The charge process for surgical services includes eight components:

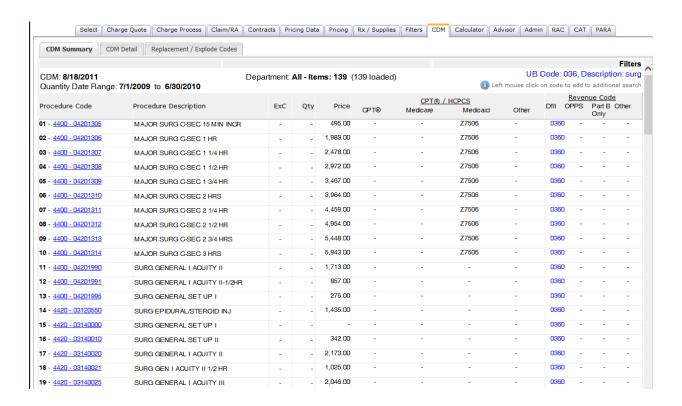
- 1. Pre-Operative Care
- 2. Anesthesia
- 3. Operating Room Time Charges
- 4. Equipment Charges
- 5. Recovery/Post-Anesthesia Care Unit (PACU)
- 6. Supplies
- 7. Drugs
- 8. Post PACU Care

Below is a summary of how each of these components applies to charging for surgical services.

Pre-Operative Care:

The pre-operative care includes the starting of IVs, administration of drugs, scrubbing and shaving of the patient. Pre-operative antibiotic IV therapy is separately billable as a nursing service if there is medical justification and a physician order.

It is not appropriate to charge for pre-operative care, the majority of hospitals have a cost center dedicated to this process; zero charges are used for the recording of workload.



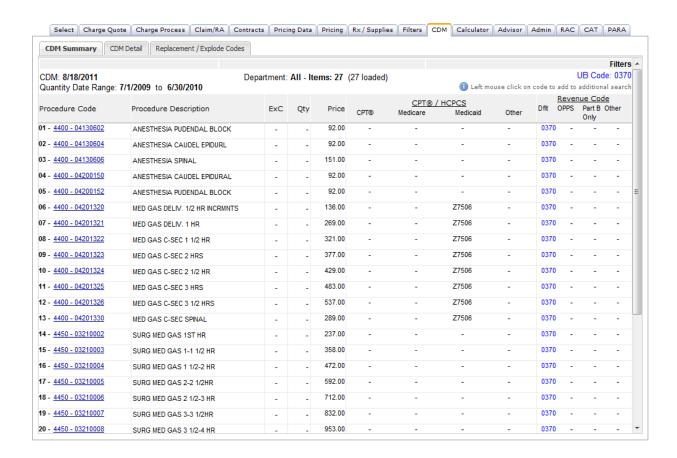
Anesthesia:

There are eight different types of anesthesia:

- 1. Local
- 2. Block
- 3. Epidural
- 4. Moderate Sedation
- 5. Monitored Anesthesia Care
- 6. TIVA
- 7. General
- 8. General with Block

Anesthesia services can be either charged individually for supplies, drugs, and gasses, but more common is a time-based charge for the type of anesthesia provided. Some managed care contracts do not allow the combination of both an itemized anesthesia service with a time-based charge.

Timing of anesthesia (CS, MAC and General) charges is based on the start/stop time recorded on the anesthesia record. The base time period is 30 minutes, with an add-on charge for each additional 15 minutes. Add-on periods are charged after the first five minutes of usage within the period.



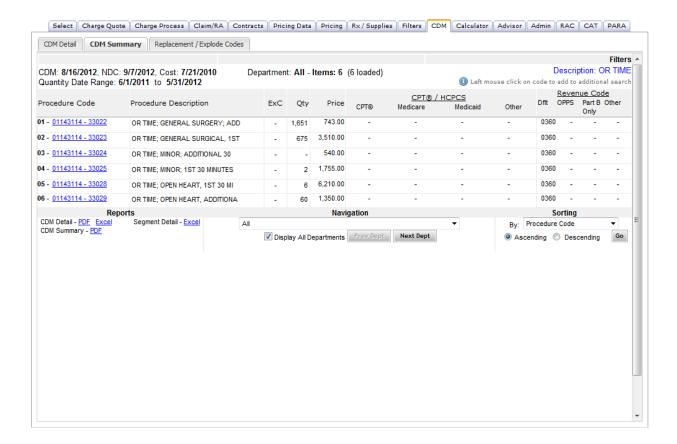
Operating Room Time Charges:

The operating room costs are classified into three different components, which are relieved by billing a time based level charge. The components of the OR room costs are:

- 1. Room Set-Up Time
- 2. Staff Surgical Time Charge (Nurses, Tech, and First Assistant) Charges
- 3. Rental/Special Equipment Charges

ParaRev recommends that the OR time charge be based on levels which are determined by the setup, staff, and equipment charges.

OR room time charges are based on the start/stop surgical time on the anesthesia record or "wheels in to wheels out." Add-on periods are charged after the first five minutes of usage within a period.



Equipment Charges:

Special and rental equipment are usually "packaged" into the OR room time charge by "bumping" a level, some Fiscal Intermediaries will allow the billing of equipment charges on an OR line on the UB04 claim form using revenue code 0360.

When determining the additional charges associated with new equipment, the following calculations can be used to ensure the cost of the equipment is factored into the cost of a procedure.

Cost Basis Charge Calculation		Market Basis Charge Calculation		Additional Cost Considerations
Capital Item Purchase Cost (include tax, shipping)	165,000	Geographic Peer Group Average Charge		Rental Cost
Useful Life Years (Standard is 5)	5	State Average Charge		Inpatient vs Outpatient
Residual Value (Standard is Zero)	0	National Average Charge		Packaged Services
Annual Depreciation Cost	33,000			Supplies
Annual Maintenance Cost	8,250	Reimbursement Basis Charge Calculation		Medications
Annual Expected Number of Procedures	255	APC Reimbursement	1.00	Payroll
Equipment Cost per Procedure	162	Projected Cange of Charge per Procedure (3x) - Low	3.00	Procedure Room
Expected Average Staff Time per Procedure (Minutes)	0	Projected Range of Charge per Procedure (5x) - High	5.00	Pre/Post Procedure
Average Staff Labor Cost per Hour	35			Anesthesia
Average Staff Benefit Cost (percent add-on)	20%	Charge per Procedure		Recovery
Staff Cost per Procedure	0			
Disposable Supply Cost per Procedure	500			
Total Cost per Procedure	662			
Projected Range of Charge per Procedure (3x) - Low	1,985.29			
Projected Range of Charge per Procedure (5x) - High	3,308.82			

Recovery/Post Anesthesia Care Unit Charges:

The required time a patient spends in the PACU is one hour for general anesthesia, with a nurse to patient ratio of 1:1. After the patient is attended for a minimum period and the nurse assessment determines the patient requires a lower staffing ratio, a nurse can attend to two patients.

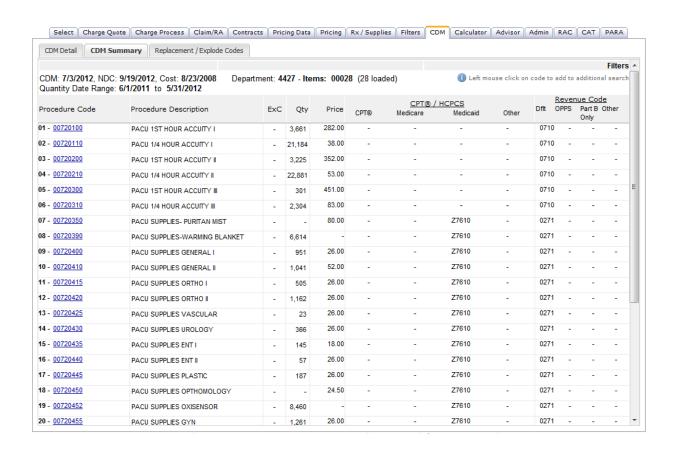
MAC anesthesia patients are to be observed for a minimum of 30 minutes.

Children are usually 1:1 nurse to patient ratio all of the time.

Charges for PACU may be set as follows:

- 1. PACU- 1st hour 1:1 ratio
- 2. PACU- additional 15 minutes 1:1 ratio
- 3. PACU- additional 15 minutes 1:2 ratio

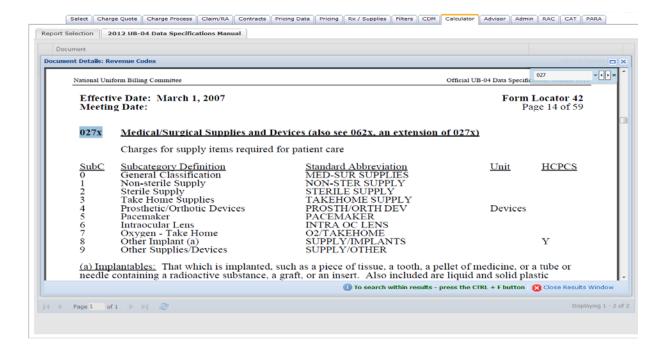
However, it is also appropriate to charge by the minute. Timing of the PACU charges are based on the PACU admit/discharge times recorded on the PACU record.



Medical Supplies:

There are seven types of supplies used in the OR, some of which should not be charged to the patient. The various types of supplies and the billing status for each are as follows:

- 1. *Routine items* Low cost, bulk stock items (i.e. Band-Aids, syringes, wipes, gowns, gloves, drapes, and packs) are not to be charged. The cost is to be billed using the OR time charge.
- 2. *Sterile* Higher cost items are itemized on the charge form; multiple units are allowed. These items are to be billed with a HCPCS code (if possible) and 0272 revenue code.
- 3. *DME exempt* These are DME items which can be billed to the Medicare program, they include orthotics (splints, braces, collars, and belts.) These items are billed using a HCPCS code and a 0274 revenue code.
- 4. *DME non-exempt* Non-billable DME items (i.e. crutches, canes, and walkers) are not to be billed to the Medicare program on a bill type UB04.
- 5. *Implants* Hard items which remain in the patient post-procedure, these items may have a HCPCS code and are billed using a 0278 revenue code.
- 6. *IOL Lenses* Billed using a HCPCS code (if possible) and a 0276 revenue code. High cost lenses can be billed to the patient (lens cost less the \$150 Medicare allowance.)
- 7. Pacemakers- Requires a HCPCS code and a 0275 or 0278 revenue code.



Hospitals should be cautious when billing for supplies. Medicare considers some supplies routine and not separately billable, other are covered, billable, and payable, and some are covered and billable but packaged and not separately paid.

The following criteria should be met to determine when to separately bill for supplies according to the Medicare Provider Reimbursement Manual, Section 2203.2:

- 1. Directly identifiable to a specific patient
- 2. Furnished at the direction of a physician because of specific medical needs (this must be documented in the patient's medical record)
- 3. Either not reusable or representing a cost for each preparation

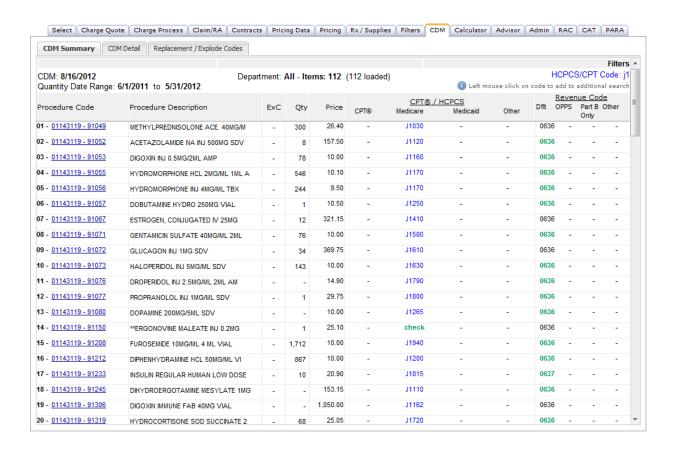
Adminastar Federal, a Fiscal Intermediary, also created a checklist for determining billable supplies. Adminastar Federal also used the Medicare Provider Reimbursement Manual, Section 2203.2 as a guide in creating this checklist:

- 1. Is the item medically necessary and furnished at the discretion of a physician? (Not a personal convenience item such as slippers, powder, lotion, etc.)
- 2. Is the item used specifically for or on the patient? (Not gowns, gloves, masks, used by staff or oxygen available but not specifically used by the patient.)
- 3. Is the item not ordinarily used for or on most patients or was the volume or quantity used for one patient significantly greater than normally used for or on most patients in the billed setting? (Not blood pressure cuffs, thermometers, patient gowns, soap.)
- 4. Is the item not basically stock (bulk) supply in the billed setting and the amount or volume used is typically measured or traceable to the individual patient for billing purposes? (Not pads, drapes, cotton balls, urinals, bedpans, wipes, irrigation solutions, ice bags, IV tubing, pillows, towels, bed linen, diapers, soap, tourniquet, gauze, prep kits, oxygen masks, and oxygen supplies, syringes.)

There is not an all-inclusive list of billable supplies. Facilities must create a process to use in determining the billable status of a supply that is used for all supply items. As with any billable item, documentation and medical necessity must be substantiated in the patient's medical record.

Drugs:

All drugs are to be charged; multiple units allowed. The nursing service to administer the drugs is **not** billable.



Post PACU Care:

Routine care provided to a patient post-PACU and prior to discharge is **not** separately billable to the Medicare program.

https://apps.para-hcfs.com/pde/documents/PARA ObservationChargingBillingComplianceAndReimbursement April 2012.pdf

Observation – Charging, Billing, Compliance and Reimbursement

290.2.2 - Reporting Hours of Observation

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services. Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). Observation time ends

Example Perioperative Charge Process Point System:

ParaRev recommends creating a point system for OR, Anesthesia, and PACU level determinations. Below is an example of a recommended point system.

Pre / Post PACU + Set-up Time - Minutes	Points	Operating Room Staff	Points	Extensive Equiptment Use	Points
<30	0	1	1	Yes	1
31 -> 90	1	2	2	No	0
91 -> 120	2	3	3		
		4	4		
		5	5		
OR Level Determination	# of Pts				
Pre / Post / SU					
OR Staff					
Equiptment					
Total					
OR Level Points	1st Hour time charge	Additional 1/4 time charge			
1					
2					
3					
4					
5					
6					
7					
Anesthesia Type	Time Basis	1st Hour / Initial Procedure	Additional 1/4 Hours / Subsequent procedures		
General	Elapsed time				
TIVA	Elapsed time				
MAC	Elapsed time				
IV Sedation	Elapsed time				
Epidural	One time		N/A		
Block	One time		N/A		
Local	One time		N/A		
Pain	Per Injection				
	. er injection				
PACU - Nurse Patient Ratio	1st Hour time charge	Additional 1/4 time charge			
1:1					
1:1					
ICU Holding					