# *Reimbursement Policy*

## High-Dollar Charge Validation

**REIMBURSEMENT POLICY NUMBER:** 20

**Effective Date:** 7/1/2025

**Last Review Date:** 6/2025

**Next Annual Review:** 6/2026



**INSTRUCTIONS FOR USE:** Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

## *SCOPE AND APPLICATION*

*Provider Type:*

☐ Professional Claims

☐ DMEPOS Suppliers

☐ All health care services billed on CMS 1500 forms

☐ All health care services billed on CMS 1500 forms, and when specified to those billed on UB04 forms

☒ Facilities

☒ All health care services billed on UB04 forms (CMS 1450)
Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☒ DRG

*Plan Product:*

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

**SCOPE:** Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☒ Modified DRG

☒ Percentage of billed charges/per diem

## POLICY STATEMENT

I. Providence Health Plan reserves the right to reprice high-dollar facility services when submitted charges do not align with the facility's Charge Description Master (CDM).

II. Items or services may be selected for high-cost review when billed on an inpatient or outpatient facility claim with supporting revenue codes, CPT, and/or HCPCS codes.

III. If the billed charges for the items or services selected for review exceed the pricing listed on the facility CDM, the **reimbursement will be reduced to the facility CDM pricing**.

   *A. In order to be considered for reimbursement, a corrected claim or additional facility documentation to support the reasonableness of the charges submitted will be required.*

IV. In addition to criterion II. and III. above, reviews of high dollar items or services may also include, but is not limited to, the following elements (A.-E.):

   A. Medical necessity of the item/service and the indication(s) it is being used for (including off-label device use); **and**
   B. Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and are considered routine services and not separately billable in the inpatient and outpatient environments; **and**
   C. Items or services that are wasted, broken, or destroyed; **and**
   D. Items or services that are determined to be duplicative; **and**
   E. Items or services that are determined to be inappropriate or excessive.

## *POLICY GUIDELINES*

**DOCUMENTATION REQUIREMENTS**

In order to provide an effective and accurate review, the following documentation **must** be provided. If any of these items are not submitted, the review may be delayed and any decision outcome could be affected:

- Detailed itemization of services rendered
- Rationale for charge variations
- Evidence supporting higher charges

## BACKGROUND

### Purpose

To ensure appropriate reimbursement for high-dollar facility services where billed charges are inconsistent with the provider's established Charge Description Master (CDM). This policy outlines Providence Health Plan's methodology for evaluating and repricing such services to ensure fairness, consistency, and alignment with industry standards.

### Charge Description Master (CDM)

Also known as a chargemaster. A comprehensive, hospital-maintained list of all billable services, procedures, items, and medications that a healthcare provider offers to patients. Each entry includes a charge code, description, price, and associated billing codes (like CPT, HCPCS, or revenue codes), which are used to generate claims and invoices.[1]

Key Functions of a CDM

*Billing Foundation*

CDMs drive the hospital billing process for services rendered to patients. Accurate and maintained CDMs ensure not only price transparency but correct patient billing.

*Pricing Transparency and Regulatory Compliance*

Under CMS's Hospital Price Transparency Rule (effective Jan 1, 2021), each hospital operating in the United States is required to provider clear, accessible pricing information online about the items and services they provide.[2] This information is intended to make it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going into the hospital.

*Coding, Reimbursement, and Payment Integrity*

CDMs link clinical services to revenue codes, CPT/HCPCS codes, and descriptions used in insurance claims billing to ensure accurate payment to both providers and facilities.

## DEFINITIONS

### Charge Description Master (CDM)

A comprehensive database that contains detailed information about healthcare services, procedures, and supplies, including their corresponding charges.[1]

### High-Dollar Services

Services with submitted charges that exceed standard thresholds as defined by internal analytics or industry benchmarks. For the purposes of this policy, high-dollar services are considered those items/services with billed charges meeting or exceeding $10,000.

**Repricing**

The process of adjusting submitted charges to reflect reasonable and customary rates, or to align with CDM-based pricing methodology.

## *CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)*

As of 5/1/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified:

- Centers for Medicare & Medicaid Services (CMS)Hospital Price Transparency Final Rule (CMS-1717-F2)[3]
- Affordable Care Act §2718(e)
- Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

## *CROSS REFERENCES*

- Facility Supplies and Services, RP43
- High Dollar Drug Review, RP10

**The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.**

## *REFERENCES*


1. MD Clarity. Charge description master (CDM) - RCM Glossary https://www.mdclarity.com/glossary/charge-description-master-cdm. Accessed 4/29/2025.
2. Centers for Medicare & Medicaid Services | Hospital Price Transparency https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency. Accessed 4/29/2025.
3. Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and payment Rates. Price transparency requirements for hospitals to make standard charges public. Federal Register. https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and. Published 11/27/2019. Accessed 4/29/2025.
4. American Medical Association. Current Procedural Terminology (CPT)© 2025 Professional Edition. 2025.
5. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS). 01/2018. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf. Accessed 4/29/2025.

## *POLICY REVISION HISTORY*

| Date | Revision Summary |
|---|---|
| 5/2025 | New policy |