

HEALTHCARE PURCHASING NEWS

Industry leader for over 32 years.



Tightening those database loopholes

Revenue cycle-supply chain links sync data, drive data standards

July 2009

by Rick Dana Barlow

While data standards may be just the protective garb that battle-weary supply chain managers must don to continue the war on cost increases its only a considerable component of a more comprehensive strategy.

Think of it more like a high-tech battle suit that must be fortified and fueled by internal electronics and human power. At the center of that engine is the chargemaster (CDM) and the item master (IDM), overseen by revenue cycle and supply chain managers, respectively.

A growing number of healthcare supply chain professionals extol the value of linking the two. In fact, according to *Healthcare Purchasing News'* 2009 Materials Management Salary Survey results, 42 percent of survey respondents indicated that they've gotten involved in revenue cycle management, and 17 percent in recovery audit contractor audits.

But closing the fiscal loop between the expense and revenue sides of the balance sheet requires monumental effort to maximize surefire rewards, including extrapolating the most out of an adopted data standardization and synchronization strategy.

As a result, *HPN* tapped eight experts for their views on charge code applications, as well as common CDMs and IDMs, linked or not, across the enterprise.

HPN: Should every single supply item have a charge code in a facility's system? Why?

Kathy Schwartz, R.N., director, supply revenue operations, [MedAssets Inc.](#), Atlanta

A health facility's clinical interface system determines the type of requirements that facility needs to capture charge codes for supply items. Individual system requirements dictate the chargemaster structure and whether it should be one-to-one, one-to-many or a cost-level structure. What's critical is having the tools and capabilities to constantly audit and update systems to capture cost-to-charge data transparency and ultimately provide the facility with a defensible pricing strategy.



Nick Gaich, partner and Chief Strategy Officer, [Appleseed Healthcare Resources](#), Ann Arbor, MI

No, not necessarily. That really depends on the individual institution's charge model; not all supplies/services are 'chargeable.' It's just as important to guard against over-burdening administrative transactions. The solution is to have a charge code for every item master supply/service with a transactional revenue charge.

Jim Morrison, vice president and general manager, HIS/revenue cycle solutions, [McKesson Provider Technologies](#), Alpharetta, GA

No, most organizations will have a dollar threshold of what items they will charge for and which items they will not. Only those items that meet and exceed the threshold need a charge code. Additionally organizations will have different usage areas that depending on where the item is used define if that item is chargeable or not. For example a catheter used in the [operating room] is chargeable, but, if used in the cath lab that item is considered part of the procedure charge and not charged to the patient.



John Hansel, vice president, product marketing for provider solutions, [MedeAnalytics](#), Emeryville, CA

To keep the linkage between the IDM and CDM manageable, hospitals should start by mapping their high-cost supplies (typically used in surgical procedures) that represent the majority of 'charge-sensitive' items. Other standard medical supplies are often reimbursed as part of a DRG case rate, so their costs and charges have less value in the revenue cycle

Cindy Fry, vice president, revenue management, [Catholic Health East](#), Newton Square, PA

No, every single supply item should not have a charge code. At CHE, there are 77,000 supply items in the item master and only 35 percent are chargeable. Chargeable supplies are defined as all CDM line items with revenue codes 270-279 and 621-624. If non-chargeable items are kept out of the CDM, it lessens the possibility that a non-chargeable line is inadvertently charged. Further, it streamlines maintenance.



Patricia Daiker, R.N., vice president, marketing, [MEDHOST Inc.](#), Addison, TX

No, in our experience many facilities are very successful bundling basic supplies into [evaluation and management] level charges and procedure charges. [But] we are not a conventional revenue cycle or supply chain offering. MEDHOST's EDIS is a comprehensive emergency department information system that offers patient tracking, discharge instructions, physician order entry, clinician documentation and detailed reporting. As charging is an automated byproduct of documentation, all services provided are captured and billed, and the resulting bill is always supported by documentation without any clinical bias. The charges do not require clinical input or education – only accurate documentation of care provided. The subjectivity of human interpretation and error is removed. Since approximately 60 percent of inpatient admissions begin in the ED, the impact to hospital revenue cycle is significant. The automated integration with a facility's coding platform expedites claim submission and decreases [accounts receivable] time. Additionally the real-time nature of the application supports cash collection of private pay patients at discharge, which adds significant cash to the bottom line. The ED, long considered a drain on a hospital's financial health, can be a source of growth, revenue and prosperity.

Should facilities use software to link the item number with the charge code or make the item master share the same number as the chargemaster? Why? Pros and cons of either approach?

SCHWARTZ: Facilities that don't link supply items to charge codes stand to lose valuable insight into how supply items are being captured – if they are being captured at all – and whether charges are in line with their mark-up strategies. Additionally, without a link between the supply item and charge code, facilities' ability to address markup in the context of the greater financial impact is impaired due to an incomplete or inaccurate picture of where they are today versus where they need to be in the future. With the push for electronic medical records, it will become even more important for systems to be in sync with accurate and compliant data.

By linking supply chain and revenue cycle data, health facilities can gain a deeper understanding of how high-cost-supply-driven departments utilize and capture supplies to ensure compliance and revenue capture and enforce mark-up strategies.

Denise Ashlin, ERP program manager, finance, [Mayo Clinic](#), Rochester, MN

Utilizing a common number scheme will allow for transparency throughout the entire procurement cycle both internally and externally. Also, using the same number as the chargemaster will eliminate the need to maintain cross references and allows for consistency across all business functions.

FRY: This is a complex decision and a single answer does not fit all. One consideration in the decision making should be whether creating this link facilitates easier and more efficient reporting and resource utilization. Further, there are a variety of approaches a facility can

take in creating this mapping between the item master and CDM. They can develop a mapping utilizing supply groupings and a cost matrix with direct linkage to the common item master. Or they can link the item master directly to the CDM with a one-to-one mapping. Or they can create a hybrid by linking the item master directly to the CDM with one-to-one mapping and have supply groupings for special order or one-off items that are not entered into the common item master. There are pros and cons with each approach, however, if there is no link between the item master and CDM, there is lack of consolidated reporting and comparison reporting across the organization, increased difficulty in monitoring supply revenue and usage across systems, inconsistency in bundling versus unbundling, lack of consistency regarding a billable versus a non-billable supply and continued variability across hospitals in charging approaches and methodologies.

GAICH: Having the same charge code or number for both the item master and the chargemaster may not be possible, depending on the systems used and inherent software constraints. That said, it's important to align the item master with the chargemaster to enable routine centralized oversight.

DAIKER: MEDHOST can accommodate universal or specific codes. In regards to E&M charges our standard database is pre-coded with CPTs, which we then crosswalk to a facility's CDM number. Supplies can directly interface to chargemaster or supply systems.

Should healthcare systems maintain a common chargemaster and item master across all of their facilities? Why? What are the pros and cons of either?

SCHWARTZ: Yes. Maintaining a common chargemaster and item master across facilities is critical in helping healthcare systems drive efficiencies, especially as these hospital systems face increasing financial pressures to deliver fast and advanced medical care. By creating a corporate chargemaster standard with links to a corporate item master, healthcare systems gain a valuable knowledge source that allows individual facilities to capture and view key information and streamline processes. Ultimately, the move towards common chargemasters and item masters results in more consistent charge captures and increased consistency in coding and compliance processes, delivering numerous benefits for the corporation as a whole.

Without linking the chargemaster and supply information, systems are much more likely to contain errors resulting from under charges and compliance exposures (items priced well above the set markup.)

FRY: In a perfect world, a common charge master would be optimal. However, most health systems have been formed through acquisition and unless a new HIS system is being installed, the expense, resources and complexity required for standardizing the CDM is not justifiable. A 'true' standard would require the creation of common charge numbers and those new numbers would need to be mapped to all clinical and ancillary systems, an overwhelming task. What can be accomplished at a more reasonable cost is a 'hybrid' standard whereby hospitals can map their existing CDMs to a corporate standard utilizing one of the available CDM maintenance tools/vendors. This creation of a standard allows for greater control in the use of accurate and valid billing codes as well as the identification of revenue opportunities. Further, it is more efficient to manage one corporate CDM across multiple facilities and push down changes and updates one time, to multiple sites, through interface scripting technology.

GAICH: The only way to maximize overall margin performance is with continuity and consistency. Very large IDNs with significantly different locations and clinical services may not be able to achieve absolute continuity/consistency because of clinical specialties and/or practice patterns, but every effort should be made to achieve the highest possible degree of continuity/consistency across the enterprise.

HANSEL: While driving and maintaining standardization takes a tremendous amount of work, gaining visibility into health system- or IDN-wide supply usage provides many important strategic benefits, enabling standardization initiatives, benchmarking analyses, and enhanced leverage with suppliers – and perhaps even group purchasing organizations – to name a few.

DAIKER: Enterprise EDs with a common set of codes allows sites to implement system-wide updates, changes and standard software implementations thereby streamlining the front end deployment and subsequent maintenance. Sites that do not have a common chargemaster experience may experience more granular configuration requirements. **HPN**