Management of Chargeable Items White Paper

The Management of Chargeable Items White Paper is an executive briefing for CEOs, CFOs, and other health leaders. This briefing describes how to improve the charge description master (CDM) from the consumer's perspective. It gives insight on how to improve patient understanding by streamlining the CDM, improving CDM accuracy and compliance, and using easier-to-understand descriptions in the CDM.

The Executive Summary highlights key areas from the Management of Chargeable Items briefing. The summary is designed as a starting point for discussion and action by senior management. A number of potential operational improvements can be achieved by taking a patient-focused approach.

This document is intended for broader distribution within your organization.

Executive Summary

The Patient Friendly Billing Task Force was established to help hospital and health system leaders create a more patient-focused (and friendly) healthcare billing-and-collection process. The task force has made significant progress in outlining the means and opportunities to make this process a reality. The process requires a committed effort from providers to implement improvements in the way they generate bills not only to insurers but also to patients. This briefing is intended to describe one area of importance: the management of the charge description master (CDM).

Many patients experience frustration in trying to reconcile their patient billing statement against their explanation of benefits (EOB). Their efforts toward reconciliation are often fraught with confusing terms, billing errors, and complexity of details. Improving this reconciliation experience is important for both patients and providers. Establishing a process that manages the CDM and seeks to continuously monitor and refine how well it works is extremely important for providers.

Providers that have adopted many of the recommendations contained in the following briefing have shown improvements in their cash flow, quality of billing statements, and, most importantly, patient relations. While many providers receive high marks for the quality of care they provide, they often forget about the importance of the total healthcare experience, including the billing process. How well providers handle the billing process has a profound effect on patients' view of their healthcare experience.

The briefing outlines the importance of managing the CDM because it is the "heart" of the bill-preparation process. The briefing describes a working framework to improve the CDM and, ultimately, the billing process. The challenge for providers is to create a CDM capable of achieving regulatory compliance while it also strives to improve patient billing. These two areas should not be viewed as mutually exclusive approaches. Instead providers should look to establish a well-coordinated collective CDM strategy that is capable of achieving these goals. Such an approach is necessary for the organization to fully achieve its organizational goals and improve on its operational efficiency.

The most significant portions of the Management of Chargeable Items briefing are highlighted below:

- Assemble a cross-functional team to spearhead your organization's management of the CDM process; include a senior executive to be responsible for coordinating the team activities.

- Examine current organizational policies and procedures, especially around mark-up approach, frequency of review, compliance, security, and charge audit validation. Compare organizational revenue objectives against specific regulatory reporting requirements and contracted arrangements with insurers; examine how these affect CDM maintenance and regulatory compliance.

- Identify and track areas for improvement.

    - Billing errors. Identify items recorded incorrectly in the CDM, such as price, description, HCPCS number, revenue code number, and unit assigned to service.
    - Patient complaints about the clarity of charges reported on the billing statement. Examine terminology used, and adjust terminology to achieve patient understanding.
    - Educate staff and physicians about regulatory changes, coding requirements, and documentation requirement to support CDM assignment.
    - Simplify and reduce the number of CDM items; avoid pitfalls of reporting nominal supply items that contain excessive mark-ups, such as $10 for aspirin.
- Perform periodic reviews of the management of the CDM process, and report to senior management on additional support and tools needed to make improvements, stay current with regulatory changes, and educate staff.
- Ease patient reconciliation of EOB and patient's bill by designing patient billing statements to reflect the contractual approach to the health plan's bill.
    - Provide itemized statement only when patient requests such a statement.

Finally, this briefing is intended to raise the level of importance for managing the CDM process to improve patient relations. There are other efforts that, when combined with this process, will further facilitate improvements to the patient billing process. It should be viewed as a continuous process that seeks to improve the accuracy of the billing process, strives to improve patient understanding through simplification, and seeks to reduce costs through improved cash flow.

Outline for:

Management of Chargeable Items

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- Achieving higher level of patient satisfaction and understanding from billing statements

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Benefits of Success

Example Charge Section of Patient Billing Statement

Management of Chargeable Items White Paper

Introduction

The charge description master (CDM) is a file that contains a list of a provider's chargeable services. In addition to the list of services, the file includes the corresponding price, a short description of the chargeable item or service, a unique reference number assigned by the provider (generally organized by department), the UB-92 revenue code number (institutional providers only), and, if available, the appropriate HCPCS code. In the institutional provider setting, each routine and ancillary care department is responsible for organizing the chargeable items it intends to include in the CDM. Effective and efficient operation of the CDM requires close coordination and collaboration by each of the various departments. Nevertheless, the primary purpose is to help the provider develop an accurate summary of the charges and services it provides during the course of patient care. When rendering services to the patient, caregivers must record the service they provide and transfer this information along with other patient information to produce a bill containing all the services provided for that episode of care.

Generally, each provider organization should have a CDM policy distributed to department managers or others responsible for the maintenance of the CDM. The intent of the CDM policy is to guide employees in their management and maintenance decisions about the CDM. These policies should, at a minimum, be reviewed annually and include guidance about various maintenance issues such as the mark-up percentage or formula to apply to determine the charge amount. The policy should also describe the procedures for adding or removing items from the CDM along with instructions on creating the short descriptions and applying the corresponding revenue code and HCPCS numbers. It is important to keep the CDM current to match the annual changes that occur to the HCPCS. Other regulatory changes, such as bundling or unbundling of services or the handling of new technology items or services, can occur more frequently and therefore make the maintenance task even more daunting. Nevertheless, almost all organizations will benefit from a formal process that routinely seeks to improve the maintenance and management of the CDM.

Of paramount importance is developing a review process that will enable the provider to continually improve the accuracy of the bill. The review process should seek to eliminate all billing errors, whether they result in overcharging or undercharging. The effort is geared toward the development of an accurate billing statement that reflects all of the resources rendered to the patient. Some of the most common causes for overcharging are billing for services not rendered and duplicate billing of services. Most irritating for consumers, and consumer action groups, is pouring over a bill that contains items that have excessive mark-ups for items that should have a very nominal charge. The consequences for improper CDM management are negative publicity, which can be devastating to providers and undercut much of the good work and trust that they seek from their community. Consequently, providers need to look at a process that constantly fine-tunes the CDM.

Revenue Management

The CDM pricing should be designed to ensure the organization has the appropriate revenues it needs to operate. The CDM helps the provider organize the items and services that the routine and ancillary departments provide to patients. Each department should track the number of patients requiring care in its area along with a summary of the type of services provided over the year. Each year budgets are prepared to anticipate the resources that a department may need during the coming year. During the budget process, departments should also look at their objectives and strategy for improving patient care and match these with the resources required to meet these goals. Each department unit should work closely with the budgeting and reimbursement specialists, contract management team, and others to help them understand the implications that government regulation and health plan contracting have on their departmental operations. These external variables are important in helping guide the provider in determining its approach to mark-up strategy and revenue management.

The external variables that will influence your approach toward marking up a particular service will be:

- Payer mix
- Volume of a service rendered
- Cost of delivering a service, including direct and indirect costs
- Fee schedules associated with a service
- Market forces, including usual and customary, pricing by local competing facilities, etc.

Another area for improvement is handling missing or lost charges that result in undercharges on the bill. Efforts should focus on examining the cause for these missing charges and the steps that can be taken to reduce such events. One suggestion in the routine care areas is to reduce the number of charge items, for example incorporating supplies that are routinely given to patients into the room rate. According to some studies these efforts have reduced the administrative burden involved in tracking charges and have provided better inventory management of supply item furnished in the unit.

Insurance Billing

Another important source of information for managing the CDM involves examining the results of your insurance billing. The organization's ability to track revenue volume by different health plans is important. Generally, tracking this information helps providers improve on their billing accuracy by letting them know whether errors occurred in the quantity reported for a particular service, how often duplicate service errors occur, or whether charges are missing from the billing statement. Conducting such a review helps providers analyze whether to apply any discounts to existing CDM prices during their contract negotiations with health plans and, to some extent, the reason for further reductions. It should be noted that in 1993 *The National Billing Audit Guidelines* issued recommendations about the importance of establishing an audit log for each claim subject to a medical review. The audit log should track the type of claim being reviewed, the

health plan asking for the medical review, and the findings of the review, including overcharges and undercharges, the net change in billed amounts, and the percentage change in the amount originally billed. The purpose of the audit log is to help providers improve on their billing processes, serve as a reference point in future contract negotiation with health plans, and improve the promptness of claim payment.

Another important tracking item, similar to the audit log, involves tracking changes to payment made by insurers. Most of these adjustments are made to bring the provider's charges in line with the usual and customary charges. It is important to identify whether such changes are appropriate and to determine whether the charges in the CDM are out of line and why. Another factor to consider are the special contract arrangements with insurers that call for specific preestablished prices. Providers must have the ability to validate the terms of such an agreement, especially for handling pricing changes made by the health plan. Providers should have the appropriate validation tools to verify adherence to the terms of the contract.

Another important component that requires close coordination between the provider and insurer is the implementation of a real-time process to validate the patient's deductible and co-payment obligations. Knowing this information before the end of patient care would improve the communication to patients about their portion of the bill and would reduce the cost of extensive follow-up work.

Patient Billing Statement

Comments received from the patient billing statement are important. Tracking and analyzing patients' comments is necessary so providers can improve the billing process. In addition, providers should view this activity as an opportunity to improve the content of the patient billing statement. Understanding the nature of the complaints is important because it allows providers to determine plans for corrective action. In some instances, analyzing complaints allows providers to gauge the adequacy of the terminology used on the patient billing statement and the charge information presented on the patient's bill. Patients who ask for help in reconciling their billing statement with the health insurer's explanation of benefits (EOB) becomes another opportunity to improve the portion of the billing statement related to deductibles, co-payments, and noncovered items. Many patients require assistance in understanding the difference between "noncovered" and "not medically necessary." It is important to communicate to the patient early in the process why a service would not be covered by the health plan. Some facilities have developed various messages or scripts that are given to the patient to make them aware that a particular service will not be covered or is likely to be deemed not medically necessary by their health plan.

This information should be communicated to each department that is involved in billing and collections so they can identify potential corrections that might reduce the number of noncovered items that appear on a patient's bill, especially during preregistration and regular registration. Doing so also provides the departments with a list of items that might require issuing an advance beneficiary notice.

These issues can have a significant impact on the CDM and subsequent information that is reported on the patient's billing statement.

Management of the Charge Description Master (CDM)

Initially, providers must understand the factors that influence their organizational goals. This paper focuses on three factors that affect the management of the CDM: departmental units, regulatory requirements, and contractual agreements.

Departmental Units

While all hospital departments have operating expenses, patient care departments have the ability to generate operating revenue. Much of the strategy for setting prices within a department depends on several factors, including analyzing the mix of patients with and without healthcare coverage and determining the impact that these contracted or regulatory arrangements impose. These factors further limit the amount of payment for the services that are listed in the CDM. Each department should not impose a price-setting decision on all the other departments. Instead, the decision must be a collective effort involving multiple departments and reimbursement experts, taking into account the organization as a whole.

Each department, however, plays a key role in determining which items or services to include in its section of the CDM. The department provides the expertise to further evaluate the rendering of services to patients within their departmental unit and the method for capturing and reporting these services to patients' bills. In some cases, the department may suggest the appropriateness of bundling some services as one packaged CDM item rather than list each item individually. Such efforts require investigation to determine whether it is appropriate to bundle these services and whether regulatory requirements exist would prevent this from occurring. Each department should assign a leader to review the section of the CDM that contains the list of items or services the department provides within its operating unit. They should also verify whether all of the other variables that go with each CDM item are correctly included. This means reviewing the description of the item, including revenue code and HCPCS code if available and the unit level indicated on the CDM.

Larger healthcare providers will have more departmental units and therefore will face greater coordination challenges, especially regarding pricing for similar service items listed in the CDM. The Medicare Cost Report requires reporting of similar services to reflect the same "gross-up" in the charges. Therefore, reimbursement and cost-reporting personnel need to be informed if departments have different pricing for the same item so the proper cost-report adjustment occur. As a rule, however, any HCPCS that is found in various departments should be assigned the same price. Such an approach enhances the provider's credibility and becomes especially important in future contract negotiations.

Regulatory Requirements

Providers that render services to Medicare and Medicaid patients will be subject to a number of regulatory requirements that affect the CDM. Initially, the Medicare program's basis for provider payment was cost. An elaborate series of regulations have since been created that affect much of the provider's payment. As mentioned before, the Medicare Cost Report is one activity that influences decisions related to the CDM. The original purpose of the cost report was to develop a cost-to-charge ratio for determining payment to providers. Medicare requires providers to report on the cost report the same price for the same item even if two different departments furnish the same items at different prices. This means that when preparing the cost report, providers must adjust department charges to be the same for identical items provided to patients. That way, the cost-to-charge ratio becomes comparable.

Other regulatory requirements involve the use of the HCPCS code set. The HCPCS identifies the common procedures furnished by providers. Each year the HCPCS code set is updated, with some items added and some removed. Medicare uses this code list to derive payment for outpatient and physician services. For hospital outpatient services, the HCPCS determines the assignment of the ambulatory patient classification (APC), the basis for reimbursement. . For physician billing, the HCPCS has an assigned fee schedule that determines the amount the physicians receive for their services. These limitations influence how providers view the pricing strategy for certain items or services. For physician claims, some supply items are considered included in the fee schedule while others are not. The determining factor is the HCPCS reported on the bill. The requirements also impose another level of complexity in trying to help patients understand the billing process and the affect this process has on their portion of the bill.

The approach you follow will depend greatly on the regulatory requirements imposed on your operations. There are still many small rural facilities such as Critical Access Hospitals (CAHs) that are paid based on cost. Their approach to HCPCS and cost reporting will require a different approach to CDM management.

Contractual Agreements

Today, contractual arrangements with health plans are commonplace. These arrangements however, impose additional requirements on providers to ensure that the contractual provisions are carried out according to the terms of the agreement. These arrangements often require the application of a contracted price list for services rendered by the provider. Providers need to familiarize themselves with how they intend to validate health plan payment for these services. In many instances, the provider needs additional software support to ensure that prices for items in the CDM correspond to contracted prices for those items. Providers should validate whether payment is made according to the terms of the contract; if not, they will find it difficult to reconcile their patient accounts receivable. Not being able to fully reconcile their receivables makes the task of communicating to patients about their portion of the bill more complex.

These are some of the planning and management process issues for the CDM.

Assembling the CDM Team

Management of the CDM requires a coordinated team effort led by a senior manager. Team participants should include representatives from patient accounting, patient advocacy, patient financial services, financial reimbursement and contract management, and various patient care departments, including routine nursing, intensive care, operating room, and other ancillary and clinic departments.

The primary purpose of the team is to review the CDM policies and procedures and to improve the management and understanding of the CDM. The team should review all the new items and services it intends to add to the CDM. In addition, the team should be able to suggest changes to existing CDM items. To facilitate the review, the team should use a CDM change request form (see example in attachment 1). The purpose of the form is to help the team evaluate the change request and determine the type of changes that should be made to the CDM. The form can also provide a historical context for an item or service added to the CDM and is helpful in identifying similar changes made in the past.

The team should diagram the process flow for making changes to the CDM. This effort involves following a checklist of review activities that include entering and validating information. Using the CDM change form with the checklist would be helpful. The team should ensure that the staff receives training on making changes to the CDM and who has the authority to do so. The CMD team should work with the information technology (IT) department to identify security measures needed to prevent unauthorized changes to the CDM. The IT staff should know who is responsible for developing and ordering charge tickets, charge sheets, or making modifications to the input screens. Staff should receive regular training about CDM items, particularly in terms of unit packaging and whether items are used with another CDM item. The staff needs to understand the type of documentation necessary to support the service rendered to the patient.

The CDM team should develop a list of training requirements to help guide staff on the managing the CDM, including compliance, documentation, and reporting requirements. The CDM team should ensure that sufficient budgetary resources are available for such educational programs.

The CDM team should establish a “charge-audit” process to ensure that all new charges and planned changes to existing charges are properly captured, reported, and documented. The focus of this audit is to examine not only the accuracy of the billing statement but also the supporting medical record documentation to prevent the charge from being denied.

The team should also examine any related billing problems, such as overbilling, underbilling, and duplicate billing. Another area for periodic review is patient and insurance billing complaints. The team should examine the readability of the descriptions and whether other patient-centered descriptions should be routinely used on the patient

billing statement. Other team activities include tracking media reports of healthcare price overcharging and developing a strategy to avoid similar incidents in their own organization.

Whenever possible, the team should simplify and reduce the number of items in the CDM. This activity includes reviewing the hospital's policy on the minimum-charge threshold and whether it should apply to nominal-cost items, such as aspirin, bandages, and gauze. These nominal-cost items can become an embarrassment when the media publicizes them. It is hard for any hospital administrator to justify charging $10 for an aspirin. Ideally, the team should try to avoid such a pitfall by rolling charges for routinely used supplies into the basic service being provided. CMS is allowing providers to include the charge for routine supplies in the routine room-and-board charge for a unit. The same approach could apply to the operating room for supply items that are routinely given to patients in that unit.

The CDM team should organize the policies and procedures and place them in an easily accessible binder, folder, or on-line file. The content should be organized into sections that reflect key performance criteria. The policies should address security efforts to maintain the integrity of the CDM process. The material should include an executive summary and an index of chapters describing various procedural criteria, along with a list of the CDM team, the team leader, and each departmental representative. The content should also include a chart depicting the organizational flow for managing the process, and important dates describing the routine maintenance and review process, frequency of meetings, and other data-collection requirements. The material should identify what type of supporting documentation is necessary, the location of that information, and the responsibility of the individual(s) to communicate any unusual findings.

The policies and procedures should also include a schedule for performing routine audits of the CDM. The scope of the audit should include tracking of billing accuracy to health plans, establishing "like-item pricing" for services that appear in different departments, gauging the accuracy of developing patient billing statements, and examining the CDM maintenance process to ensure that appropriate security measures are in place. Policies and procedures should also include examples of specific CDM pages, the change-request form, comparison of bills with post-audit reports, usage reports of each chargeable item, comparison of billed amounts with paid amounts, and patient and health plan complaint/error tracking.

Vendor Support and Selection

During the review of the CDM process and its interface to patient billing, the CDM team should also examine the information system's capabilities. The team should be familiar with all the features and functions of the information systems before evaluating whether there is a deficiency in its design. If the design contains limitations, the team can ask its vendor what other modules are available that will meet the provider's objectives.

The CDM team should undertake such a review every year. If necessary, it should investigate the feasibility of adding other modules or of selecting another vendor. If new modules are needed, the team should prepare a report explaining the limitations of the existing system and a capital budget that can meet future needs.

Benefits of a Successful CDM Process

Managing the CDM provides numerous benefits to providers, health plans, and, especially, patients. The primary thrust of managing the CMD is to develop a process that continually monitors and improves the billing process. Getting correct information from the beginning is less costly than correcting and modifying information later. Doing so also allows providers to build the necessary trust with patients and others.

The process requires careful orchestration of several important steps that involve different individuals from your organization. Senior management must take the initiative to pull together the necessary resources to achieve the goals outlined in the policies and procedures. Ultimately, these efforts culminate in a patient billing statement that is correct, easy to interpret, and contains the necessary information to help patients better understand the services they receive.

Although the entire process involves numerous billing details, the result will enable the provider to properly communicate these details in a manner that makes sense to the recipient of this information. The billing message for health plans is different from the one for patients. Despite these differences, there has to be a way to reconcile how a health plan processed its portion of the bill – such as discounts taken and bundling and unbundling – and the remaining portion that becomes the patient's responsibility. The remaining patient liability includes the deductible, co-payment amounts, and noncovered items. The difficulty for patients is that they often do not understand the contractual arrangement between the provider and the health plan. Providers need to bridge this gap by including all of the pertinent components that explain how they arrived at the amount due on a patient statement.

The ***PATIENT FRIENDLY BILLING®*** Chargeable Items Workgroup believes that the patient billing statement should be modified and tailored slightly to fit different contractual approaches to the adjudication of the bill. The modifications and tailoring exercise should not be overly complex, but rather it should communicate how different contractual approaches affect the patient's portion of the provider bill. Nevertheless, our workgroup believes it is best to provide patients with a summary of how these amounts were determined. Given the complexity of many different reimbursement contracts with health plans, simply presenting an itemized statement to the patient is likely to increase confusion. Healthcare organizations should offer patients an itemized statement only upon request. They should never refuse to provide an itemized statement when it is requested, because the facility would appear to be trying to hide something from the patient. The patient statement should always include details about noncovered services or services that are subject to a percentage deductible.

The summary of the CDM charges is the starting point for beginning this process. If the charges captured from the CDM are accurate and reasonable, the next step will be much easier. Contractual arrangements, such as Medicare's inpatient DRG classification system, provide an opportunity to start the explanation to the patient of which hospital services are covered according to the contractual terms and which are noncovered or require a deductible or co-payment by the patient. It is our workgroup's belief that consumers would find it easier to understand a patient billing statement that starts the explanation with the pertinent facts presented concisely and logically organized.

For example, the summary of all hospital charges from the CDM may amount to $12,500. A UB-92 prepared and sent to the Medicare fiscal intermediary indicates that, because the provider agrees to follow the Medicare Conditions of Participation, payment is based on data relevant to the Medicare DRG classification system. The Medicare program bases payment on the specific DRG assigned to the bill as based on the diagnosis and procedure codes along with other variables such as age, sex, and underlying comorbidities. For purposes of illustration, assume the DRG classification results in assigning payment at $7,200, a deductible of $700 has to be met, and some services were deemed noncovered. A detailed list of all the services provided that add up to the $12,500 would be less helpful to the patient than an explanation of how a $4,200 contractual discount was applied to the $12,500 (total charges). The contractual payment amount of $7,200 was reduced by the $700 patient deductible. In addition, the patient received $100 in services that the health plan's benefit policy does not cover (Medicare, in this case). During the course of treatment, the patient was notified that payment for these services were the patient's responsibility.

An example of a simplified patient statement follows:

Example of Charge Section of Patient Billing Statement

Total Charges	Contracted Insurance Discounts	Payments	Deductibles	Patient Responsibility Amount Co-Pay	Noncovered	Please Pay
$12,500	$4,200	$7,200	$700	$0	$50 xyz test $50 abc test	$800

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