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Mastering CDM Maintenance: A Guide to Year-End Readiness

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Agenda

1. Overview – Best Practices
2. Monthly / Quarterly Basics
3. Year-End Preparation and Implementation
4. Summation

Objectives

- Overview of HCPCS / CPT Changes and how to implement those changes
- What does OPPS tell us that is important to CDM management (Revenue Codes and E & M guidelines)
- Using your revenue and usage to isolate zero volume items for potential inactivation
- How to find a GTIN and why it is important for supply coding and management
- Mapping a frequent source of under / overcharge
- How to conduct a claims Review
- Q&A

Poll 1

When did your facility last have a full charge master review?

A. Yearly

B. Every 2-3 years

C. >3 years

D. I don’t know

Overview of Best Practices

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Benefit Category Required Prior to Payment

- In order to expect reimbursement from a chargemaster item the team must ensure that the service, supply or medication is medically necessary. If it is not there is not a “benefit category” and without one there should not be an expectation of reimbursement.
- Our guidance comes from the Social Security Act and further clarified through 42 CFR, Manuals, Transmittals and MAC guidance in that hierarchy order.
- **Section 1862(a)(1)(A) of the Social Security Act**.
- This section states that no Medicare payment shall be made for items or services that are **"not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."**
- This seemingly simple statement has several key implications and is further elaborated upon by the Centers for Medicare & Medicaid Services (CMS) and various medical policies:

Benefit Category Required Prior to Payment

Reasonable and Necessary: This is the overarching criterion. It means the service or supply must be:

- **Safe and Effective:** Supported by scientific evidence and generally accepted medical practice. Experimental, investigational, or unproven services are typically not covered.
- **Proper and Needed:** Directly related to the diagnosis or treatment of a patient's medical condition. It's not for convenience or solely for the economic benefit of providers or health plans.
- **Provided for Diagnosis, Direct Care, and Treatment:** This includes services that aim to improve a patient's current condition, maintain their current condition, or prevent or slow further deterioration.
- **Consistent with Accepted Standards of Medical Practice:** This refers to the general consensus within the medical community regarding appropriate care for a specific condition.
- **Furnished at the Most Appropriate Level/Setting:** Services should be provided in the least intensive and most cost-effective setting that can safely and effectively meet the patient's medical needs (e.g., outpatient care vs. inpatient hospital stay if outpatient is sufficient).

Benefit Category Required Prior to Payment

Diagnosis or Treatment of Illness or Injury: The service must be for a defined medical purpose. This generally excludes cosmetic procedures (unless required for the prompt repair of accidental injury or a congenital anomaly), routine physical checkups (though preventive services are often covered under specific provisions), and certain routine care like foot care (with some exceptions for specific medical conditions).

Improve the Functioning of a Malformed Body Member: This covers interventions aimed at correcting or improving the function of a body part that is malformed, whether congenitally or due to injury or disease

OIG Compliance Guidance

- The OIG – Supplemental Hospital Guidance, Federal Register on January 31, 2005 (70 Fed. Reg. 4858) specifically discusses some key criteria for chargemasters.
- Guidance is also peppered through CMS regulations such as price transparency and other CMS and OIG publications
- OIG has several key criteria:
  - **Foundation of Billing:** The OIG recognizes that the chargemaster (also known as the Charge Description Master or CDM) is the hospital's comprehensive list of all billable items and services, along with their corresponding charges.[2] It's the starting point for generating claims to Medicare, Medicaid, and other payers.
  - **Compliance Risk:** The OIG consistently highlights that **outdated or inaccurate chargemasters create significant compliance risks for hospitals.**

CDM Basics

- For every test, service, supply or pharmaceutical expected to have met the expectation of reimbursement through achievement of a benefit category there should be a CDM line.
- HFMA continues to state a 1-3% loss from charge capture and the CDM is part of that process
- The OIG states in OIG Supplemental Guidance for Hospitals that outdated CDMs pose a risk
- Chargemaster is also known as the “aorta” of charge capture
- Every service, supply, pharmacy and Evaluation and Management must be represented
  - Failure to have a complete and accurate CDM will inevitably lead to charge capture concerns
  - Incorrect CPT codes, deleted or changed remaining in the CDM can create billing delay or denials

Key Concept – Accurate, Complete and only medically necessary services, supplies, pharmacy

Required Data for Each Individual CDM Line

- Each CDM Line needs to be unique and identifiable
  - Unique CDM ID number
  - Unique Description
    - Should closely approximate the CPT code description
      - Avoid internal descriptions such as “Dr. Jones Kit”
    - May be a limitation on characters based on the EMR
    - Generally short AMA description will fit
  - Coding:
    - CPT – Numeric - defined by the AMA
    - HCPCS – ALPHA numeric defined by CMS
    - Revenue Code – 4 digit (often represented by 3 digits) defined by AHA
    - Modifiers – CPT / HCPCS as appropriate
  - Patient Charge

Revenue Code Application

- In the past, many facilities just defaulted to making whole departments singular revenue codes.
- In fact, this is really driven by the OPPS Final Rule Revenue Code to Cost Center Crosswalk
  - https://www.cms.gov/files/zip/2025-nfrm-opps-revenue-code-cost-center-crosswalk.zip
- The revenue code should be associated with the cost center provided on the cost report

Crosswalk 2025

2023 Revenue center ID	Description (applicable to CY 2023 claims)	Used in 2025 OPPS (2023 claims)	Primary cost center source for CCR	Primary cost center name
0429	Physical Therapy: Other physical therapy	Y	5000	Physical Therapy
0430	Occupational Therapy	Y	5100	Occupational Therapy
0431	Occupational Therapy: Visit charge	Y	5100	Occupational Therapy
0432	Occupational Therapy: Hourly charge	Y	5100	Occupational Therapy
0433	Occupational Therapy: Group rate	Y	5100	Occupational Therapy
0434	Occupational Therapy: Evaluation/re-evaluation	Y	5100	Occupational Therapy
0435	RESERVED	N		
0436	RESERVED	N		
0437	RESERVED	N		
0438	RESERVED	N		
0439	Occupational Therapy: Other occupational therapy	Y	5100	Occupational Therapy
0440	Speech-Language Pathology	Y	5200	Speech Pathology
0441	Speech-Language Pathology: Visit charge	Y	5200	Speech Pathology
0442	Speech-Language Pathology: Hourly charge	Y	5200	Speech Pathology

Revenue Code Application

- Listing as provided on Noridian - https://med.noridianmedicare.com/web/jea/topics/claim-submission/revenue-codes

- 110- 219 – Room and Board
- 230 – Incremental Nursing Charge
- 25x – Pharmacy
- 26x – IV therapy
- 27x – Supplies
- 28x – Oncology etc.…

CPT & HCPCS Codes

- CPT is specific to physician services and procedures
- CPT can be used by facilities with certain limitations
  - Cannot put physician only codes in the CDM unless the CDM incorporates both facility and professional
  - Example 93010 - (Electrocardiogram, interpretation, and report), because it is designated as a **professional-only code** that is included in the facility fee for services under OPPS
- CPT defines procedures and services, generally not supplies
- HCPCS: Defines supplies, pharmaceuticals, prosthetics, orthotics, ambulance
  - Used in both professional and facility billing

Facility E & M vs. Professional E & M

- Professional
  - Driven by AMA and CPT
  - Uses 1995 or 1997 standards for Medicare
  - Commercial payers tend to use CPT guidance
  - Major trend and change is the use of “time” in the calculation of the level
  - Based on what the provider does – being paid for their skill and knowledge
- Facility
  - For Medicare driven by OPPS
  - For commercial they have their own guidelines that frequently do not match the CMS guidelines
  - Must represent the FACILTY resources consumed and cannot include physician services
  - **2008 OPPS Final Rule** (specifically, the CY 2008 OPPS/ASC Final Rule, published November 27, 2007, 72 Fed. Reg. 66580) is indeed where CMS explicitly laid out these "11 points" or principles

2008 OPPS Guidance

- We [CMS] do not believe that facilities and physicians would be expected to bill similar levels of service for the same encounter. The resources used by a facility for a visit may be quite different from the resources used by a physician for the same visit.
- Facilities should code a level of service based on facility resource consumption, not physician resource consumption."

What are those principles?

1. Guidelines must be in writing
2. Guidelines must be applied consistently to all patients
3. Guidelines must only require documentation that is clinically necessary for patient care.
4. Guidelines should not facilitate "upcoding" or "gaming."
5. Guidelines should be clear to facilitate accurate payments
6. Guidelines should be based on the intensity of hospital resources used.
7. Hospitals should develop their own unique guidelines
8. Hospitals should audit their E/M coding periodically
9. Hospitals should train their staff
10. The guidelines should reasonably relate the intensity of hospital services to the different levels of HCPCS codes.
11. Services furnished must be medically necessary and documented

Let's Talk Modifiers

- Modifiers are frequently represented as "hard-coded" in the chargemaster
- Only modifiers that are NOT variable are allowed in the CDM
  - Variable modifiers will be applied by HIM based on the medical record documentation
  - Should not be in the CDM:
    - Modifier 59
    - Modifier 73 or 74 – cancelled procedure
- Those that can be in the CDM (non-variable):
  - Anatomic modifiers such as RT, LT, 50, FA, …
  - Repeat service modifiers such as 76, 77, 91
  - 52 – reduced service only with Radiology otherwise HIM
  - 25 – significant, separately identifiable E & M (only on visits)
  - JW, JZ – pharmacy wastage

Pricing

- OPPS specifically states that the patient charge should relate directly to the resource consumption of the facility
- Many facilities use third party firms for strategic pricing to ensure that this correlation is met and market sensitive.
- Should at least be at or above the APC reimbursement
- Follow your commercial contracts – some limit how much you can change the price in a calendar year
- Need to involve finance in pricing this should not be a CDM team function unless under the direction of the finance team.

Importance of Revenue and Usage Reports

- CDM should only contain items with usage within the last billing cycle (12-18 months based on facility protocol)
- Zero Use chargemaster lines should be inactivated, not deleted.
  - CDMs must keep a record for the time of IRS guidance which is usually 7 – 12 years
  - Do not reactivate these lines – build new ones should the occasion occur to ensure the most accurate information and pricing is present.
- Essential for charge capture reconciliation
  - Look at the total visits and ensure that for outpatient areas, that provide evaluation and management services, the volumes match
  - ***REVIEW OFTEN !*** Ensure there that charge leakage is not occurring
  - Look for usage on deleted or changed CPT / HCPCS codes to ensure compliance
- These should be reviewed quarterly to remove any zero usage items which could cause charge capture errors

Mapping

- The facility can have a meticulous CDM and still have charge created errors on the claim.
- Take this hypothetical example:
  - Small hospital did not have a Cath lab or interventional radiology
  - The mapping between Radiology Information System to the CDM was such that the 2 View chest Xray (correct in the CDM and RIS) was erroneously mapped to an aortogram.
  - Result - each 2V CXR performed charged in RIS, an aortogram which resulted on the claim. This created fines and penalties and ultimately payback of the funds to the payers
    - No order or documentation to support an aortogram
- Every new CDM line should have a test to see how it comes over to a test claim. This is the only way to determine if the flow from order entry through the modules to the chargemaster and eventually onto the claim is accurate and working as designed.

Key Concept – always perform random test of the process from beginning to end on the claim to ensure accuracy

Supplies and Pharmacy

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Poll 2

How Familiar are you with the importance of GTIN?

A. Never heard of it

B. Know of it but it doesn't apply to my work

C. Relegated to Supply Chain Only

D. Use in CDM maintenance to ensure proper code assignment

What is a Supply GTIN – Is it important ?

- **Global Trade Item Number** is a unique, globally recognized identifier for a product or service. It's part of the GS1 system of standards, which aims to improve supply chain efficiency, visibility, and patient safety across various industries, including healthcare.
- Basically, a product number from which barcoding, UPC and other supply management metrics come from.
  - Globally Unique number (www.GS1US.org)
  - Assigned by Brand Owner / Manufacturer
  - Identifies the Trade items – which are anything that can be ordered and priced
- Used in the hospital chargemaster as a way of accurate supply identification.
- Also improves supply chain efficiency and most importantly enhance patient safety
- GTINs should be assigned to all supply items in your chargemaster to ensure accuracy and provide relevant population of supply items in the EMR and for charges.

Supply CDM

- Supply chargemaster components are also required to be medically necessary
- Two categories – separately billable and routine (non-separately billable)
  - Both may be charged but in different fashions
  - Routine items should not be charged separately but included in the overall cost and price for the major procedure or room rate.
    - These are items that are common to all of the same procedure such as gowns, gloves, microscope covers, EKG patches, band-aids
    - Generally, routine supplies are of low cost nature
    - Should not be in the CDM as a separate line but inventory maintained in the supply module or cabinet
  - Separately billable items are designated as those requiring a provider order or specifically identifiable to a patient.
    - Include items such as cardiac catheters, sheaths, pacemakers, prosthetic / orthotic

Supply CDM - DME

- Durable medical equipment requires a DME license to dispense these items
- These are those items primarily defined in the “E” HCPCS code
  - Crutches, Canes, Walkers, Raised Toilet Seats, Infusion pumps…
- These should not be in the CDM unless the facility has a DME license
- With a license these items could be included but must have revenue code 0290-0299 indicating these are DME items
- It is important to not that the “L” HCPCS codes, prosthetics and orthotics, are generally not considered DME and may be billed by the facility on a UB.
  - This is defined by the prosthetic fee schedule by a PO designation
  - July 2025 - https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule/dme25-c

Importance of ”Carve Outs”

- Implantables and high dollar devices must be accurately coded.
  - CMS / OPPS defines a CPT code (procedure) as being “device dependent”
    - Device is packaged into the procedure charge
    - Has a “device offset” for certain APCs especially replacements or no cost
    - Failure to have the correct device coded and, on the claim, will likely result in a denial or erroneous offsets
  - Commercial and Managed Care Contracts:
    - May have contractual carve outs for additional payment or a percentage of cost payment for high dollar devices and supplies
    - These carve outs are not typically included in the payment bundle for the procedure or hospital stay and paid individually at a percentage of cost or agreed upon contractual amount
- Carve Outs are identified by:
  - HCPCS Code for the device
  - Revenue codes – 274 (rare) 275, 276, 278

Pharmaceuticals

- The pharmacy chargemaster is an entirely different animal
- Key metric is a current and accurate drug code called an NDC
- Maintaining these in the pharmacy module and chargemaster is time consuming but an essential action in ensuring accurate reimbursement. Must be performed by personnel knowledgeable regarding the medication, coding guidelines and regulatory standards
- Pharmacy must have:
  - 90xxx codes for vaccines
  - HCPCS code (J or C) for the medications separately reimbursed
- The multiplier is key – the ordered and dispensed dose must be converted using a multiplier into the billing units.

Key Concept – failed multipliers are the consistent cause of lost reimbursement.

UB-04 and 1500 Reviews

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Importance of Claims Reviews

- The UB-04 or 1500 form is the benchmark “source of truth”
- Whatever is on the claim is a result of a charge capture action, CDM or mapping or a combination of these 3 items.
- During year end maintenance any new CDM lines must be tested to ensure that the new item is accurate and completely represented on the claim, as specified by the payer.
- Random claim reviews should be performed by internal audit to make sure the documentation support the charges, the diagnosis codes and the overall claim.
- Whenever a denial occurs, the UB must be evaluated against documentation
  - Great opportunity to identify errors or lost charge opportunities
- Known areas of charge capture error are medications, behavioral health services, and E & M code assignment (especially the facility side), and finally infusions and injections
- Each revenue producing department must be audited at least once during the year

Importance of Claims Reviews

- Average department claim selection is 25 random claims
  - Make sure to take into account observation and recurring accounts on the outpatient side
- Every high-cost drug and device should have a claim edit that looks for the drug, infusions (as indicated) or the device.
- In addition to the claims review most facilities use automated charge capture technology.
  - Consumes 100% of the daily charges
  - Reviews against rules, AI comparisons and machine learning to indicate inaccurate charges
  - Some examples are Vitalware®-VitalIntegrity, EPIC – Revenue Guardian and others that perform this task
  - Increases the clean claim rate and decreases lost charges.

Key Concept – audit randomly, audit often and always work the stakeholders to review findings.

Monthly & Quarterly Maintenance

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Poll 3

How often does the CDM coordinator meet with department managers to discuss coding updates?

A. Monthly

B. Quarterly

C. Annually

D. Not at all

CDM Maintenance Policy

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CDM Maintenance Policy

Why is it important?

- **Governance and Accountability**
  - A policy establishes ownership and oversight (e.g., Revenue Integrity, Compliance, HIM, Finance)
  - It defines who reviews updates, how often audits occur, and who approves changes.
  - Reduces silos and ensures accountability across the revenue cycle
- **Regulatory and Compliance Accuracy**
  - Policy ensures the CDM stays aligned with CMS, Medicare, Medicaid, and commercial payer rules
  - Regular updates reduce the risks of denials, fines, or audits due to outdated or incorrect codes
  - Allows for a centralized document that outlines which tasks are performed at which point throughout the year, and who the responsible party/parties should be.
- **Industry Changes**
  - Coding updates occur quarterly/annually
  - A maintenance policy ensures timely updates in response to industry coding changes, pricing shits, and payer requirements

Monthly CDM Maintenance Tasks

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Monthly CDM Maintenance Tasks

***High- Touch items that need continuous monitoring to avoid compliance or revenue issues**

1. Regulatory & Payer Updates
   - Review payer bulletins and CMS Transmittals for new coding requirement or reimbursement policy changes
   - Apply urgent updates (e.g. temp Covid codes, new HCPCS for drugs, etc.)
2. New Services and Supplies
   - Add new procedures, supplies, implants, or drugs as they are introduced by clinical departments
   - Ensure correct CPT/HCPCS code assignment, revenue code, and charge price before services are provided.
3. Error Resolution
   - Investigate billing denial patterns and update CDM entries if errors are tied to charge description, code assignment, or pricing mismatches.

Monthly CDM Maintenance Tasks (cont.)

***High- Touch items that need continuous monitoring to avoid compliance or revenue issues**

4. High-Volume/High-Dollar Items
   - Monitor and validate charges for areas like pharmacy, imaging, surgery, and labs where mistakes can have significant financial impact.
5. Departmental Change Requests
   - Process requests submitted by clinical or operational departments to add/remove/update charges

Quarterly CDM Maintenance Tasks

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Quarterly CDM Maintenance Tasks

***Broader review and audit tasks that focus on data integrity and compliance**

1. Incorporate Quarterly Coding Updates:
   - Review and Implement quarterly CPT and HCPCS code updates from CMS and AMA.
   - Remove expired codes and add new/temporary codes
   - Validate all impacted service lines. (e.g., infusions, drugs, radiology, outpatient procedures)
2. Compliance Audits
   - Ensure no obsolete or duplicate codes remain in the CDM.
   - Confirm charge descriptions meet regulatory and payer standards
3. Denial Trend Review
   - Analyze quarterly denial data to detect recurring CDM-related issues.

Quarterly CDM Maintenance Tasks (cont.)

***Broader review and audit tasks that focus on data integrity and compliance**

4. Pricing Review (Market & Reimbursement)
   - Compare charges against Medicare fee schedules, payer contract, and cost benchmarks.
   - Begin preparing for annual pricing adjustments
5. System Reconciliation
   - Validate CDM alignment across EHR, billing, and financial systems to avoid mismatched data. (Chart Reviews are helpful for identifying issues)

Year-End Requirements

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Regulatory & Compliance

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Year-End CDM Maintenance Tasks

Regulatory & Compliance Updates

1. January 1 / Q1 Coding Updates:
   - Review Q1 and Implement Q1 code updates from CMS and AMA for effective date 01/01
     - CPT, HCPCS, MS-DRG, APC Updates
   - Remove expired codes and add new/temporary codes
   - Validate all impacted service lines. (e.g., infusions, drugs, radiology, outpatient procedures)
2. Compliance Audits
   - Ensure no obsolete or duplicate codes remain in the CDM
   - Confirm charge descriptions meet regulatory and payer standards
   - Update LCD/NCD and medical necessity requirement policies
3. Denial Trend Review
   - Analyze yearly denial data to detect recurring CDM-related issues

Price Transparency Compliance

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Year-End CDM Maintenance Tasks

Price Transparency Compliance

1. January 1 Machine-Readable Files:
   - Ensure all payer contract pricing is accurately updated
   - Generate updated machine-readable files for website posting January 1
2. Shoppable Services List
   - Update shoppable services list with new pricing effective January 1
3. Audit and Review
   - Review Cash/Self-Pay pricing and disclosures reflect January 1 changes
   - Verify and audit price estimator tool reflects January 1 changes
   - Audit price transparency website

Payer Contract Review

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Year-End CDM Maintenance Tasks

Payer Contract Review

1. Contracted Pricing Rate Review:
   - Review payer contracts that renew on a calendar year basis
     - Determine any changes/percentage increases and implement effective January 1
   - Review contracts that renew on contract date basis
     - Determine any changes/percentage increases
     - Set calendar reminders / implement changes post-dated
   - Update fee schedules and ensure accuracy of any Medicare-based payment calculations
2. Audit and Review
   - Verify and audit price estimator tool reflects January 1 changes
   - Audit price transparency website

Department Collaboration

Year-End CDM Maintenance Tasks

Department Collaboration

1. Educate & Discuss:
   - Meet with clinical departments to discuss January 1 changes
   - Review any new services to ensure appropriate charge capture
   - Review any key denial trends or department concerns

Summation

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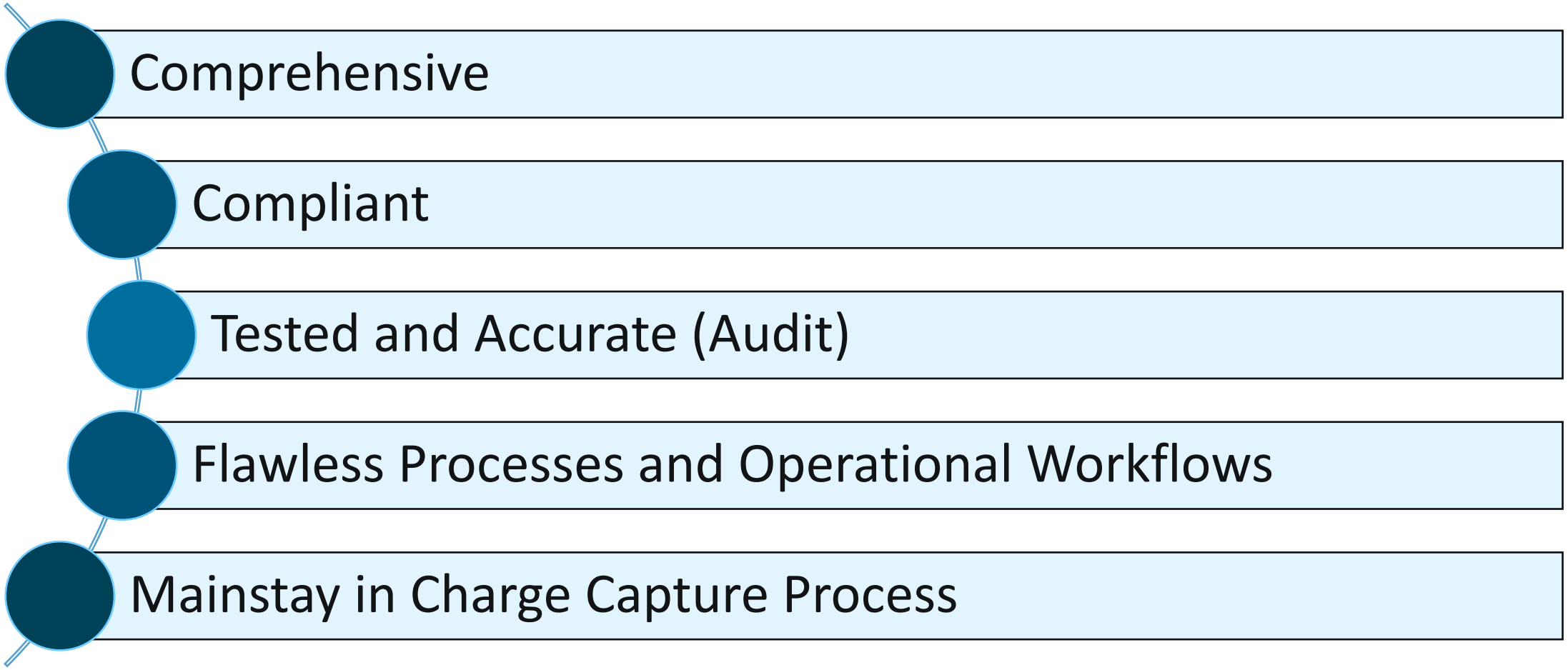
Chargemaster Success



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