Priority Health	BILLING POLICY No. 206
CHARGE MASTER POLICY	
Date of origin: 07/2026	**Review dates: 07/2026**

POLICY DESCRIPTION

Priority Health is committed to ensuring that facility chargemaster updates are reported accurately to ensure reimbursement is administered in accordance with contractual chargemaster provisions. Pursuant to facility agreements, Priority Health may conduct chargemaster validations to confirm that facility-reported chargemaster changes and associated charge increase percentages are accurate and consistent with contractual thresholds.

This policy establishes the process used to validate chargemaster changes, review resulting reimbursement impacts, and address identified discrepancies.

This policy does not amend facility agreements and is issued pursuant to existing contractual rights and obligations.

DEFINITION

Charge Master: The charge master, also known as the chargemaster, is a comprehensive listing of items billable to a hospital patient or a patient's health insurance provider. It serves as a master file that contains all necessary information about a hospital's charges, including rates for each service, and procedure.

MEDICAL POLICY

- N/A

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Facilities are expected to:

- Provide timely notification of chargemaster changes when required under their Agreement.
- Accurately report on chargemaster change percentages and support information requested by Priority Health.
- Maintain documentation supporting chargemaster updates and associated calculations.
- Cooperate with Priority Health requests related to chargemaster validation activities.

Validation Review

Priority Health retrospectively evaluates the financial impact of chargemaster changes using utilization-weighted analyses, claims experience, reported charge increase percentages, and other methodologies determined appropriate by Priority Health.

Findings and Facility Review

In the event a validation identifies a discrepancy, Priority Health will share findings with the facility. The facility will have thirty (30) calendar days from receipt of findings to submit additional information, clarification, or supporting documentation for consideration.

Remedies
Priority Health will review all submitted information and issue a final determination. Where validation identifies discrepancies that result in reimbursement exceeding contractual requirements or thresholds, Priority Health may pursue corrective action consistent with the applicable facility agreement, including adjustment of future payments, recovery of overpayments, or other remedies available under the agreement.

Disputes
The Facility may submit a written dispute with supporting documentation within thirty (30) days of receiving findings. Priority Health will then review the dispute and issue a determination within the next thirty (30) days. If the parties cannot resolve the matter informally, parties will follow the dispute resolution process outlined in the Agreement. If the Facility does not submit a dispute within the first thirty (30) days, the results are considered final.

Documentation
Not applicable

Resources
Provider Manual | Priority Health

Related policies
This policy is supported by applicable provisions of the Priority Health Facility Agreement, including but not limited to:

- Overpayment
- Payment Integrity Programs
- Facility Obligations
- Medical Record and Billing Reviews
- Compliance with Policies and Procedures
- Payment Administration
- Chargemaster

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
07/2026	Review. No changes are needed except for updating the format.