

The Chargemaster Essentials Toolkit

Second Edition



Valerie Rinkle, MPA, CHRI

NAHRI

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ISBN: 978-1-68308-998-8

Product Code: TCET2

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About the Author

Valerie A. Rinkle, MPA, CHRI, 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 35 years of experience in the healthcare industry, including more than 15 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, Second Edition, 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 required resources as well as other important 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 and price transparency requirements.

This second edition contains updated information on certain field locations, supply charge considerations, changes to the 340B drug pricing program, functional reporting requirements for physical and occupational therapy, and a new section on price transparency. It also includes updated regulatory information throughout all chapters to provide the latest information on topics relevant to chargemaster operations and management.

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 offers 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 such as the chargemaster.

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 Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, appropriate National Uniform Billing Committee (NUBC) 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 overarching goal of revenue integrity is crucial. Only with this context is it 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, but the National Association of Healthcare Revenue Integrity (NAHRI) defines revenue integrity as follows:

The basis of revenue integrity is to prevent recurrence of issues that can cause revenue leakage and/or compliance risks through effective, efficient, replicable processes and internal controls across the continuum of patient care, supported by the appropriate documentation and the application of sound financial practices that are able to withstand audits at any point in time.

Chargemaster Structure and Principles

A charge description master, or CDM, is a file or application in a patient accounting system. The file contains certain standard fields, and the purpose of the file is to produce claims that meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction set requirements, payer requirements, and financial reporting requirements. Collectively, these requirements are known as the Administrative Simplification Act. The National Uniform Billing Committee (NUBC) is the entity that, by law, has the authority to maintain the institutional claim or Uniform Bill operating rules and transaction sets. The Centers for Medicare & Medicaid Services (CMS) website provides additional information about the Administrative Simplification Act, transaction sets, requirements, and enforcement at <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html>.

The CDM may also be known by other terms, including:

- *Chargemaster*
- *Line item master*
- *Financial item master*
- *Service item master*
- *Price list*
- *Charge list*

Access to the file within the accounts receivable (AR) system should be limited to a few individuals, and all changes made to the file should be tracked due to the significant compliance and financial risks associated with the use and purpose of the chargemaster. The information in the chargemaster feeds the overall income statement of the hospital, so

financial auditors require appropriate internal controls and other features to prevent both inadvertent changes and changes that may be made with a nefarious intent.

The chargemaster has multiple purposes, including:

- Facilitating accurate financial reporting of revenue
- Facilitating comprehensive and compliant billing
- Supporting capture and categorization of patient care revenue by department or service line
- Providing data to assess and manage resource utilization
- Providing one source of data to support inventory management
- Facilitating Medicare and Medicaid cost reporting

Chargemaster Fields

The chargemaster has standard fields as well as some variable or user-defined fields. For each of these fields, the underlying resource or authority and the nature of the field will be described as a basis for understanding a typical chargemaster.

Figure 2.1 shows a typical flat, or static, file layout for a chargemaster.

Figure 2.1 **Sample flat layout**

Charge Number	Charge Description	Procedure Charge	Rev Code	Month to Date Volume	Year to Date Volume	CPT4 Code	IP GL#	OP GL#	Record Status
7901259	FBC HBO PER 30 MIN G0277	248.90	413	344	1547	G0277	30131000	30132000	A
7901341	WOUND CARE VISIT G0463	193.80	761	276	1462	G0463	30131000	30132000	A
7901036	WC NONSELECT DEBRIDE 97602	269.20	761	83	375	97602	30131000	30132000	A
7900756	SLCTV WND DEBRIDEM </= 20 CM 9759	215.80	761	19	107	97597	30131000	30132000	A
7900699	APPLY MULTLAY COMPRS LWR LEG 2958	280.50	761	10	44	29581	30131000	30132000	A
7901234	BEHAV CHNG SMOKING 3-10 MIN 99406	39.80	942	0	0	99406	30131000	30132000	A
7901242	BEHAV CHNG SMOKING > 10 MIN 9940	43.20	942	0	0	99407	30131000	30132000	A
4700316	DIABETIC ED INDV 30MIN G0108	107.40	942	24	160	G0108	30151000	30152000	A
4700324	DIABETIC ED GRP 30MIN G0109	63.80	942	0	0	G0109	30151000	30152000	A
2212645	INJECT SUBCU/IM 96372	136.60	260	309	1587	96372	30201000	30202000	A
2212694	INFUSION INITIAL TO 1 HR 96365	442.30	260	254	1149	96365	30201000	30202000	A

Consider This

A good exercise is to have both coding and billing departments hold accounts until a weekly meeting where coders and billers are in the same room with the chargemaster coordinator. Coders can then access the account and demonstrate to all present in the meeting (e.g., use a projector) how the codes on the account either edit or do not edit. Billers can then access the same account to demonstrate how the codes on the account edit and show whether the edits are from the AR system, the clearinghouse, or the Medicare Direct Data Entry system. The billers and coders can then discuss if the edits are the same and whether they should be. Only with this meticulous problem-solving can the chargemaster coordinator design charges in the chargemaster that are used appropriately by the departments and reduce the incidence of edits at both coding and billing.

The CMS requirement to post the same charge for the same service to all patient accounts, regardless of whether the patient is covered by Medicare and inpatient or outpatient, will be discussed later in this chapter. This is colloquially known as “billing all patients the same,” although that is not exactly what the requirement states. Nevertheless, coding edits often result in either removing or changing the charges on an account. As a result, it is best practice to apply the edits to all accounts, not merely to government payer accounts. Therefore, the edits applied by the grouper program at coding should be applied to all accounts, not just to Medicare and Medicaid accounts.

Relationship Between Chargemaster and Other AR System Files

The chargemaster coordinator must understand all of the steps to develop and bill a claim for each major patient type and account type. Most AR systems have three major patient types: emergency, inpatient, and outpatient. Even though an emergency patient is a type of outpatient, the patient is often treated separately in the AR system. Insurances are grouped by major financial class, and each hospital has made its own decision whether to group Medicare Part C plans into the Medicare or commercial financial class. Then there are other possible patient types, such as diagnostic, series outpatient therapy accounts, and non-patient referred laboratory specimen accounts. These definitions are needed to meet different payer billing requirements.

For example, laboratory specimens are registered under a unique patient type, because there is a unique claim type for this service: a 014x claim that must be used for all payers as it is defined by NUBC.

Chargemaster Management and Maintenance Strategies

Chargemaster coordinators frequently inherit a chargemaster from those who previously set up and maintained the chargemaster. Each chargemaster coordinator begins by approving, disapproving, or modifying the chargemaster update requests received from departments. However, a chargemaster coordinator should perform a deep dive into each department's charges at least annually, identifying additional changes that should be made. The chargemaster coordinator must also execute annual price increases. The combination ultimately results in the inherited chargemaster changing into one that is owned by the new chargemaster coordinator, reflecting the philosophy of the organization as well as the philosophy and knowledge of the new coordinator.

This chapter will describe strategies and tactics a chargemaster coordinator can use to successfully manage and maintain the chargemaster. The scope spans how to prepare and conduct a department-specific review to the annual price increase and quarterly Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) updates typically required due to changes described in the Centers for Medicare & Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) quarterly transmittals.

The Team Approach to Chargemaster Maintenance

Many hospitals have established a chargemaster maintenance team that may (but does not have to) be led by the chargemaster coordinator. Typically, this team has key revenue cycle staff from patient access, health information management (HIM)/coding, and patient financial services as well as compliance. Electronic medical record (EMR) informatics staff may also be needed on the team to describe the documentation and charge capture triggers that need to be built into the EMR for the charge additions and changes. Charge inactivations

Present-on-admission indicator (FLs 67, 67A–Q, and 72, supplemental locator)

The present-on-admission (POA) indicator is used to indicate whether a condition was present upon inpatient admission. The *Official ICD-10-CM Guidelines*, Appendix I, discusses the POA reporting guidelines. Reporting of the POA indicator is required for inpatient claims submitted by hospitals paid under the Inpatient Prospective Payment System (IPPS). Critical access hospitals, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, cancer hospitals, and children’s hospitals are exempt from POA reporting requirements for Medicare claims, but other payers may require POA reporting for these provider types.

Admitting diagnoses (FL 69)

For inpatient claims, the “condition identified by the physician at the time of the patient’s admission requiring hospitalization” must be reported in this field per the *NUBC Manual*.

Patient’s reason for visit (FL 70A–C)

For outpatient claims 013X and 085X, the patient’s reason for the visit must be reported in this field for claims having revenue codes 0450, 0516, and 0762, representing emergent, urgent, and observation services. These additional diagnoses can be used to separately report signs and symptoms that would not otherwise be reported as secondary diagnoses. These codes are to be reviewed at claims processing and must qualify for meeting medical necessity coverage determinations based on ICD-10-CM diagnosis codes. These fields should not be populated automatically by using the first three diagnoses as a default.

Consider the example from Figure 4.1:

**Figure
4.1**

Patient reason for visit case study

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an electrocardiogram and cardiac enzymes, the patient is diagnosed with a recurrence of gastroesophageal reflux disease (GERD) (K21.0).

Question: What diagnosis or diagnosis codes should be reported on the claim and in what field or fields?

Analysis: The GERD (K21.0) should be reported in FL 67 Principal/First Listed Diagnosis Code. The chest pain (R07.9) must also be reported in FL 70 Patient Reason for Visit because this was an emergency visit and a Patient Reason for Visit must be reported on emergency department visits. The chest pain further provides the justification for the cardiac-related tests, even though the final diagnosis for the patient was GERD.

Principal procedure (FL 74) and other procedures (FLs 74A–E)

These fields are required only for inpatient claims and are used to report ICD-10-PCS procedure codes. ICD-10-PCS codes per HIPAA transaction sets are only required on inpatient claims. The principal procedure is “the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication,” according to the coding guidelines. Medicare inpatient claims systems process 24 procedures in addition to the principal procedure, for a total of 25 procedures. If a prior outpatient claim is combined with an inpatient claim due to three-day payment window requirements, the HCPCS procedure code must be recoded to an ICD-10-PCS code and reported in one of these fields with the date of the procedure, which would be up to three days prior to the date of inpatient admission. The “from” date of the claim will also need to be updated to encompass the procedure date.

Attending provider name and identifier (FL 76)

As stated in the *NUBC Manual*, this field is used to report the name and NPI of the individual who has “overall responsibility for the patient’s medical care and treatment” reported in the claim/encounter. No specific field corresponds to the ordering physician on claims, so this is the field used to report the ordering physician on outpatient claims because the ordering physician retains overall responsibility for the patient’s record and treatment.

Due to the rise in the specialty of hospitalists, it may not be easy to determine the attending physician—it is the admitting physician, discharging physician, or hospitalist that had most of the visits with the patient during the inpatient stay. It may be a good idea to discuss this with the chief medical officer and medical executive committees and develop a written policy so that accounts are billed with consistent information.

Consider This!

Do not put a physician name and NPI in this field if the service is self-referred. This applies to claims for self-referred mammography services. The provider should report his or her own NPI in the Attending Provider Name and Identifier field as outlined in Chapter 18, Section 20.4, of the *Medicare Claims Processing Manual*.

Operating provider name and identifier (FL 77)

This field is used to report the name and NPI of the individual with the primary responsibility for performing the surgical procedures listed on the claim. If there is more than one surgeon, the other provider name and identifier fields can be used to report additional

Most of the departments in a hospital are ancillary departments, and most hospitals have a significant number of different ancillary departments comprising their respective service mix as well as their chart of accounts in the general ledger (GL). Because there is such a wide variation in ancillary departments, this toolkit focuses on the main ancillary departments. Concepts described can be applied to other ancillary departments. Given the large number of different ancillary departments, the ancillary services section of this book is divided into two parts.

This chapter will address the following ancillary services, which may or may not be composed of more than one department per service area:

- Pharmacy and radiopharmaceuticals
- Drug administration services, blood administration, and oncology
- Supplies, devices, and implants
- Laboratory, pathology, and blood products
- Imaging and therapeutic radiology
- Perioperative services

Each section will discuss important chargemaster, billing, and coding concepts applicable to the services and chargemaster; charge capture strategies a coordinator may use or be expected to consider; and key resources to consult.

paid single-use vial can be the total amount even if less than the vial dosage is administered, hospitals are required to purchase the drug in the lowest package amount that is closest to the ordered amount to be administered. Unused portions of multiuse vials may not be billed to Medicare.

Unused portions of a single-use vial or other single-use package are separately billable to Medicare if the drug is separately payable, a portion of the drug is administered to the patient, and the remainder is discarded. The provider is limited to billing total units of both the administered and discarded drug up to the smallest vial available for purchase from the manufacturer that could have provided the appropriate dose for the patient.

Modifier -JW

Beginning January 1, 2017, hospitals are required to report modifier -JW for any portion of a single-dose vial of a separately paid drug that is wasted along with the unmodified HCPCS code for the amount administered. The following is an example of how this should be reported.

Dosage amounts for omalizumab are based on body weight, but typical dosages are 150 or 300 mg every four weeks or 225 or 375 mg every two weeks. For the latter dosage, wastage would be 75 mg per visit for the smallest vial size available of 150 mg. The HCPCS code for omalizumab is J2357 per 5 mg, and, under OPPS, the status indicator is K for a separately payable drug.

The hospital would bill this as follows, assuming the 225 mg dosage and both claim lines should have the associated price/cost of the drug:

Revenue code 0636	J2357	45 units on line one
Revenue code 0636	J2357JW	15 units on line two

Medicare Part B payment for newly approved drugs and biologicals is available once the product is approved by the Food and Drug Administration (FDA). CMS will incorporate biosimilars that are approved under the abbreviated biological approval pathway into the ASP payment methodology and issue additional guidance as necessary. Initially, once the manufacturer's wholesale acquisition cost (WAC) is available, Medicare will pay 106% of the WAC for the product until ASP information is available. Once ASP information is available for this biosimilar product, Medicare payment will equal the ASP for the biosimilar product plus 6% of the ASP for the reference product.

National Drug Codes (NDC) were required on claims for drugs reported with HCPCS detail due to the Medicaid drug rebate reporting requirements as of January 2008. The units of

NEMA created a safety equipment standard that Congress requires, or the payment for the CT scan will be reduced by 15%. Modifier -CT applies to the following series of CPT codes:

- 70450–70498
- 71250–71275
- 72125–72133
- 72191–72194
- 73200–73206
- 73700–73706
- 74150–74178
- 74261–74263
- 75571–75574

If a CT scan is paid as part of an imaging family composite APC, the APC composite payment is reduced by 15%. No reduction is applied to CT scans reported with modifier -CT that are packaged into payment for other services (i.e., composite or comprehensive APCs).

An x-ray taken using a plain film machine must be reported with modifier -FX. The payment is reduced by 7% in 2019 and will be reduced by 15% starting in 2020.

Finally, an x-ray taken using computed radiography technology/cassette-based imaging must be reported with modifier -FY. The payment is reduced by 7% at the time this book was published, and the reduction will be increased to 15% in the future.

Charge capture

Note that visit codes for radiation oncology consultation visits performed in hospital departments are often missed in chargemasters for radiation oncology departments. Because the space and staff that support the physicians is a hospital expense, it is appropriate for a facility visit charge for these services. For imaging tests, ensure the radiology technologists have the ability to change the ordered exam to the performed exam so that exams charged are correct according to what is performed.

GL and finance considerations

Typically, each therapy modality or specialty has its own expense and revenue center in the hospital GL. At times, the inpatient therapy departments are also separated from the outpatient therapy departments.

When therapy teams are treating patients, it is best if each specialty is represented in the team meeting and each specialty develops their own separate report regarding assessment and treatment recommendations. In these situations, each specialty bills separately for its respective services.

Coding and edit issues

All outpatient hospital claims with therapy services must comply with the therapy billing rules. This means that if CPT services in the 97xxx range are performed by providers other than therapists (e.g., nurses for “sometimes” therapy codes like wound care), the specific therapy revenue codes and therapist modifiers are not appropriate.

Consider This!

CMS provides a helpful training resource describing therapy billing scenarios on its website. To access this information, go to https://www.cms.gov/Medicare/Billing/TherapyServices/billing_scenarios.html or search for “PT and OT Billing Scenarios” on www.cms.gov.

Therapy services performed by a qualified therapist under a therapy plan of care are billed under specific therapy revenue codes and with specific therapy modifiers:

- Revenue code 042X, modifier -GP for physical therapy (PT) services
- Revenue code 043X, modifier -GO for occupational therapy (OT) services
- Revenue code 044X, modifier -GN for speech therapy and language pathology (SLP)

(See the *Medicare Claims Processing Manual*, Chapter 4, Section 200.9, and Chapter 5, Section 20.1, for additional information).

When reporting services with CPT/HCPCS codes defined by time (e.g., 15 minutes), all face-to-face time with the patient in a single day is rounded to the closest 15-minute increment, subject to the guidelines in the *Medicare Claims Processing Manual*, Chapter 5, Section 20.2 B, C. At least eight minutes of therapy must be provided to report one unit of

Modifier -59

While modifier -59 is reportable, note that CMS established four more specific HCPCS modifiers, referred to as the -X{EPSU} modifiers, to be used in particular situations in lieu of modifier -59. These modifiers are described in Chapter 1 of the *NCCI Manual*. These modifiers were effective, but not required, as of January 1, 2015. CMS initially encouraged providers to rapidly adopt the new modifiers; however, CMS later indicated it would provide additional guidance on the modifier use and planned to require them in a gradual, controlled fashion. No other information has been forthcoming other than that published in the *Special Edition MLN Matters 1422* and *One-Time Notification Transmittal 1422* from CMS.

Medically Unlikely Edits (MUE)

MUEs represent the maximum number of units reportable for a HCPCS code by the same provider for the same beneficiary for the same date of service or, at times, for the encounter as reported on a single claim. Chapter 1 of the *NCCI Manual* describes MUEs. CMS publishes an MUE file containing the MUE limits for some (but not all) HCPCS codes. The file is updated quarterly, and there is a separate file for practitioner, facility, and durable medical equipment (DME) services.

The MUE file contains a column with the rationale for each of the MUEs. The MUEs are based on the following considerations:

- Anatomic considerations (e.g., appendectomy)
- Code descriptions (e.g., a code with the term initial in its title)
- Established CMS policy (e.g., bilateral procedures)
- Nature of the analyte (e.g., 24-hour urine collection)
- Nature of the procedure and the amount of time required to perform the procedure (e.g., overnight sleep study)
- Nature of the item (e.g., wheelchair)
- Clinical judgment based on input from physicians and clinical coders
- Submitted claims data from a six-month period

The MUE file contains a column indicating whether an MUE will be applied by date of service or by claim line. All claim lines with the same CPT/HCPCS code on the same date of service will be summed and compared to the MUE value, regardless of modifier. The claim lines will be denied if the units summed in this way exceed the MUE value. Claim lines are

Beginning January 2016, the MUE was reduced to 2 and subsequently reduced back to one. This was likely due to an analysis of claims where providers did not change their billing practices back to reporting each medically necessary unit after the MUE unit limit was increased to 10 in July 2015. This example shows where adjustments to the Medicare and Medicaid claims as depicted in scenarios #1 and #2 result in reporting less cost for services than that reported to a commercial account where the MUEs do not apply.

Figure 8.1

Examples of MUE for 94640 with ED visit

Claim A—Commercial						
				Rev Code	CCRs	“Cost”
99284	1/15/2016	1	\$500.00	450	0.210	\$105.11
94640	1/15/2016	1	\$75.00	410	0.294	\$22.07
9464076	1/15/2016	2	\$150.00	410	0.294	\$44.15
Total			\$725.00			\$171.32
Claim B—Medicare						
Scenario #1—Hospitals Remove Both Unit(s) and Associated Charges in Excess of MUE						
99284	1/15/2016	1	\$500.00	450	0.210	\$105.11
94640	1/15/2016	1	\$75.00	410	0.294	\$22.07
9464076	1/15/2016	2	\$150.00	410		
9464076	1/15/2016	1	\$75.00	410	0.294	\$22.07
			\$575.00			\$127.18
Scenario #2—Hospitals Remove Unit(s) in Excess of MUE and Leave Total Charges the Same						
99284	1/15/2016	1	\$500.00	450	0.210	\$105.11
94640	1/15/2016	1	\$225.00	410	0.294	\$66.15
9464076	1/15/2016	2	\$150.00	410		
			\$725.00			\$171.26
Scenario #3—Hospitals Remove Entire Line with Unit(s) and Charges in Excess of MUE						
99284	1/15/2016	1	\$500.00	450	0.210	\$105.11
94640	1/15/2016	1	\$75.00	410	0.294	\$22.07
9464076	1/15/2016	2	\$150.00	410		
			\$575.00			\$127.18
<p>MUE applied only to Medicare account, and at least three scenarios for hospital staff to respond to MUE edits. Note that both the commercial and Medicare claims meet CMS’ requirements for charges to be posted at the gross level and applied consistently, but the data CMS receives for rate setting can be significantly skewed to account for the same hospital and across all hospitals.</p>						

Consider this list of helpful resources for chargemaster professionals:

- **837 Format** – <https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/5010A2837ACG.pdf>
- **Accountable Care Organizations** – <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acol/>
- **Accreditation Organizations** – <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation.html>
- **Adverse Event Information from the Office of Inspector General (OIG)** – <http://oig.hhs.gov/newsroom/spotlight/2012/adverse.asp>
- **Affordable Care Act (ACA) Information** – <https://www.hhs.gov/healthcare/about-the-acalindex.html>
- **ACA Required Benefits** – <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>
- **ACA Tax Provisions** – <https://www.irs.gov/Affordable-Care-Act/Affordable-Care-Act-Tax-Provisions>
- **Agency of Healthcare Research and Quality Archive** – <http://archive.ahrq.gov/>
- **America’s Health Insurance Plans (AHIP) organization** – <https://www.ahip.org/>
- **Article Regarding the Relationship Between Charges and Payments** – <http://healthaffairs.org/blog/2013/10/07/no-method-to-the-madness-the-divergence-between-hospital-billed-charges-and-payments-and-what-to-do-about-it/>
- **Behavioral Health Benefits under ACA** – <https://www.healthcare.gov/coverage/>

Access the tools accompanying your toolkit at www.hcpro.com/downloads/12545:

- Adverse Event Reporting and Non-Insurance Billing Procedures
- Cancelled Accounts Policy
- Chargeable Supplies Policy
- Chagemaster Change Request Form
- Chagemaster Maintenance Policy & Procedure
- Departmental Chagemaster Review Calendar
- Key References per Department
- Late Charge Procedure Policy
- Need for Advance Beneficiary Notice/Waiver for Nonphysician Practitioners Ordering Hospital Services
- Orders for Outpatient Services Policy
- Responding to Patient/Physician Office Inquiries on Patient Accounts Policy
- Sample Major Departmental CDM Charge Capture Questionnaire
- Terminated Procedure Policy



The Chargemaster Essentials Toolkit **Second Edition**

Valerie Rinkle, MPA, CHRI

No matter the size or scope of a healthcare facility, the effort involved in maintaining a chargemaster is immense. Chargemaster coordinators, analysts, and other revenue integrity professionals must stay on top of billing and coding trends and changes, cost reporting, and charge capture. While the list of responsibilities for revenue integrity professionals grows every day, the work they perform has a significant impact on a facility's reimbursement and overall revenue. Thus, the increasing state and federal focus on price transparency means it is more important than ever to have an accurate, updated, and compliant chargemaster.

In its second edition, *The Chargemaster Essentials Toolkit* returns to provide readers with the tools needed to optimize their chargemaster and ensure accurate reimbursement and revenue integrity across their organization. This edition contains a new section on price transparency as well as updated information on certain field locations, supply charge considerations, changes to the 340B drug pricing program, and functional reporting requirements for physical and occupational therapy. It also includes updated regulatory information throughout all chapters to provide the latest information on topics relevant to chargemaster operations and management.

About Simplify Compliance

Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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