



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 16: Charge Description Master Management and Maintenance Strategies

I. Annual Pricing Updates

A. The chief financial officer, with direction from the board of directors, typically determines the annual price increase for the hospital based on financial goals and other factors.

B. Special considerations

1. A price increase may be:

- a. Relative (some prices are raised and others frozen or decreased; the goal is for the percentage increase to equal the sum of the annualized volume times new prices, divided by the sum of the annualized volume times current prices);
- b. Absolute (each price is increased by the percentage increase); or
- c. Cost-based as it may represent an increase for cost-based prices (e.g., drugs and supplies and devices/implants).

2. Managed care contract annual price increase caps must be considered and typically, the overall price increase is no more than the most restrictive or limiting contract price increase cap.

3. The overall annual price increase **should not be** applied to cost-based charges as this will result in a deviation from the mark-up policy.

4. Some departments or types of services have price sensitivities or price transparency goals.

a. Examples include:

- (i) Increased competition for MRI and CT may result in wanting to reduce prices

- (ii) Organizational goals with regard to pricing position relative to competitors in the provider's community and/or state

C. Determine the method to apply differential ~~increase~~increase.

1. Revenue code changes
2. Accommodation changes
3. Phased-price decreases

II. Annual CPT®/HCPCS Updates

A. CPT® coding changes

1. CMS publishes new CPT® codes in the OPPS and MPFS proposed rules published around July 1 each year. ~~—~~ This is a good source to get advanced notice and have additional time to plan for the CPT® changes effective January each year.
2. If the current CPT® code has a different definition from the past CPT® code, it may be best to create a new charge code versus updating the CPT® code in the existing charge.

B. HCPCS Level II changes

1. These occur quarterly, so departments need to be prepared and watch for these updates.
2. The quarterly I/OCE changes are an excellent source to understand the most critical quarterly HCPCS changes.

C. Modifier changes

1. Considerations:
 - a. Are any charge lines hard coded with the modifier that has changed?
 - b. Have you conducted any audits through the year to ensure hard-coded modifier charges are used appropriately?
 - c. Is there a feedback mechanism from HIM to the department if the hard-coded modifier charge is used incorrectly?
 - d. How about positive feedback for when the charge is used correctly?
 - e. Are the modifiers to be added by coding staff?

- f. Do you need to review the criteria for the modifier?
- g. Do any new or changed modifiers require education of department staff to update documentation practices?
- h. Are any modifiers added by system logic?
 - (i) For example, modifier -PO or -PN based on department/location of service.

III. Public Reporting Requirements of Chargemaster or Selected Chargemaster Line Items

- A. Is there a reporting requirement for changes throughout the year or just annually?
- B. Providers should incorporate deadlines to allow time to file the required CDM elements with the state authority.
- C. CMS has now imposed a requirement to post charges for all items and services online in a machine-readable format. This stems from an ACA provision that the prior administration interpreted as requiring hospitals to publish the method by which patients could obtain price estimates for services.

Link: CMS Price Transparency FAQs under Revenue Integrity and Chargemaster Boot Camp

1. For more information on Pricing Transparency see the presentation in the materials behind the outline.
2. All hospitals must post a list of all items and services online in a machine-readable format of their charges and update such list no less often than annually.
 - a. In addition, IPPS hospitals (subsection d hospitals) must also post a list of charges by MS-DRG.
 - b. All hospitals must comply with CMS' revised "price transparency" requirements as published in Medicare and Medicaid Programs: CY Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency <84 Fed. Reg. 65524> Requirements for Hospitals To Make Standard Charges Public.
3. Note that some states have specific laws that define price transparency.

4. Some states have anti-markup laws for certain types of services like purchased lab tests which apply to hospitals and/or suppliers.

Tip: Monitor account credits applicable to patient payments on accounts having up-front payments—hone estimates. Are errors due to benefit information from payer or due to variability in charges for services that comprise the encounter? How can variability in charges for services be reduced?

IV. Transmittals, Regulations (Proposed and Final), and Other Policy Changes Throughout the Year

- A. Consider subscription services where department staff receive push notifications of updates applicable to their departments.
- B. Is Revenue Integrity responsible for pushing information/notifications to departments?
- C. Not every reader will understand the dense regulatory language or the operational and/or compliance implications of the transmittals, so how will they be conveyed to departmental staff?
- D. Does your organization submit comments to CMS?

V. Chargemaster Maintenance Via a Team

- A. Does the team review every change or only additions or restructuring?
- B. Who leads the team?
- C. Does the team define review steps/questions regarding the change request?
- D. Does the CDM coordinator execute the requirements for CDM changes?

VI. CDM Lines with No Volume

- A. Review charge lines with no volume as part of annual maintenance or according to department calendar.
- B. A threshold should be in place for inactivating charges with no volume in CDM policies.
 1. Risks of inactivating a charge line with no volume include the department selecting the closest current charge rather than requesting reactivation or a new charge.

C. When a new charge request is made, check whether the charge already exists and has been inactivated.

1. If reactivating a charge, check whether the charge needs to be updated.

D. Considerations:

1. Is the charge line valid?

2. Are the revenue and HCPCS codes correct?

3. Is this an infrequent, but still possible service?

4. Are the credentialed staff required to perform the service still employed or contracted?

5. When was the last time any volume was posted? Two years ago? Three? Five?

VII. Working with Departments

A. Chargemaster changes cannot be made without considering the department's knowledge and corresponding changes in its charge capture, documentation, or other related/associated activities.

1. Considerations:

a. Department managers and staff change;

b. New releases or changes in department systems that interface or generate charges;

c. Claim and medical record reviews; or

d. Who is responsible?

(i) See Attachment A for a sample revenue integrity specialist job description.

2. Under arrangement services

a. The key is that the hospital must exercise quality control over these contractors: for example, requiring certification (CLIA, accreditation, etc.); reviewing quality and patient experience scores; and ensuring the contract spells out requirements for medical records, billing, and coding, including where and when to direct invoices.

- (i) Ensure medical records are returned immediately and included in the hospital's EMR.
 - (ii) Ensure itemized charges with HCPCS codes are provided within 24 hours so that charge, plus any appropriate markup, can be added to the patient's account.
- 3. Best practice is to have a more in-depth review of department chargemasters and charge capture processes at least annually.
- 4. A comprehensive review includes looking at the line items for each revenue department and then looking at the overall revenue cycle, including charge capture interface, coding interface, repetitive coding/billing edits, modifier application, coverage and documentation of key services, and the proper generation of claims.
- 5. Develop a calendar working from departments that account for the largest proportion of revenue to departments that account for the least.
 - a. Avoid December to account for annual code updates and schedule fewer reviews for March, June, and September to account for quarterly updates.

VIII. Tracking CDM Changes for Compliance

- A. The chargemaster must be archived to allow claims to be regenerated based on the chargemaster parameters that were in place at any given point in time.
 - 1. This supports re-billing of claims for adjustments or appeals.
 - 2. Because compliance audits may go back several years, a hospital may need to regenerate claims from a relatively distant point in the past.
- B. Many organizations contract with vendors for chargemaster maintenance support or database tracking. Requests for changes or annual CPT®/HCPCS updates are entered; they are reviewed and approved by various organizational roles, then documented and recorded; and the effective date and supporting rationale for changes are documented.
 - 1. It is recommended to archive a monthly copy of the chargemaster so that, should an update occur that causes problems, the changes are captured from one month to the next.
 - 2. Some organizations update in the vendor software, which is then interfaced to the AR system chargemaster. Others print the vendor software changes and manually enter changes into the system. In either case, a reconciliation should occur between the system and the vendor software database.

IX. Charge Integrity Monitoring

A. Many charges are related to diagnoses and/or devices. Consider monitoring to proactively ensure complete charges and codes are on accounts. Examples include:

1. Pacemaker or defibrillator insertion:
 - a. Codes for procedure
 - b. Codes for pacemaker
2. Lab tests on cerebrospinal fluid:
 - a. Lab test charges
 - b. Lumbar puncture charge
 - c. Supply charge, if applicable
3. Injectable/infused drugs:
 - a. Chemotherapy with chemotherapy drug administration
 - b. Vaccines with vaccine administration
 - c. Infusions with drug administration
 - d. IV solutions with hydration or infusion charges
4. CT or MRI with contrast:
 - a. Check for contrast charges

B. Programming the reports

1. Timing
2. Associations/fields
3. Who will work the reports/work queues?
 - a. Putting accounts on bill hold?
 - b. Working edits in a timely manner—concept to ~~consider~~:consider those that make the error, correct the error.

C. Resolving root cause problems and accountability.

ATTACHMENT A

Revenue Integrity Specialist JOB DESCRIPTION

The Revenue Integrity Specialist is primarily responsible for resolving claim edit/coding issues and supporting revenue capture and review of clinical services/procedures within specified revenue producing departments throughout the Health System.

JOB QUALIFICATIONS:

	Minimum Qualifications	Preferred Qualifications
Experience	3 years experience in the health care industry, with at least one year in an accounting-type position or a coding position. Experience in medical record documentation with emphasis on Medication Administration Records, CPT and HCPCS coding rules and billing procedures.	
Education	Associate degree or equivalent. Medical terminology. Coding course or equivalent (coding systems include CPT4, HCPCS, and ICD-9).	
Certification/ Registration/ Licensure/ Age-Specific Competency	Possession of a valid Driver's License with proof of safe driving record for the past ten years and proof of insurance may be required	Accredited Records Technician - certified by Medical Record Association (see RHIT), Registered Records Administrator, Certified Coding Specialist, or Certified Procedural Coder with outpatient medication coding experience. LPN with hospital experience. Paramedic licensure.

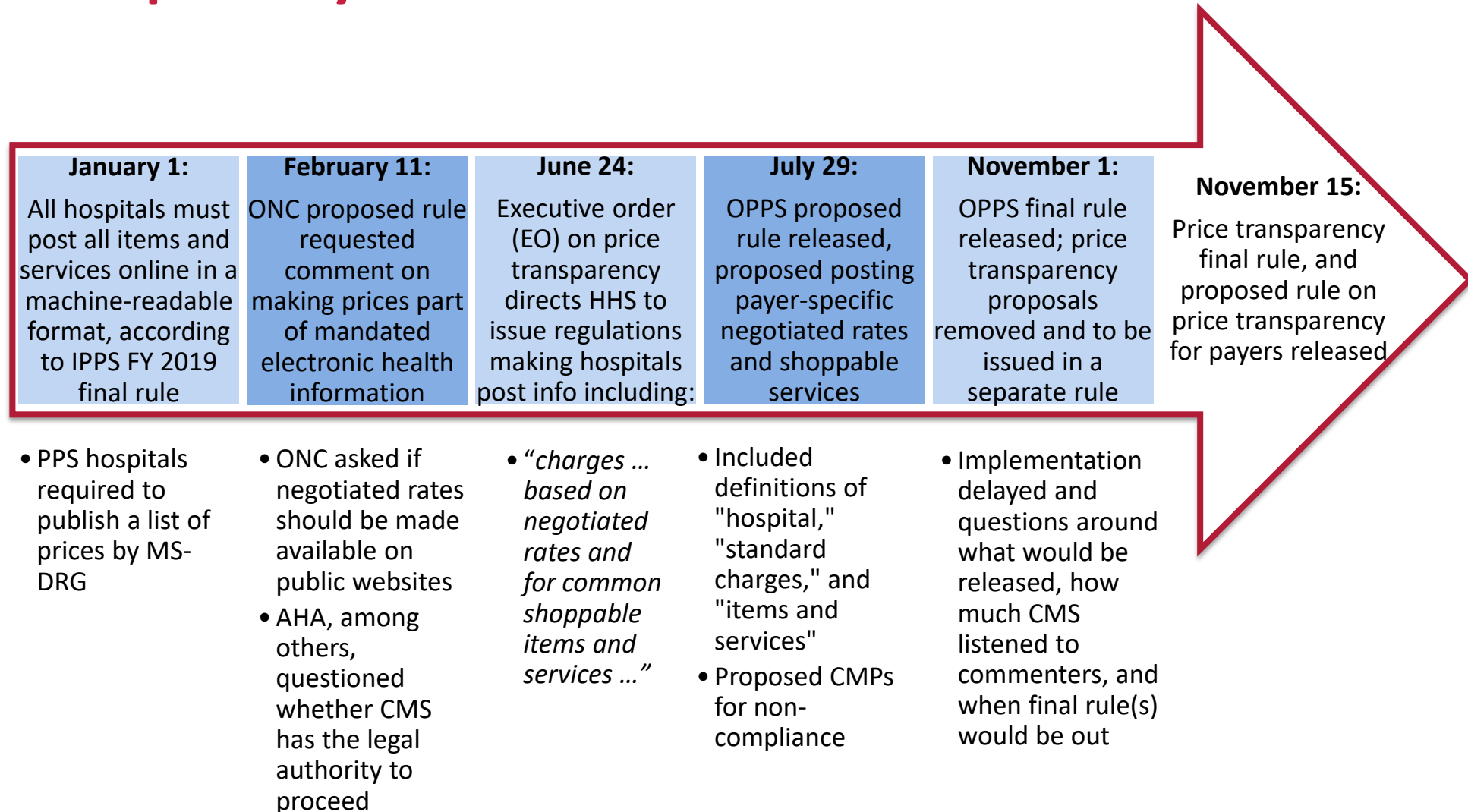
Analytical Skills/ Customer Relations Skills/Teamwork/ Professionalism	Ability to analyze data. Must be able to work independantly, organize and prioritize work. Must have good math and communication skills. Ability to accurately produce detailed work. Ability to function as a team member and communicate appropriately with other departments, particularly Business Office, revenue department managers/directors & charge capture staff and HIS Coders. Flexible regarding work schedule. Must be able to travel between hospitals. Demonstrated computer and typing skills including Microsoft Office applications.	Knowledgeable of AR system files and capable of performing computer queries.
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JOB DESCRIPTION:

Accountabilities and Performance Standards	
1	<p>Responds to Business Office Patient Account Representative emails concerning claim edits for coding or other charge related issues.—. Resolves claim edit<u>edit</u>, if possible, with review of medical record, as necessary and charge credit/modifier application as appropriate.—.</p> <p>Measurement – Feedback from Business Office and Medical Records concerning timely response and effective resolution of claim edit issues.</p>
2	<p>Analyzes and trends claim edit issues for root cause resolution to include charge master corrections, department charge capture education, coder education or other process improvements.</p> <p>Measurement – Claim edits in HIM, <u>SYSTEM</u> and Clearinghouse are reduced/minimized as reported by Business Office.</p>
3	<p>Captures appropriate drug administration charges on outpatients from a review of the medication administration records.—.</p> <p>Measurement – Maintains drug administration gross revenue levels comparable to previous time periods adjusted by volume of patients.</p>

4	Works with Charge Capture Specialists, Nurse Managers, Department Managers, Nurse Auditors <u>Auditors</u> , and other departmental staff to identify process improvements for effective charge capture. Measurement – Charge errors/omissions reduced as reported by Nurse Auditors and the late charge report.
5	Works with Charge Capture Specialists, Nurse Managers, Department Managers, Nurse Auditors <u>Auditors</u> , and other departmental staff to perform coding and billing reviews to identify opportunities to improve charge capture through better documentation or use of departmental information systems. Measurement – increased revenue before and after process improvement and feedback from managers/directors regarding effectiveness of reviews
6	Analyzes drug administration charges to determine improved methods of charge capture to include specialized Pharmacy Information System, Medication Administration Record/Checking system or <u>SYSTEM</u> reports/queries and other means for automating charge capture. Measurement – reduced days in billing holds for outpatient claims held for drug administration charges
7	Monitors CMS transmittals and other coding educational resources to ensure knowledge of charge capture remains up-to-date and in compliance with governmental billing rules. Measurement – denials related to obsolete codes or inappropriate charge practices are few to none.
8	Works collaboratively with Revenue Integrity Director to develop educational materials for Charge Capture Specialists, Nurse Managers, Department Managers, Nurse Auditors <u>Auditors</u> , and other departmental staff to keep them up-to-date and in compliance with governmental documentation, coding and charge capture rules. Measurement – Feedback from departments on value and effectiveness of education.

Price Transparency Overview

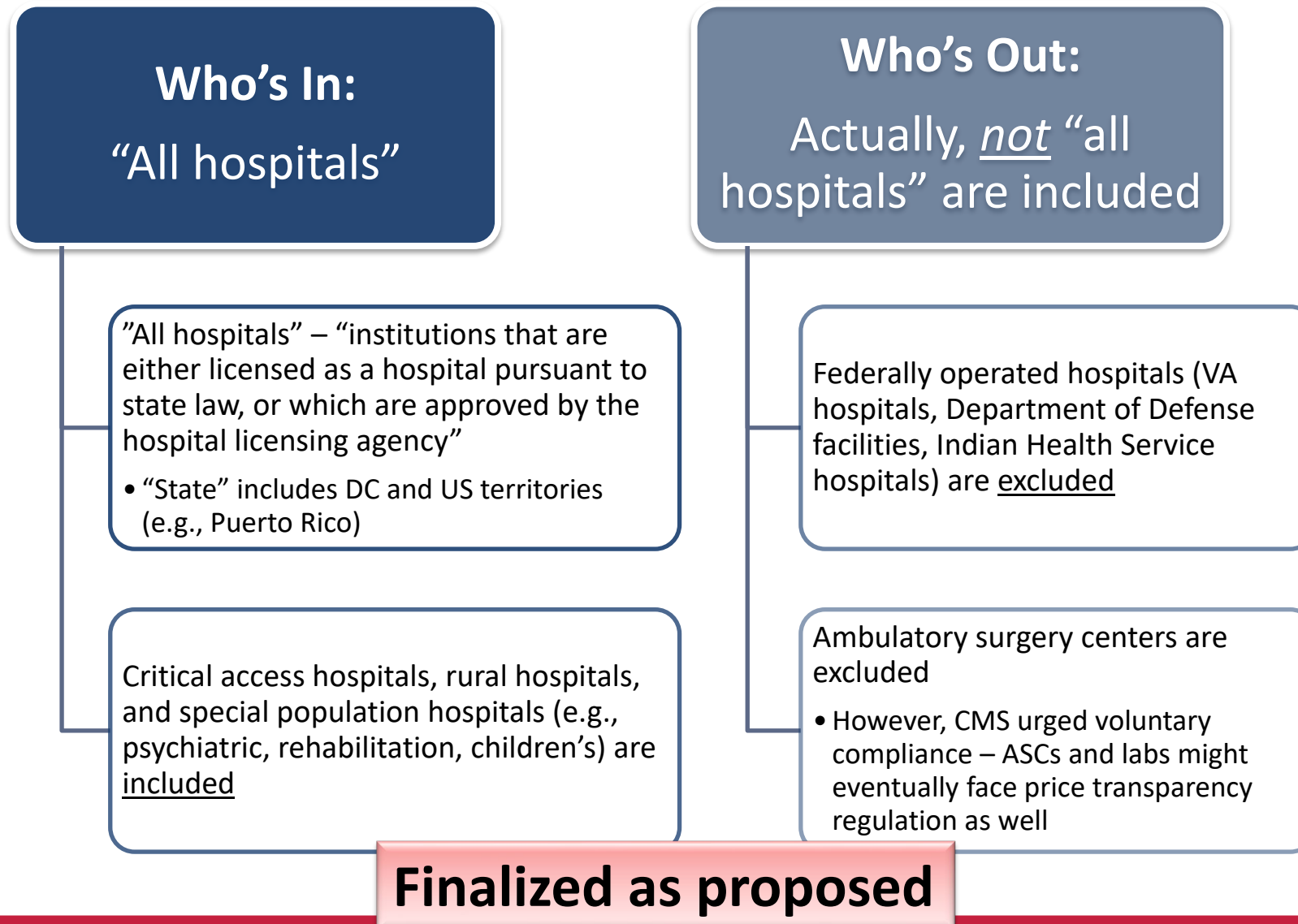


Overview of the Major Finalized Hospital Price Transparency Provisions

Finalizing Price Transparency in Part 180, Title 45 of the *CFR*

- (1) a definition of “hospital”
- (2) definitions for five types of “standard charges” (gross charges and payer-specific negotiated charges, as proposed, discounted cash price, de-identified minimum negotiated charge, and de-identified maximum negotiated charge) hospitals required to make public
- (3) definition of hospital “items and services” that would include all items and services (both individual and packaged) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit
- (4) federally owned/operated facilities are deemed to have met all requirements
- (5) requirements for making public a machine-readable file that contains all five types of charges
- (6) requirements for making public charges for 300 “shoppable” services that are displayed and packaged in a consumer-friendly manner, plus a policy to deem hospitals that offer Internet-based price estimator tools as having met this requirement
- (7) monitoring hospital noncompliance with requirements for publicly disclosing standard charges
- (8) actions to address hospital noncompliance, issuing a written warning, requesting corrective action plan (CAP), and imposing civil monetary penalties (CMPs) on noncompliant hospitals and publicizing these penalties on a CMS website
- (9) appeals of CMPs

“Hospitals”: Who’s In, Who’s Out



Defining Included Items and Services

<p>Definition applies not to just individual items/services, but also to "services packages"</p>	<p>Definition: Items and services provided by a hospital pursuant to an inpatient admission or an outpatient department visit for which the hospital has established a standard charge</p> <hr/> <p>Included items/services: Room and board, supplies, facility fees, procedures, etc.</p> <hr/> <p>Included items/services: A service package is a single charge or per diem rate for an aggregation of individual items or services for a common procedure or patient characteristic that has one single charge inclusive of separate individual items and services furnished</p>
<p>Professional charges are counted as a service</p>	<p>This means charge information would be required to be posted for services provided by employed physicians and non-physician practitioners</p> <div data-bbox="917 1263 1630 1378"> <p>Finalized as proposed</p> </div>

Price Transparency: “Standard Charges”

CMS requires the posting of “standard charges” and defines 5 types, adding three types to the initially proposed two

Gross charges (chargemaster charges)

Cash-discounted price (if hospital has one, otherwise post gross charge)

Payer-specific negotiated rates (for each item/service/“service package”)

Minimum deidentified negotiated payer rate for item/service/“service package”

Maximum deidentified negotiated payer rate for item/service/“service package”

Hospitals required to display all five types of “standard charges” in “machine-readable” single file on the hospital website

CMS acknowledged in the final rule language that payer-specific rates were not in the chargemaster, but stated they were in hospital billing systems or in rate tables in contracts

Text in red was what was added or revised in the final rule

Public Posting of Charges and File Format

Building on the IPPS FY 2019 final rule guidelines update, CMS requires posting of “standard charges” for “all items and services provided by the hospital” online:

The first of two required postings is for hospitals to post a single comprehensive, machine-readable file

- Each hospital location must publish its own file
- Machine-readable means formats like CSV, JSON, XML format (not PDF)
- Annually updated, with date of last update indicated

The file must be “prominently displayed,” must be searchable, and can’t require email address or information input to access

CMS finalized a naming convention for the file:
`<ein>_<hospital-name>_standardcharges.[json | xml | csv]`

It must contain the following:

- Descriptions
- Gross charges and “payer-negotiated specific charges” and the payer associated with the charge
- Cash-discounted charge, if applicable
- Deidentified min negotiated charge
- Deidentified max negotiated charge
- Applicable setting (inpatient/outpatient) if charges are different by setting
- Billing code (DRG, CPT, HCPCS, NDC or other applicable codes), ~~revenue code~~

Text in red was what was added or revised in the final rule

Public Posting of "Shoppable Services"

Text in red was what was added or revised in the final rule

Display Requirements

- Hospitals to display payer-specific charges for primary service ~~or service package~~ alongside related ancillary items/services
 - "an item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service"
- Display = plain language description of the services, location where provided, and primary billing code
- CMS did not specify a format, but suggested developing/using an application programming interface (API); **said hospitals could display a "flat file" or separate files for each payer in final rule**

Number of Services Requirements

- 300 total services must be displayed
- Hospitals would be required to post as many of 70 listed shoppable services the hospital provides (Table 37): E&M Services, Lab and Pathology, Radiology, Medicine, General Surgery
- To reach the 300 required number, **CMS suggested finalized selecting services based on the utilization or billing rate of the services in the past year**
- **CMS will deem a hospital as having met the shoppable services requirement if they have in a consumer-friendly manner an internet-based price estimator tool that provides estimates for as many of the 70 CMS-specified shoppable services provided by the hospital, and as many additional hospital-selected shoppable services and that allows consumers at the time they use the tool obtain an estimate of the amount they will be obligated to pay**

Requirement to create a display of "shoppable services" (aka, services/~~service packages~~ that can be scheduled in advance), from the required machine-readable file of "all items and services

Price Transparency Enforcement

- CMS said it would monitor compliance by evaluating individual or entity complaints about non-compliance, but may eventually initiate its own audits of hospital websites
- CMS proposes the following penalties:
 - Written notice of non-compliance
 - Requirement of a corrective action plan
 - Civil monetary penalties (maximum daily amount of \$300) and being called out on the CMS website; per day maximum for 365 days equals \$109,500
- Providers would have some recourse through an appeals process

Finalized as proposed

Transparency in Coverage Proposed Rule

- **Negotiated rates on public website:** health insurance companies and group health plans that cover employees proposed to be required to disclose negotiated rates for in-network providers and allowed amounts paid to out-of-network providers
- **Transparency tool:** insurers proposed to be required to offer a transparency tool to members that would provide personalized out-of-pocket cost information for all covered services in advance
- **Comments due:** January 14, 2020

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB93

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 147 and 158

[CMS- 9915 -P]

RIN 0938-AU04

Transparency in Coverage

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rule.

Comments due: January 14, 2020



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Hospital Price Transparency Final Rule

Tuesday, December 3, 2019

Presenters:

Dr. Terri Postma
Heather Grimsley



Acronyms in this Presentation

- **ALJ** – Administrative Law Judge
- **DRG** – Diagnosis-Related Group
- **EO** – Executive Order
- **HCPCS** – Healthcare Common Procedure Coding System
- **PII** – Personal Identifying Information



CY 2020 Hospital Outpatient Prospective Payment System Policy Changes: Hospital Price Transparency Requirements^{16 - 22}

- On November 15, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services
- [Final rule:](#)
 - Further advances the agency's commitment to increasing price transparency
 - Requirements apply to each hospital operating in the United States
 - Effective date is January 1, 2021



Increasing Price Transparency of Hospital Standard Charges

16 - 23

- On June 24, the President signed an [Executive Order](#) (EO) on Improving Price and Quality Transparency in American Healthcare to Put Patients First:
 - It is the policy of the Federal Government to increase the availability of meaningful price and quality information for patients
 - The EO directed the Secretary of HHS to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information
- The final rule implements Section 2718(e) of the [Public Health Service Act](#) and improves upon prior agency guidance that required hospitals to make public their standard charges (defined as the hospital's chargemaster charges) upon request starting in 2015 (79 FR 50146) and subsequently online in a machine-readable format starting in 2019 (83 FR 41144)
- Section 2718(e) requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act



Who Must Comply? Definition of 'Hospital'

16 - 24

- The final rule defines 'hospital' to mean an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing:
 - A State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands
 - The definition includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements)
 - Federally owned or operated hospitals (for example, hospitals operated by an Indian Health Program, the U.S. Department of Veterans Affairs, or the U.S. Department of Defense) are deemed to be in compliance with the requirements for making public standard charges



What are Hospital 'Standard Charges'?

16 - 25

- CMS finalized the definition of 'standard charges' to include the following:
 - Gross charge: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts
 - Discounted cash price: The charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service
 - Payer-specific negotiated charge: The charge that a hospital has negotiated with a third party payer for an item or service
 - De-identified minimum negotiated charges: The lowest charge that a hospital has negotiated with all third-party payers for an item or service
 - De-identified maximum negotiated charges: The highest charge that a hospital has negotiated with all third-party payers for an item or service



Which Hospital 'Items and Services' Are Included?

16 - 26

- CMS finalized the proposal to define hospital “items and services” to mean all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge
- Examples include, but are not limited to, the following:
 - Supplies and procedures
 - Room and board
 - Use of the facility and other items (generally described as facilities fees)
 - Services of employed physicians and non-physician practitioners (generally reflected as professional charges)
 - Any other items or services for which a hospital has established a standard charge



Two Required Ways for Making Public Standard Charges

16 - 27

Hospitals must make public their standard charges in two ways:

1) Comprehensive Machine-Readable File

- A single machine-readable file that contains all five types of standard charges for all the items and services provided by the hospital
- Based on public comment, we believe this information and format is most directly useful for employers, providers, and tool developers who could use these data in consumer-friendly price transparency tools or who may integrate the data into electronic medical records and shared decision making tools at the point of care; and

2) Consumer-Friendly Shoppable Services

- A consumer-friendly list of some types of standard charges for a limited set of “shoppable services” (including 70 CMS-specified and 230 hospital-selected) provided by the hospital
 - A ‘shoppable service’ is a service that can be scheduled by a health care consumer in advance
- We believe these requirements will allow health care consumers to directly make apples-to-apples comparisons of common shoppable hospital services across health care settings



Requirements for Making Public All Standard Charges for All Items and Services in a Machine-Readable Format^{16 - 28}

- Each hospital location operating under a single hospital license that has a different set of standard charges must separately make public the standard charges that are applicable to that location
- Required Data Elements:
 - A description of each item or service
 - All standard charges (gross charges, payer-specific negotiated charges, discounted cash prices, minimum and maximum negotiated charges) that apply to each item or service when provided in, as applicable, the hospital inpatient and outpatient department setting
 - Any code used by the hospital for purposes of accounting or billing for the item or service, for example, HCPCS codes, DRG codes, or other common payer identifier



Requirements for Making Public All Standard Charges for All Items and Services in a Machine-Readable Format ^{16 - 29}

- Format
 - The information must be published in a single digital file that is in a machine-readable format
 - **Machine-readable format** means a digital representation of data or information in a file that can be imported or read into a computer system for further processing
 - Examples of machine-readable formats include, but are not limited to, the following formats: .XML, .JSON, and .CSV
- Location and Accessibility
 - The file must be displayed prominently and clearly identify the hospital location with which the standard charges information is associated on a publicly available website using a CMS-specified naming convention
 - The hospital must ensure the data is easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to establish an account or password or submit Personal Identifying Information (PII), and is digitally searchable
- Updates
 - Data must be updated at least annually and clearly indicate the date of the last update (either within the file or otherwise clearly associated with the file)



Comprehensive Machine-Readable File: Sample Display of Gross Charges¹16 - 30

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		\$1,000.13	\$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		\$251.13	\$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		\$1,061.85	\$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				\$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				\$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				\$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				\$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			\$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			\$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			\$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	\$251.13	\$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	\$926.40	\$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	\$0.00	\$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		\$185.00		
GENETIC COUNSEL 15 MINS	S0265		\$94.00		
DIALYSIS TRAINING/COMPLETE	90989		\$988.00		
ANESTH, PROCEDURE ON MOUTH	170		\$87.00		

¹ Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.



Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner^{16 - 31}

- Hospitals must display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 shoppable services, including 70 CMS-specified shoppable services and 230 hospital-selected shoppable services:
 - If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must indicate that the service is not offered by the hospital, and select additional shoppable services such that the total number of shoppable services is at least 300
 - If a hospital provides less than 300 shoppable services, the hospital must list as many shoppable services as it provides
 - The shoppable services selected for display by the hospital should be commonly provided to the hospital's patient population



Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner^{16 - 32}

- For each shoppable service displayed, the hospital must:
 - Include a plain-language description of each shoppable service and any primary code used by the hospital for purposes of accounting or billing
 - Group the primary shoppable service with the ancillary services that the hospital customarily provides in conjunction with the primary shoppable service
 - Indicate the location at which the shoppable service is provided, and whether the standard charge for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both
- Format:
 - Hospitals have discretion to choose a format for making public the consumer-friendly information
- Location and Accessibility:
 - The information must be displayed prominently on a publicly available Internet location that clearly identifies the hospital location with which the information is associated
 - The information must be easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to register, establish an account or password or submit PII, and is searchable by service description, billing code, and payer
- Updates
 - Information must be updated at least annually and clearly indicate the date of the last update



Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner^{16 - 33}

- CMS will deem a hospital as having met the requirements for making public standard charges for 300 shoppable services in a consumer friendly manner if the hospital maintains an internet-based price estimator tool that meets the following requirements:
 - Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services
 - Allows health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay for the shoppable service
 - Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password



Sample Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	\$750
	Anesthesia (Medication Only)	[Code(s)]	\$122
	Physician Services	Not provided by hospital (may be billed separately) Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results		
	Facility Fee	[Code(s)]	\$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	\$54
Vaginal Delivery	Primary Procedure	59400	[\$]
	Hospital Services	[Code(s)]	[\$]
	Physician Services	Not provided by hospital (may be billed separately) Not provided by hospital (may be billed separately) Not provided by hospital (may be billed separately)	
	General Anesthesia		
	Pain Control		
	Two Day Hospital Stay	[Code(s)]	[\$]
	Monitoring After Delivery	[Code(s)]	[\$]

- CMS has the authority to monitor hospital compliance with Section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites:
 - Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may assess a monetary penalty after providing a warning notice to the hospital or after requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements
 - If the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital not in excess of \$300 per day, and publicize the penalty on a CMS website
 - The rule establishes an appeals process for hospitals to request a hearing before an Administrative Law Judge (ALJ) of the civil monetary penalty
 - The Administrator of CMS, at his or her discretion, may review in whole or in part the ALJ's decision



Effective Date

16 - 36

- In response to comments, CMS extended the effective date to January 1, 2021 to ensure hospital compliance with these regulations



Final List of 70 CMS-Specified Shoppable Services

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Evaluation & Management Services	2020 CPT/HCPCS Primary Code
Psychotherapy, 30 min	90832
Psychotherapy, 45 min	90834
Psychotherapy, 60 min	90837
Family psychotherapy, not including patient, 50 min	90846
Family psychotherapy, including patient, 50 min	90847
Group psychotherapy	90853
New patient office or other outpatient visit, typically 30 min	99203
New patient office or other outpatient visit, typically 45 min	99204
New patient office or other outpatient visit, typically 60 min	99205
Patient office consultation, typically 40 min	99243
Patient office consultation, typically 60 min	99244
Initial new patient preventive medicine evaluation (18-39 years)	99385
Initial new patient preventive medicine evaluation (40-64 years)	99386



Final List of 70 CMS-Specified Shoppable Services (continued)

16 - 38

Laboratory & Pathology Services	2020 CPT/HCPCS Primary Code
Basic metabolic panel	80048
Blood test, comprehensive group of blood chemicals	80053
Obstetric blood test panel	80055
Blood test, lipids (cholesterol and triglycerides)	80061
Kidney function panel test	80069
Liver function blood test panel	80076
Manual urinalysis test with examination using microscope	81000 or 81001
Automated urinalysis test	81002 or 81003
PSA (prostate specific antigen)	84153-84154
Blood test, thyroid stimulating hormone (TSH)	84443
Complete blood cell count, with differential white blood cells, automated	85025
Complete blood count, automated	85027
Blood test, clotting time	85610
Coagulation assessment blood test	85730

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Final List of 70 CMS-Specified Shoppable Services (continued)

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Radiology Services	2020 CPT/HCPCS Primary Code
CT scan, head or brain, without contrast	70450
MRI scan of brain before and after contrast	70553
X-Ray, lower back, minimum four views	72110
MRI scan of lower spinal canal	72148
CT scan, pelvis, with contrast	72193
MRI scan of leg joint	73721
CT scan of abdomen and pelvis with contrast	74177
Ultrasound of abdomen	76700
Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus	76805
Ultrasound pelvis through vagina	76830
Mammography of one breast	77065
Mammography of both breasts	77066
Mammography, screening, bilateral	77067

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Final List of 70 CMS-Specified Shoppable Services (continued)

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Medicine and Surgery Services	2020 CPT/HCPCS/DRG Primary Code
Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	216
Spinal fusion except cervical without major comorbid conditions or complications (MCC)	460
Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC).	470
Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC).	473
Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	743
Removal of 1 or more breast growth, open procedure	19120
Shaving of shoulder bone using an endoscope	29826
Removal of one knee cartilage using an endoscope	29881
Removal of tonsils and adenoid glands patient younger than age 12	42820
Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope	43235
Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope	43239
Diagnostic examination of large bowel using an endoscope	45378
Biopsy of large bowel using an endoscope	45380
Removal of polyps or growths of large bowel using an endoscope	45385
Ultrasound examination of lower large bowel using an endoscope	45391
Removal of gallbladder using an endoscope	47562
Repair of groin hernia patient age 5 years or older	49505
Biopsy of prostate gland	55700
Surgical removal of prostate and surrounding lymph nodes using an endoscope	55866
Routine obstetric care for vaginal delivery, including pre-and post-delivery care	59400
Routine obstetric care for cesarean delivery, including pre-and post-delivery care	59510
Routine obstetric care for vaginal delivery after prior cesarean delivery including pre-and post-delivery care	59610
Injection of substance into spinal canal of lower back or sacrum using imaging guidance	62322-62323
Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	64483
Removal of recurring cataract in lens capsule using laser	66821
Removal of cataract with insertion of lens	66984
Electrocardiogram, routine, with interpretation and report	93000
Insertion of catheter into left heart for diagnosis	93452
Sleep study	95810
Physical therapy, therapeutic exercise	97110

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Question & Answer Session



Resources

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- [Final Rule](#)
- [Press Release](#)
- [Fact Sheet](#)
- [Hospital OPPS](#) website
- PriceTransparencyHospitalCharges@cms.hhs.gov



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