows for the charging of waste
  – Medicare Claims Processing Manual chapter 17, section 40 Discarded Drugs and biologicals: “modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological.”

• Example: Cancer patient on Avastin® (bevacizumab)
  – Vial: 1,000 mg; patient dosed 950mg
  – Avastin’s® HCPCS: J9035; billed per 10mg
  – In this scenario we would bill the following:
    - \( J9035 \times 95 \) (95 billing units \( \times 10 \text{mg per unit} = 950\text{mg dosed} \))
    - \( J9035JW \times 5 \) (5 billing units \( \times 10 \text{mg per unit} = 50\text{mg wasted} \))
CHARGE RECONCILING

• Who in the organization is responsible for reconciling charges?

• Is there a standard process?

• Are departments held accountable?
• Why is charge reconciliation so important?

• Systems are so automated now that without a review of charges it is very easy to unintentionally commit fraud or lose revenue
  – Example: Lab Director submits a new test that will be performed. CDM Analyst gets the charge built and the Lab Analyst also builds the test so it can be ordered. The Lab System Analyst forgets to place the CDM number in the field that would make it chargeable.
  – In this example everything was built but no charges crossed because the charge was not mapped.
CDM TEAM COMPOSITION

• Finance
• Patient financial services
• HIM
• Compliance
• Clinical department representatives
CDM TEAM RESPONSIBILITIES

- Quarterly updates
- Annual review
  - Codes released in the fall to be effective for beginning of year
  - Prime opportunity for annual review
    - Deleted charges, is there a replacement?
    - New charges, is that service being done?
    - Revised Services - does the way the service is being done still meet the criteria for the code?
  - Good time to review charge reconciliation procedures
  - Utilization review: delete items with no use over 3 years
- Stay abreast of changes
  - Contract
  - Regulatory
  - Clinical
CDM TEAM RESPONSIBILITIES (CONT)

- Educating staff on changes
- Develop policies and procedures
- Formal review of all changes
CHANGE REQUESTS

• Are there controls in place?
  – Limited number of individuals should have access to change the master file
  – Separation of duties, person entering the charges should not have access to change the charges
  – Change request process
    ▪ Form
    ▪ Sign off from department head, CDM analyst, applications analyst, others if needed

• Is there a policy or procedure?
DEPARTMENT OWNERSHIP

- Revenue producing departments need to be accountable for their revenue!
  - Do they know the codes?
  - Are they familiar with the charge entry process?
  - Is someone reconciling the charges daily?
  - Is there a back-up to the person reconciling charges?
  - Are they engaged as part of the review process?
  - Is there a formal annual sign off process?
ANNUAL REVIEW

• Recommendation:
  – Have a formal meeting process with all departments
  – Provide department with their CDM showing which charges are impacted with CPT® changes
  – Review changes
  – Give them deadlines to complete items
    ▪ All charges with changes need answers by MM/DD
    ▪ Remainder of CDM needs to be formally signed off by MM/DD
    ▪ Have them attest that there is a charge reconciliation process in place
CHARGE AUDITING

- The reconciliation process should be tested regularly
  - Are the clinical users entering in the charges/orders correctly?
  - Are those charges coming across the interface correctly?
  - Is the CDM set up correctly?
  - Did billing change anything before it went out the door?
CLAIM SCRUBBER

• Most organizations have a claim scrubber
• Application where staff will modify claims to ensure faster payment
• Best practice is to have coding work any edits that require looking into documentation
  – Column 1/Column 2 edits
  – Medically Unlikely Edits (MUE)
  – Medicare and other specific insurance edits
  – CPT® mismatch
CHANGES / ERRORS

• Keep a central repository/log of all changes to the CDM
  – Knowing why a change was made or who wanted it changed is important for future reference

• Keep a central repository of any errors uncovered
  – What was the error
  – How was it discovered
  – How fast was it corrected
  – Did any billing have to be refunded
  – Reasoning behind why corrected claims did or did not have to be filed
SCENARIO 1: LAB TEST

Physician creates order for service
- Language or CPT® code of services. ICD-10-CM diagnosis for why test selected

Order Entry
- Staff enter test based on order description

Charge entry
- Upon order entry or lab, resulting will trigger the charge to go from the lab system to patient accounting

Coding
- The service is coded

Claim Drop
- Claim goes through scrubber and then gets submitted to the payor
LAB SCENARIO (CONT)

• Patient walks into a hospital with two lab slips from two different doctors
  – Order 1- Dr. Smith
    ▪ Lipid Panel - 80061
    ▪ TSH - 84443
    ▪ PSA - 84152 (G0103 for Medicare)
  – Order 2 - Dr. Jones
    ▪ Total Cholesterol, serum - 82465
    ▪ TSH-84443

• What tests should be done?
• What test should be charged?
• How many claims should be produced?
• What test should be resulted? And to Who?
LAB SCENARIO (CONT)

• Patient walks into a hospital with two lab slips from two different doctors
  – Order 1- Dr. Smith
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  – Order 2 - Dr. Jones
    ▪ Total Cholesterol, serum - 82465
    ▪ TSH-84443

• What tests should be done? 80061,84443,84152
• What test should be charged? 80061,84443,84152
• How many claims should be produced? 1
• What test should be resulted? And to Who? As ordered
SCENARIO 2: EMERGENCY VISIT

REASON FOR VISIT: CHEST PAIN

Physician sees patient, does work up, orders Troponin every 4 hours, EKG, IV, aspirin

Order Entry: Staff enter orders similar to Scenario 1

Charge entry
- Upon order entry or lab, resulting will trigger the charge to go from the ancillary system to patient accounting
- EMR or Charge Entry staff will generally calculate the facility E/M, enter Infusion charges, procedure shells, supplies, etc.

Coding: The encounter is coded for Diagnoses, and CPT® codes will be entered (hard vs. soft coding)

Claim Drop: Claim goes through scrubber and then gets submitted to the payor
SCENARIO 3: TOTAL KNEE REPLACEMENT

Patient brought into the OR and has a total Knee Replacement

Order Entry: Staff enter orders (lab, pharmacy etc..) similar to Scenario 1

Charge entry
- Ancillary charges will be enters as orders like we discussed in scenario 1
- Supplies are generally entered through a preference card
- OR time is generally system calculated for how long the patient was in the OR

Coding: The charge master will drop the CPT® codes for supplies, drugs, lab etc. Coding will abstract the operative report and assign CPT® code 27477

Claim Drop: The CPT® code will be assigned to the surgical time on the claim
TOTAL KNEE SCENARIO CONT.

• Supplies are often charged from a preference card
  - The Circulating RN is generally responsible for filling out the preference card correctly for what supplies do or do not get used.
  - What is there is a supply that is used that is not on that preference card? How does that supply get charged. Will it be charged timely and not be a late charge?

• Supplies opened but not used, you cannot charge for them.
  - Is there sufficient documentation in the system to really discern what was used and not just opened for physician convenience?

• Consignment items. Often for items like the total knee the hospital does not own it until it is used. What is the process for consignment items?
QUESTIONS??
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