Financial Housekeeping in the Cath Lab: Time for Spring Cleaning?

By Catherine DiNardo

With focus on new beginnings, Spring is the perfect time to make changes to departmental processes, regularly-used documents, and, perhaps most importantly, the chargemaster, a list of all billable hospital services. Performing regular chargemaster maintenance will help your hospital avoid potentially costly errors that result from outdated or incorrect information.

Indeed, a chargemaster can never remain static. In fact, regularly updating this important list can be the difference between accurate payment for patient services rendered and incomplete or inappropriate reimbursement. The new Medicare outpatient reimbursement rates became effective in January 2009, along with new CPT coding changes—a typical occurrence at the beginning of the calendar year. Oftentimes, an organization can struggle with charging and coding practices. But, Corazon believes that an accurate and complete chargemaster is the first step to optimal charging and coding practices.

The American Medical Association publishes new CPT manuals annually, and CMS updates the HCPSC codes periodically throughout the year. The Cath Lab Department Manager should regularly compare the chargemaster to the list of revised and deleted codes. If the chargemaster contains any of the newly-invalid codes, it’s necessary to consult with coding professionals in the hospital’s HIM department for assistance in assigning new codes to the services listed in the chargemaster. Failure to do so could again result in denials or incorrect payments.

Inaccuracies in the chargemaster can cause incorrect payments back to the hospital and/or even payment delays or denials.

Several problem areas can arise during chargemaster maintenance. The below sections detail these areas and explore ways to overcome the challenges associated with them:

**Charge Capture**

Missed charges mean missed revenue for the hospital. The chargemaster plays a central role in charge capture, making accuracy within this important list a financial priority. Reviewing service code line items sorted by volume will focus attention on low-volume and zero-volume service codes. Lower than expected volumes can indicate a problem and the need to conduct an audit of the charging process. Corazon often recommends education to help department staff with understanding their daily role in charge capture and this role’s impact on the ‘big picture’ financials of the hospital as a whole.

To accurately assess whether the department’s chargemaster is complete, start by comparing the chargemaster, the current CPT manual, and the Medicare outpatient PPS Addendum B. The department manager should evaluate whether codes that appear in the CPT manual and on the Outpatient PPS payment schedule should be included in the chargemaster. Generally, all services that are currently offered (or those planned for the future) should appear in the chargemaster.

**Setting a Charge**

Comparing Addendum B to the chargemaster may reveal some revenue opportunities. Addendum B shows the outpatient payment amount by CPT and the associated APC code. Medicare will reimburse the lower of the payment listed in Addendum B or the

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**Basic Financial Terms: A Primer**

Note these important definitions and abbreviations:

- **CMS** (Centers for Medicare & Medicaid Services) – Federal agency that administers Medicare and Medicaid Health Insurance Program.
- **Chargemaster** (also known as charge description master or CDM) – an electronic listing of every billable hospital service that can be provided to the patient. The CDM includes the service code, service code description, revenue code, CPT/HCPCS code, and the charge amount.
- **Service code** – an internal code that the hospital has assigned to the item or service.
- **Service code description** – the name and description of the item or service.
- **Revenue code** – four-digit billing code indicating the type of service provided that often references the Department or Unit where the service was performed.
- **CPT code** (Current Procedural Terminology code) – Codes used to describe physician procedures and certain hospital outpatient services. CPT codes are created and updated annually by the American Medical Association.
- **HCPCS code** (Healthcare Common Procedure Coding System) - Codes created and updated by CMS to supplement the CPT coding system. This system does not include codes for non-physician services such as administration of injectable drugs and specific supply items.

- **Modifier** – a two-digit code appended to CPT and HCPCS codes to provide additional information.
- **Charge** – price charged for the item or service on the patient’s bill.
- **Hard-coded** – CPT code or HCPCS code listed in the CDM. Selecting a service code in the charge entry system automatically places the CPT or HCPCS code on the patient bill.
- **Soft-coded** – CPT codes assigned to the patient bill by the HIM coders.
- **HIM** – Health Information Management.
- **APCs** (Ambulatory Payment Classifications) – CMS method for paying for outpatient services.
billed amount. To receive the Medicare payment amount, the
department manager has to set charges at least equal to the
Medicare payment amount. The rule holds true for other payor
contracts as well. For example, if the insurance company contracts
to pay $4000 per outpatient for cardiac cath procedures, but the
patient bill is $3800, the insurance company will pay the $3800.
Hospital prices can be set via various ways, but the manager’s goal
is to assure that reimbursement reflects a match with overall
resource utilization so that the hospital receives correct payment for
the care delivered. At minimum, reimbursement should cover the
costs of performing the procedure.

Correct Coding

Understanding what service or supply is provided for each service
code is the first step to ensure the correct CPT or HCPCS codes are
assigned. After verifying the appropriateness of each service and the
associated description in the chargemaster, determine if the correct
HCPCS, CPT, and revenue code are present. If the department
manager is uncertain about the assignment of the correct HCPCS or
CPT code, they should consult with the coding experts in the
hospital’s HIM department.

In Corazon’s experience, ancillary departments such as the Cardiac
Cath lab generally hard-code the majority of the CPT and HCPCS
codes into the chargemaster. Since these codes eventually appear
on the patient bill with minimal review by the HIM coders, it is
necessary to hard-code the complete code, including the modifiers,
into the chargemaster. For example, the insertion of an
intracoronary stent, code 92980, requires a modifier identifying the
location of the stent placement. The modifiers that can be used with
this code are the right coronary artery (RC), Left circumflex artery
(LC), and the left anterior descending artery (LD). Hard coding this
service into the CDM would require the addition of three service
codes with the CPT code and modifiers: 92980RC, 92980LC, and
92980LD. While such an effort could be time consuming at the
outset, this initiative could save valuable time, effort, and dollars in
the long-term.

The department manager should verify that charge sheets contain
the same descriptions and CPT/ HCPCS codes as the electronic
copy of the chargemaster. It is not uncommon for charge sheets to
be updated with new CPT codes while the computer maintenance on
the chargemaster and the charge entry system are overlooked.
Such oversights can cause payment problems and potentially trigger
an audit. Likewise, charge codes should match the clinical
documentation on the medical record. Corazon encourages Cath
Labs to utilize their CVIS systems to facilitate a more automated
approach to clinical documentation—one that is linked to the coding
and billing process.

Miscellaneous and Stat-only Charges

Miscellaneous codes oftentimes create billing problems. Since there
are no HCPCS, CPT, or revenue codes associated with miscellaneous service codes, these charges inevitably become “non-
covered charges” on the patient bill. If the miscellaneous item is not
denied outright, payors will request further documentation for the
miscellaneous item, which will generally delay payment for the entire
patient bill. Excessive use of “miscellaneous” line-items indicates
that service-specific line items need to be developed.

Statistic-only service codes with zero prices can also create billing
problems. Corazon’s review of one hospital’s chargemaster
revealed that the staff was inputting the service codes for all of the
statistical counters but not the service codes to bill the patient. The
employees did not realize that the service codes were statistics only,
which translates to lost revenue. The problem was two-fold: first,
the service code descriptions did not indicate that it was a statistical
counter; and, second, there were almost as many statistical codes in
the CDM as there were actual service codes. Corazon recommended use of the actual service code volume for their
statistical counts and use zero-price statistical counters only when the
volume was not captured elsewhere.

Partial or unclear descriptions are not just a problem for the Cath Lab
staff. Using clear, patient-friendly terms instead of clinical
abbreviations can reduce the number of questions from those
outside the department. Clear descriptions make it easier for the
business office staff to answer questions from auditors, insurers, and
patients as they come up, resulting in efficiencies.

Supply Charges

The chargemaster should be reviewed to identify any service codes
that should be removed. Routine supplies—those supplies that are
customarily used during the usual course of treatment—are not
billable. Examples of routine (non-billable) supplies are gloves,
bandages, tubing, and saline solutions. Defined as such, the costs
of these supplies are considered to be bundled into the payment for
the procedure. On the other hand, non-routine supplies are billable,
and include any supplies necessary to treat a specific patient’s
illness or injury based on a physician’s order and a documented plan
of care. Examples of non-routine (separately billable) supplies would
include stents and other implantable devices. Departments can set up
service codes for kits or trays that contain both routine and non-
routine supply items as long as they document the contents and the
charge amount is for the billable supply items only.

The majority of supplies used in the hospital do not require a HCPCS
code, but Medicare does require HCPCS codes for implanted
devices. When CMS developed APC payments for outpatient
services, a number of expensive items (i.e., implantable devices)
were assigned specific HCPCS codes called “C-codes” and paid
separately as a pass-through costs. While the pass-through payment status for device category codes have expired, hospitals
are still required to report the device C-codes on claims when such
deVICES are used in conjunction with a procedure billed under the
Medicare outpatient prospective payment system.

There are a number of procedures commonly performed in the cath
lab that would require a charge code for the related device. C-codes
for AICDs, leads, pacemakers, and stents should be included in the
chargemaster in addition to the charge for the related procedure.
Even though the payment for the device is now included in the
payment for the procedure, it is important that hospitals bill and
report the HCPCS codes for the procedure and the related device.
CMS uses this claims data to establish future payment rates.
Therefore, if the required HCPCS codes are not on the claim, the
claim will be returned unprocessed. Ultimately, this practice could
affect future payment rates.

The following table contains common cath lab procedures and
the related device(s). Patient bills that include a procedure from
this list must also include at least one C-code for the associated
device. In some cases, a minimum of two codes are required as
noted below.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure Description</th>
<th>Device Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>33206, 33207*</td>
<td>Insertion of heart pacemaker</td>
<td>C1779, C1785, C1786, C1898, C2619, C2620, C2621</td>
</tr>
<tr>
<td>33208*</td>
<td>Insertion of heart pacemaker</td>
<td>C1779, C1785, C1898, C2619, C2621</td>
</tr>
<tr>
<td>33211</td>
<td>Insertion of heart electrode</td>
<td>C1779, C1898</td>
</tr>
<tr>
<td>33212</td>
<td>Insertion of pulse</td>
<td>C1786, C2620, C2621</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure Description</td>
<td>CPT Codes</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>33213</td>
<td>Insertion of pulse generator (dual)</td>
<td>C1785, C2619, C2621</td>
</tr>
<tr>
<td>33214*</td>
<td>Upgrade of pacemaker system</td>
<td>C1779, C1785, C1898, C2619, C2621</td>
</tr>
<tr>
<td>33216, 33217</td>
<td>Insert lead pace-defib</td>
<td>C1777, C1779, C1895, C1896, C1898, C1899</td>
</tr>
<tr>
<td>33224, 33225</td>
<td>Insert pacing lead</td>
<td>C1900</td>
</tr>
<tr>
<td>33240</td>
<td>Insert pulse generator (AICD)</td>
<td>C1721, C1722, C1882</td>
</tr>
<tr>
<td>33249</td>
<td>Insert-reposition lead/insert pace-defib</td>
<td>C1721, C1722, C1882</td>
</tr>
<tr>
<td>33282</td>
<td>Implant pat-active cardiac recorder</td>
<td>C1764</td>
</tr>
<tr>
<td>35458, 35459, 35460, 35470, 35471, 35472, 35473, 35474, 35475, 35476</td>
<td>Repair arterial blockage</td>
<td>C1725, C1874, C1876, C1885, C2625</td>
</tr>
<tr>
<td>37205, 37206</td>
<td>Transcath iv stent, percut</td>
<td>C1874, C1875, C1876, C1877, C2617, C2625</td>
</tr>
<tr>
<td>92978</td>
<td>Intravasc Ultrasound heart add-on</td>
<td>C1753</td>
</tr>
<tr>
<td>92980, 92981</td>
<td>Insert intracoronary stent</td>
<td>C1874, C1875, C1876, C1877</td>
</tr>
<tr>
<td>92982, 92984</td>
<td>Coronary artery dilation</td>
<td>C1725, C1874, C1876, C1885</td>
</tr>
<tr>
<td>92995, 92996</td>
<td>Coronary atherectomy</td>
<td>C1714, C1724, C1885</td>
</tr>
<tr>
<td>92997, 92998</td>
<td>Pul artery balloon repr, percut</td>
<td>C1725, C1874, C1876, C1885, C2625</td>
</tr>
<tr>
<td>G0290, G0291</td>
<td>Drug-eluting stents</td>
<td>C1874, C1875</td>
</tr>
</tbody>
</table>

* These Procedures require 2 codes: one for the lead(s) and one for the pacemaker.

Source: CMS April 2009 Procedure to Device Edits and Device to Procedure Edits.

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Equipment usage charges often find their way into the chargemaster, even though they are not billable to Medicare. Corazon recommends that all equipment charges be removed from the CDM. Rather, the cost of using the equipment should be built into the procedure charge.

Ongoing chargemaster maintenance is necessary due to continual changes in medical technology, the addition of new services to a hospital's repertoire, changes in Medicare billing guidelines, and annual updates to the CPT and HCPCS coding systems. As physicians develop new methods for performing procedures, the CPT and HCPCS coding systems are revised, thus requiring that the chargemaster be updated.

Department managers need to monitor Medicare transmittals for possible changes to the CDM. These transmittals are published periodically throughout the year and often impact the billing and coding of specific services. Corazon recommends that the chargemaster be updated at least each year when the CPT and HCPCS updates are published.

Ultimately, the chargemaster drives the billing and payment process. A complete and accurate chargemaster is essential for optimal payment. Sometimes, even the most clinically-adept organizations fail to give the necessary attention to this seemingly minor services list that has huge strategic and financial import to the overall viability of the hospital. Maintaining the chargemaster is a critical first step in ensuring financial profitability, now and in the future.

Catherine is a Lead Business Consultant at Corazon, Inc., a national leader in strategic program development for the heart, vascular, neuro, and ortho specialties. Corazon offers a full continuum of consulting, recruitment, interim management, and physician practice and alignment services for hospitals and health systems across the country and in Canada. To learn more, visit www.corazoninc.com or call 412-364-8200. To reach the author, email cdinardo@corazoninc.com.