Deconstructing the enigmatic hospital chargemaster

Written by Carrie Pallardy | September 04, 2015

Patients struggle to understand healthcare costs, but the process of setting costs and charging for services rendered can be complex enough to confound industry experts. The chargemaster is at the heart of the cost structure matter, yet ask hospital executives to explain how it works. The answers run the gamut from barebones basic to overly vague.

At the most simplistic level, the chargemaster is a list of prices for any service or product a hospital offers. In this digitized age of healthcare, the chargemaster will be accessible through a hospital's EHR. "The chargemaster is a living set of data elements," says Scott Pillittere, vice president with Impact Advisors. "At its simplest form, think of it as a menu — anything you can charge a patient." But, looking past the obvious, understanding the inner workings of this set of data elements grows more difficult.

Who uses it?
Access to the chargemaster is generally restricted. One or two leaders, likely those who built and maintain the detailed list, will have the ability to make changes by adding or removing data. "The chargemaster is invisible to most people in the hospital," says Doug Barry, president of Cardon Outreach.

Though the chargemaster is inextricably linked to a hospital's finances, CFOs rarely interact with this document. "Honestly, I don't see many CFOs who would understand the details," says Mr. Pillittere.

CFOs are faced with a hospital's myriad budgetary demands. Rather than become bogged down in the details of the chargemaster, they often delegate the responsibility to a vice president of finance of revenue cycle management. "CFOs are going to have a high level understanding of costs and timing associated with payments," says Angie Grunte, executive vice president with Vizant. A team member or members in the finance or treasury department will likely know more about the ins and outs of the chargemaster than a C-suite executive.

Where is it found?
The physical chargemaster is a standard part of a hospital's IT infrastructure, but only someone intimately familiar with a hospital's contracts and market — whether an in-
house leader or consultant — can lead the building process. "The chargemaster resides in every hospital information system, whether Cerner, Epic or MEDITECH," says Mr. Barry. "It is a module standard in that purchase, but when it arrives it is an empty shell." That shell needs to be filled with the hundreds of thousands of line items that comprise all of a hospital's possible charges.

**What does it contain?**

How this intricate pricing menu is developed and managed varies based on the size of the hospital or health system and the available resources. The ideal chargemaster leader is someone with a firm grasp of the clinical and financial. "Some of the strongest [chargemaster] leaders I have seen are nurses," says Mr. Barry. "When interpreting Medicare law, it is not often you find someone with a billing background that is qualified. The talent hospitals have to hire has gotten more expensive." Larger organizations are more likely to have the bandwidth to find someone with a foot planted in each sphere of healthcare, while smaller hospitals may assign someone from the financial side as a chargemaster coordinator.

Within the chargemaster, information is generally organized by department. "Each department has a numeric code. Every charge starts with the number associated with that particular department," says Mr. Barry. "Then [organization] trickles down to the individual payer." Information on bundled services and carve outs then resides within each payer section.

**When is it updated?**

Once built and organized, the now-full shell of information does not stay static; the chargemaster is a living document. At minimum, it should be updated on a quarterly basis, but there is need for changes on a daily basis. Departments may need to add or remove charges, and a regulatory environment in flux demands updates. These "trigger events," such as new CMS guidelines or payer contract updates, can necessitate chargemaster changes beyond a scheduled quarterly review, says Mr. Pillittere.

Certain tools placed on top of the chargemaster will scan through the entire document, line item by line item, to identify necessary regulatory updates within a matter of minutes, according to Mr. Barry. This type of automated technology helps hospitals maintain compliance. If a hospital does not have this type of bolt-on, all changes may be handled strictly on a manual quarterly basis, or chargemaster maintenance could be outsourced entirely.

**Why is it perplexing?**

CFOs may not nimbly navigate a chargemaster's exhaustive line items, but they do understand the discrepancy between the charges included in the documents and the
actual cost of care. "There is no correlation between pricing and payment," says Mr. Barry. After moving to DRG codes, hospitals were no longer paid on a percentage of charges. Instead, payment rates are based on a multitude of factors such as length of stay, level of care administered and severity of the patient's condition, he says.

Discussion of the chargemaster becomes sticky when the question of price transparency arises. It is unlikely a hospital chargemaster will ever become available to the public given the gap between charges and what patients and payers will actually pay. Patients are concerned with their out-of-pocket expenses, not the convoluted backend of healthcare cost structure.

Price transparency is coming to healthcare, if at a gradual pace. Hospital leadership can provide that transparency using the chargemaster. "There are ways to integrate price transparency. You can create a mock bill with current charges using the chargemaster," says Mr. Barry. Alternatively, pulling average charges from past claims data can produce a patient payment estimate. Transparency will also force hospital leadership to evaluate whether pricing is fair and competitive, particularly as value-based contracts proliferate.

Price transparency and value-based care are just a few of the changes reshaping healthcare. Given this dramatic level of evolution in the industry, could a time come when the hospital chargemaster loses relevance? Mr. Barry could envision the chargemaster becoming extraneous only if healthcare went to one payment methodology. This scenario is nearly unimaginable; the chargemaster will remain the bedrock of hospital cost structure for the foreseeable future.

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