Chargemaster Management & Data Integrity
Robin Zweifel BS, MT (ASCP)
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• Maintaining the Chargemaster
  – Best-practice CDM Management
  – Scheduling of CDM Maintenance and Synchronization
  – Chargemaster Challenges
• Data Integrity of the Chargemaster
  – Linked Charges
  – Rational and Logical Relationship of Similar Services
  – Rational and Logical Relationship of Related Charges
• Pharmacy coding, pricing and accurate calculation of final billed charge
• Supply coding, pricing and accurate calculation of final billed charge
• Building Relationships
  – Selection of a Chargemaster Consulting Firm
  – Selection of Chargemaster Management Software
Chargemaster – Still in the Spotlight

• Continued importance of charge data integrity
• Today’s ‘Chargemaster’ is more than just one file
• Potential for errors
  – Large amount of data
  – Ongoing coding & regulatory updates
  – Complex HIS data relationships
• Changes impacting CDM Management
  – Acquisitions, mergers or consolidations
  – Software conversions
  – Cost-sharing payment models
  – Chargemaster consulting assistance & tools
Common Chargemaster Challenges in Today’s Hospitals

• No structured plan for monitoring charge data or pricing
• No comprehensive long-term budget for chargemaster management
• No methodology to assess or selectively audit CDM data
• No organization-wide strategy for deploying payment, coding system and regulatory references to departments
• No formal processes to facilitate effective charge communications
MANAGEMENT OF THE CHARGEMASTER

Best-practice CDM Management
Scheduling of CDM Maintenance and Synchronization
Chargemaster Update Schedules

• On-going Chargemaster maintenance should be established as the standard within an organization.
  – Departments with high frequency of changes, adds, deletes should be reviewed monthly
  – Departments with high revenue and high utilization should be scheduled for quarterly review.
• High-level overview of rule changes, codes sets and initial planning for department interviews should begin between June and July with Medicare’s release of proposed rules for IPPS, OPPS and MPFS as well as the CLAB public meeting for early release of the clinical laboratory CPT changes.
• Proactively schedule planning meetings with the Revenue Cycle team, CDM coordination team and Departments that will be most impacted by quarterly and end of year changes.
  – Changes to reimbursement methods should be considered in conjunction with CPT / HCPCS updates.
  – Action teams should be identified to lead coordination of meetings amongst cost centers where code collapse, NCCI/MUE limitations, packaging of payment, etc. will apply.
  – Outline preliminary considerations relative to charge data or pricing assessment of necessary CDM changes.
Chargemaster Update Schedules

• Stage the work plan for end of year to include the CPT code release (October) and prepare for Chargemaster file update, price adjustments, and revisions to charge protocols.
  – Be certain to have ordered new CPT and HCPCS manuals by September 1
• Order additional resource materials by October 1
• Obtain a copy of the full HCPCS list as soon as possible
  – Medicare HCPCS release will typically be released around November 15 allowing for final Chargemaster updates.
• Schedule Revenue Cycle, CDM Team as well as Departments for review of the pertinent code changes.
  – CDM coordination meetings should be complete by December 15.
  – Line item revisions should be finalized before the holiday break.
DATA INTEGRITY OF THE CHARGEMASTER

Linked Charges
Rational and Logical Relationship of Similar Services
Rational and Logical Relationship of Related Charges
Synchronization
Effective Chargemaster Management

• Review linkage of CPT and HCPCS coding to identify potential for coding errors or result in at risk charges.
  – Service Item Description Comparison
  – Revenue Code Mapping
  – NDC Validation of Formulary
  – HCPCS Billable Unit Conversion
  – Modifier(s)
  – Price and Price Transparency
  – Utilization
  – Medicare Reimbursement
• Validate order groups that are linked for “explosion” of individual line item charges.
• Synchronize Chargemasters and order entry systems that are connected through an interface to the hospital information system.
Effective Chargemaster Management

- Chargemaster maintenance process
  - Coordinate charge entry options with active service items, supply item master or pharmacy formulary ensuring accuracy of CPT/HCPCS conversion factor.
  - Identify duplicate service items for same CPT/HCPCS within department CDM and in CDM of other departments.
  - Analyze service items for hospital-based clinics and compare to same / similar service items for facility departments.
  - Establish cost threshold and differentiate “routine” and “non-routine” supplies and develop strategy for supply charge policy.
  - Focus on charges below cost, below OPPS APC rate, and below fee schedule rates as well as charges for similar services that are not rational.
- Prioritize issues and develop solutions utilizing standard reports or create custom reports.
- Summarize and prioritize issues for management reports that identify variances requiring action.
Effective Chargemaster Management

• Provide training and education on coding issues
  – Develop a Chargemaster education plan by code family or by department specific issue:
    • Correct Coding Initiative
    • Outpatient Code Editor
    • Payable and Non-Payable Services
    • Bundling and UnBundling
    • Medicare Outpatient Reimbursement Methods
    • Revenue Opportunity and Charge Standardization
    • Hospital versus Professional / Technical charge and reimbursement
Effective Chargemaster Management

- Ensure a complete, accurate, and compliant foundation for charging and billing of services
- Consider key performance indicators
- Establish benchmarks utilizing available industry data
- Monitor implementation progress and assess department compliance with tools that guide the process.
- Ensure compliance with regulatory guidelines as well as industry best practices
- Establish process to target high-utilization high-revenue generation areas
- Develop work plans for facility at the department level to guide Chargemaster management techniques.
- Summarize and prioritize issues for management reports that identify variances requiring action.
Question #1

- Which option below best describes your job title?
  - Chargemaster Coordinator
  - Compliance
  - Health Information Management
  - Revenue Cycle / Finance
  - Patient Care Department / Service
  - Payer
  - Government / Regulatory Agency
  - Other
Effective Chargemaster Management

- Often, as a result of acquisitions or mergers, health systems find their organizations in the awkward predicament of charging dramatically different prices and using inconsistent codes and descriptions for like services among their entities.
- This not only creates public relations issues but also makes it difficult to manage and provide vital reports from decision support systems.
- Successful synchronization projects will include synchronization of sub-systems to the Chargemaster and include CPT and HCPCS coding linkages to identify potential for coding errors or at risk charges.
  - Service Item Description to Orderable Description Comparison
  - CPT/HCPCS Code and Description Comparison
  - Revenue Code Mapping
  - NDC Validation of Formulary
  - HCPCS Billable Unit Conversion
  - Modifier(s)
  - Price and Price Transparency
  - Utilization
Synchronization of CDM and Sub-systems
CHALLENGES AND COMPLEXITIES

Code descriptions
Code rules
Complexities of Chargemaster Management

- Infectious Agent detection by Nucleic Acid probe vs. Molecular Pathology Infectious disease (bacterial), DNA analysis
- Inhalation Therapy series of individual back-to-back treatments vs. continuous inhalation treatment
- Facility E/M reporting CPT vs. HCPCS
- Physical Therapy always therapy vs. sometimes therapy vs. non-therapy
When I was reviewing the CMS update newsletter, I noticed that there is a new CPT code effective 5/1/2017. Would 0004U be an alternative CPT to the 87150 x 27?

- 87150  Culture, typing; identification by nucleic acid (DNA or RNA) amplified probe technique, per culture or isolate, each organism probed
- 0004U  Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate

CPT code updates from the American Medical Association are available at the link below:

DIRECT IDENTIFICATION OF INFECTIOUS AGENT FROM BLOOD CULTURE

- ENTEROCOCCUS
- VANA/B (VANCOMYCIN-RESISTANCE GENES)
- LISTERIA MONOCYTOGENES
- STAPHYLOCOCCUS
- STAPHYLOCOCCUS AUREUS
- MECA (METHICILLIN-RESISTANCE GENE)
- STREPTOCOCCUS
- STREPTOCOCCUS AGALACTIAE (GROUP B)
- STREPTOCOCCUS PYROGENES (GROUP A)
- ACINETOBACTER BAUMANNII
- ENTEROBACTERIACEAE
- ENTEROBACTER CLOACAE COMPLEX
- ESCHERICHIA COLI
- KLEBSIELLA OXYTOCA

- KLEBSIELLA PNUEMONIAE
- PROTEUS
- SERRATIA MARCESCENS
- KPC (CARBAPENENEM-RESISTANCE GENE)
- HAEMOPHILUS INFLUENZAE
- NEISSERIA MENINGITIDIS
- PSEUDOMONAS AERUGINOSA
- CANDIDA ALBICANS
- CANDIDA GLABRATA
- CANDIDA KRUSEI
- CANDIDA PARAPSILOSIS
- CANDIDA TROPICALIS
- STREPTOCOCCUS PNEUMONIA
It has come to our attention that the MUE value for CPT 87150 is 12.
The instrument utilized for testing will only result all 27 organisms, a partial panel for organism ID is not an option.
Would 0004U be an alternative CPT to the 87150 x 27?

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<th>MAI Rationale</th>
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<td>3</td>
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<table>
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<td>3 Date of Service Edit</td>
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Respiratory Therapy

How are we to bill inhalation therapy procedures? Modifier 76 doesn’t resolve the claim edit.

- CPT
  - 94640
    Pressurized or nonpressurized inhalation treatment for **acute airway obstruction for therapeutic purposes** and / or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device
  - 94644
    Continuous inhalation treatment with aerosol medication for acute airway obstruction; **first hour**
  - 94645
    Continuous inhalation treatment with aerosol medication for acute airway obstruction; **each additional hour** (List separately in addition to code for primary procedure)
  - 94664
    **Demonstration and / or evaluation** of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
National Correct Coding Initiative Policy

- CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes.

- If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) should not be reported separately.

- CPT code 94640 should only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.
  - An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.
  - If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.
  - If inhalation drugs are administered in a continuous treatment or a series of “back-to-back” treatments exceeding one hour, CPT codes 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) should be reported instead of CPT code 94640.
What is always therapy vs sometimes therapy vs non-therapy?

Beginning January 1, 2017, physical and occupational therapists CMS introduced eight new CPT codes for evaluations and re-evaluations.

Existing PT and OT evaluation codes (97001 & 97003) and re-evaluation codes (97002 & 97004) were replaced with three new evaluation codes – representing low, moderate or high complexity and one new re-evaluation code:

- Codes 97161, 97162, 97163 and 97164 are billed for PT;
- Codes 97165, 97166, 97167 and 97168 are billed for OT.

These new codes represent “always therapy” services and always require the corresponding discipline-specific therapy modifier.

Non-Therapy Services

- In addition, payment for outpatient department services that are similar to therapy services and delivered either by therapists or non-therapists is included as part of the payment for the comprehensive service.
- The services that are provided during the perioperative period are adjunctive services and are deemed to be not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers.
- We [CMS] have previously noted that therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800).
- However, certain other services similar to therapy services are considered and paid for as outpatient department services. Payment for these non-therapy outpatient department services that are reported with therapy codes and provided with a comprehensive service is included in the payment for the packaged complete comprehensive service. We note that these services, even though they are reported with therapy codes, are outpatient department services and not therapy services.
- Therefore, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply. We refer readers to the July 2016 OPPS Change Request 9658 (Transmittal 3523) for further instructions on reporting these services in the context of a C–APC service.
PHARMACY CHARGEMASTER

Coding, Pricing and Calculating Final Billed Charge
Cost per Unit Mark-up
Cost per Unit Mark-up

![Pricing Options](https://pharmauditor.com)

- **Overview**
- **Description**
- **Select Files**
- **Pricing Options**
- **Entity Selection**
- **Payor(s) Selection**
- **Audit Summary**

**Pricing Options**

- **Additional Options**
  - Active NDC
  - Inactive NDC
  - ALL

- **Markup Type**
  - Uniform
  - Tiered

- **Dispensing Fees**
  - None
  - Uniform
  - Fees By Groups

**Pricing**

- Panacea Pharamditor Demonstration

![View Markups](https://pharmauditor.com)
A payor has audited some of our accounts and they do not agree with our practice reporting HCPCS J7050 for the saline diluent billed separately from the drug that we are infusing. The payor has suggested that this is a bundled cost. How should we report the cost of saline solutions used as diluent?

- **Saline Solutions**
  - Hydration therapy infusible
    - Labeling
  - Diluent
    - Labeling

- **J7030** Infusion, normal saline solution, 1000 cc
- **J7040** Infusion, normal saline solution, sterile (500 ml=1 unit)
- **J7050** Infusion, normal saline solution, sterile (500 ml=1 unit)
Description

- This product is a sterile, nonpyrogenic solution of electrolytes in water for injection intended only for sterile irrigation, rinsing, dilution and cell washing purposes.
- Each 100 mL of 0.9% Sodium Chloride Irrigation, USP contains: Sodium chloride 900 mg, pH 5.6 (4.5 — 7.0).
- The solution is isotonic (308 mOsmol/liter, calc.) and has the following electrolyte content (mEq/liter):
  - Na+ 154; Cl¯ 154.
- This irrigation solution contains no bacteriostat, antimicrobial agent or added buffer and is intended only for use as a single-dose, short procedure irrigation, or cell washing fluid. When smaller volumes are required the unused portion should be discarded.
- It may be classified as a sterile irrigant, rinse, diluent, cell wash and pharmaceutical vehicle.

CLINICAL PHARMACOLOGY

- This irrigation solution exerts a mechanical cleansing action for sterile irrigation of body cavities, tissues or wounds, indwelling urethral catheters and surgical drainage tubes and for washing, rinsing or soaking surgical dressings, instruments and laboratory specimens. It also serves as a diluent or vehicle for drugs used for irrigation or other pharmaceutical preparations.
- 0.9% Sodium Chloride Irrigation, USP provides an isotonic saline irrigation identical in composition with 0.9% Sodium Chloride Injection, USP (normal saline).
- 0.9% Sodium Chloride Irrigation, USP is considered generally compatible with living tissues and organs.
INDICATIONS AND USAGE

- This sterile, nonpyrogenic electrolyte solution is indicated for all general irrigation, washing, rinsing and dilution purposes including blood cell washing (when used in conjunction with automated intraoperative blood salvaging equipment).

CONTRAINDICATIONS

- NOT FOR INJECTION BY USUAL PARENTERAL ROUTES.

PRECAUTIONS

- Do not use for irrigation that may result in absorption into the blood.
- Aseptic technique is essential with the use of sterile solutions for irrigation of body cavities, wounds and urethral catheters or for wetting dressings that come in contact with body tissues or for cell washing techniques.

Cost per Unit Mark-up

Select Pricing Group: LVP
Delete Pricing Group: Delete

Assign one or more drug group to a pricing group:
LVP - Large Volume Parenterals

Tier Values for Selected Group:

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<th>End Value</th>
<th>Tier Markup</th>
<th>Min Charge</th>
<th>Max Charge</th>
<th>Grp Disp Fee</th>
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We are confused by the guidelines for billing of monoclonal antibodies with the CPT series for chemotherapy administration. Are all monoclonal antibodies considered chemotherapy? How does this impact how the pharmacy charges for the drug?

Chemotherapy administration is defined as the parenteral administration of non-radionuclide antineoplastic drugs for cancer diagnoses, anti-neoplastic agents provided for the treatment of non-cancer diagnoses or to substances such as certain monoclonal antibody agents, and other biologic response modifiers.

- The drugs administered under this CPT category for administration are defined as chemotherapy and other highly complex drug or highly complex biologic agent.
Cost per Unit Mark-up

Select Pricing Group: CHEMO

Delete Pricing Group

Assign one or more drug group to a pricing group

Tier Values for Selected Group:

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## Cost per Unit Mark-up

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<th>Drug Name Manufacturer</th>
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<th>Pkg Size</th>
<th>Billable Units per Pkg Size</th>
<th>Pkg Qty</th>
<th>Billable Units per Pkg Qty</th>
<th>B/G</th>
<th>SD / MD per Each</th>
<th>SD / MD per Pkg</th>
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<tbody>
<tr>
<td>Benlysta 120 MG SOLR  GLAXO SMITH KLINE</td>
<td>49401-0101-01 NDC Pricing</td>
<td>1.00 EA</td>
<td>12.00</td>
<td>1 Vial</td>
<td>12.00</td>
<td>B</td>
<td>SD</td>
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<tr>
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<td>B</td>
<td>SD</td>
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</table>
How supplied: BENLYSTA is available as 120 mg in a 5-mL single-dose vial and 400 mg in a 20-mL single-dose vial for intravenous infusion only.
## Cost per Unit Mark-up

<table>
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<th>PharmAuditor Description</th>
<th>Formulary Description</th>
<th>TIER CODES</th>
<th>HCPCS</th>
<th>HCPCS billable per units</th>
<th>Billable Units per vial</th>
<th>IMP EXT UNIT</th>
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<tr>
<td>49401-0101-01</td>
<td>BENLYSTA 120 MG</td>
<td>BELIMUMAB 120 MG IV</td>
<td>CHEMO</td>
<td>J0490</td>
<td>10.000</td>
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<td>Entire Package</td>
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### Package Size: awp per vial

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<th>Package Size</th>
<th>awp per vial</th>
<th>Mark-Up Applied per vial</th>
<th>Sub-Total Price</th>
<th>Dispensed Unit</th>
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### NDC 5-4-1          | PharmAuditor Description | Formulary Description | TIER CODES | HCPCS | HCPCS billable per units | Billable Units per vial | IMP EXT UNIT |
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### Package Size: awp per ML

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<th>Mark-Up Applied per ML</th>
<th>Sub-Total Price</th>
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### NDC 5-4-1          | PharmAuditor Description | Formulary Description | TIER CODES | HCPCS | HCPCS billable per units | Billable Units per vial | IMP EXT UNIT |
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<td>BELIMUMAB 400 MG IV</td>
<td>CHEMO</td>
<td>J0490</td>
<td>10.000</td>
<td>40.000</td>
<td>Single Pkg Unit</td>
</tr>
</tbody>
</table>

### Package Size: awp per vial

<table>
<thead>
<tr>
<th>Package Size</th>
<th>awp per vial</th>
<th>Mark-Up Applied per vial</th>
<th>Sub-Total Price</th>
<th>Dispensed Unit</th>
<th>Sub-Total Price</th>
<th>Dispense Fee</th>
<th>Final Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 ML</td>
<td>$1,938.36</td>
<td>3.000</td>
<td>$5,815.08</td>
<td>1.00</td>
<td>$5,815.08</td>
<td>$200.00</td>
<td>6,015.08</td>
</tr>
</tbody>
</table>

### NDC 5-4-1          | PharmAuditor Description | Formulary Description | TIER CODES | HCPCS | HCPCS billable per units | Billable Units per vial | IMP EXT UNIT |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>49401-0102-01</td>
<td>Benlysta 400 MG</td>
<td>BELIMUMAB 400 MG IV</td>
<td>CHEMO</td>
<td>J0490</td>
<td>10.000</td>
<td>40.000</td>
<td>Dispense Unit</td>
</tr>
</tbody>
</table>

### Package Size: awp per ML

<table>
<thead>
<tr>
<th>Package Size</th>
<th>awp per ML</th>
<th>Mark-Up Applied per ML</th>
<th>Sub-Total Price</th>
<th>Dispensed Unit</th>
<th>Sub-Total Price</th>
<th>Dispense Fee</th>
<th>Final Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 ML</td>
<td>$96.92</td>
<td>6.0000</td>
<td>$581.51</td>
<td>20.00</td>
<td>$11,630.16</td>
<td>$200.00</td>
<td>11,830.16</td>
</tr>
</tbody>
</table>
JW Modifier for Pharmacy

- Transmittal 3538
  - Issued June 9, 2016
  - Effective January 1, 2017
  - Removing the contractors’ discretion with determinations regarding JW modifier
- Only for use with single-dose drugs
- Billing for waste from a multi-dose vial is not allowed
SUPPLY CHARGEMASTER
Coding, Pricing and Calculating Final Billed Charge
Supply

• What is the best practice for establishing a standard for supply charges across multiple hospitals?
• At minimum, an organization’s charge structure should be logical and consistently related to the cost, to include but not limited to:
  – Definition of ancillary versus routine supply
  – Bundling of routine supplies based on established cost thresholds
  – Determination of billable supply, device, implant, etc.
  – Cost to Charge mark-up and pricing strategy
• Reasons to support development of a standardized policy or to support revision of existing policy include:
  – Internal and external cost transparency
  – Support of contract negotiations
  – Support of decision making about service lines and budgets
  – Proactive defense for audits based on reasonable, logical, defensible charge strategy
  – Compliance with Medicare and other payer requirements
Polling Question #2

• Does your hospital currently use a CDM management system?
  – Yes and it works well
  – Yes, but it is difficult to use
  – No
  – Don’t know
BUILDING RELATIONSHIPS

Selection of a Chargemaster Consulting Firm
Selection of Chargemaster Management Software
Building a Reliable Business Relationship

- Ensure awareness of Chargemaster management complexities and challenges as well as the organizations priorities
- Know the full scope of services offered and the scope of service available within the budgeted price point
- Understand functions provided by chargemaster software
- Research industry standards for evaluating and selecting chargemaster software
Top Reasons to Select a Chargemaster Consulting Firm

- Major projects or initiatives
- End of year code & payment system updates
- Addition of new entities, providers, departments, services, drugs, or supplies
- Payer or other external audits
- Internal charge capture weaknesses
Top Reasons for Selection of Chargemaster Software

- Control of Revenue Cycle operations costs including:
  - Labor cost resolving erroneous charge and claims data
  - Duplicative software tools and coding sources
  - Pricing analysis investments
  - Medicare regulatory & payment system resources
  - Charge-related claims resolution references
  - Consulting support or outsourcing costs for tasks that could be internalized
How to evaluate & select CDM Software

• Develop a plan for a thorough & objective vendor selection process
  – Define the selection team (Involve primary product users to evaluate ease of implementation and long-term use of the software)
  – Identify key functions and resources required for your hospital and identify benefits, redundancies, or cost-savings potential
  – Know (or learn from your vendor) what specific data sources are essential to effective chargemaster management for your organization
  – Request one (or more) detailed demonstrations to fully understand all key functions and features of the software product being shown
  – Cost projections (software, personnel time, hardware, etc.)
  – Client Reference follow-up communications
How to evaluate & select CDM Software

• Select products that support charge management needs and workflow
  – Quick and easy research of coding & payment system data
  – Functionality to perform internal audits of CDM data
  – Library access to regulations & documentation
  – Functions to expedite charge change / delete / add requests with documented chain of communications
  – Edit research modules to resolve claim error issues
How to evaluate & select CDM Software

- Evaluate vendor’s data integrity and reliability
  - Confirm vendor’s historic data release timelines
  - Stipulate immediate and unlimited file upload capability
  - Ensure immediate access to data uploads and audit results
  - Review vendor options for customizing user-defined views and reports
  - Ensure that data and audit results are easily exported and distributed
  - Contact customer references
How to evaluate & select CDM Software

• Identify software features & functions that improve internal processes:
  – Does the product allow user-defined security with access to specific views, functions and features?
  – Can data look up, research, or targeted file analysis be easily performed?
  – Are charge-specific communications supported by the CDM tool?
  – Are high-level Charge Master auditing results available on demand?
  – Do auditing functions allow vendor-defined as well as hospital-specific audit routines?
  – Is the product easy to deploy, learn and use?
How to evaluate & select CDM Software

• Does the product support the organization’s long-term budget for chargemaster management?
  – Develop an analytical and objective evaluation process
  – Ensure leadership supports the approach for comparison and selection of vendors
  – Consider licensing period and long-term investment
  – Identify areas of achievable savings with more robust software functions and features
  – Consider budget timeframes and major CDM update milestones
  – Will the software produce financial improvements, support compliance and reduce potential for exposure through improved claims processing?
  – Check your existing contracts
How to evaluate & select CDM Software

• Look for expertise
  – Vendor product development track record, enhancement roll outs, customer satisfaction, and reliability
  – Vendor or vendor-partner expertise in varied aspects of charge management (chargemaster management & consulting, revenue cycle, coding, information systems technology, etc.)
  – References and input from vendor’s customers
  – Objective & authoritative evaluation results (such as HFMA Peer Review® process)
  – Vendor’s offerings for consulting support, advisory services, and educational options
CDMauditor® Suite
Coding and Compliance Module
CDMauditor® Suite
Coding and Compliance Module

- Users Determine View of Data Elements
- Standard CDM Fields with additional user defined custom fields
- 22 Standard Reports
- Fee Schedule Pricing Module
- Ability to Create Unlimited Custom Reports
- Sort / Group / Export to excel
- Integrated code reference and charge detail (1 click)
- Workflow module is included (no additional cost)
Other CDMauditor® Modules

- **CDM Sync™**
  - Synchronizes disparate chargemasters
- **PHARMauditor™**
  - Pharmacy coding, compliance & pricing
- **Hospital Zero-Base Pricing®**
  - Establishes defensible pricing
- **Physician Pricing**
  - Establishes defensible pricing for physicians
- **Comparative Health Data™**
  - 5,000 Hospital database & and more than 30,000 Physician medical office and freestanding facilities
QUESTIONS