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Take care with your ancillary anesthesia charges

A column on managing the OR revenue cycle

How to charge for surgical services is a frequent source of questions from OR directors and business managers. In this column, Keith Siddel, MBA, answers frequent questions about charging. He is an officer with Health Revenue Assurance Associates (HRRA), Plantation, Florida.

Q We have heard about a suit against some California hospitals over anesthesia charges. What should we be aware of regarding anesthesia billing?

Siddel: The suit was filed in April 2011 by an auditing company against Sutter Health, a dominant health system in Northern California and a managed care company, alleging false billing of anesthesia services.

In court filings, the auditing company alleged that the hospitals misused the 37x anesthesia code that is used to bill for ancillary services, such as an anesthesia tech, anesthetic gases, and anesthesia-specific disposables. The suit alleged that the hospitals appeared to charge this code even for cases performed only with local or regional anesthesia and for radiology patients when there was no indication of anesthesia being provided.

Because these charges are alleged to be for services not actually rendered, the suit alleged the charges are "fraudulent, false, and misleading" under California law.

Further, the suit contended that when the 37x code was billed legitimately, the charge was for the entire time the patient was in the OR, though this code is not intended to be used on a time basis. For example, court papers say, one hospital's chargemaster had a 37x code set at $1,610.55 for the first half hour of OR time, or part thereof, and $457.50 for each 15 minutes thereafter, resulting in charges of $3,000 to $5,000, when such ancillary charges typically are no more than $150 to $250.

The case is in discovery with a trial date of January 2013, according to the auditing company's law firm.

Sutter denied the allegations and said it is "committed to compliant billing and charging practices."

The message for readers: If this suit is successful, hospitals will need to restructure their anesthesia charges. It might be wise to consider examining your current charge structure sooner rather than later.

Though this lawsuit breaks new ground and attempts to limit what can be billed under specific revenue codes, this isn't the same as if we had received this information from the Centers for Medicare and Medicaid Services (CMS). Nevertheless, if you can alter your anesthesia charges to avoid scrutiny in the future, it may be something you should consider. Keep in mind that in most cases, any changes in this area can be made with virtually no financial impact.

Keep an eye on developments.

Q We have several levels of charges for OR time. One criterion is the number of personnel in the room. Can we include an assistant employed by a surgeon whose practice is owned by the hospital? Also, should we include the radiology tech?

Siddel: You should not include the assistant because that cost belongs to the physician. Because hospital charges are designed to reflect hospital costs, I wouldn't include an assistant employed by a surgeon in your OR time charge.

It's fine to include the radiology tech because the tech is on the hospital payroll. But that can lead to a mismatch between the department incurring the cost (the radiology department employing the tech) and the department gaining the revenue (the OR), which isn't a good accounting practice.

Q How should we handle billing for an implant that is wasted?

Siddel: Let's say you open an implant, a surgeon tries it, and it doesn't fit. If your hospital has to pay for it, you can bill the patient. You will get audited, but it is defensible. You want to make sure this doesn't happen a lot.

If you have to discard an implant that the hospital has paid for and use a second one, it is acceptable to bill for both, provided there is a medical reason that the first implant didn't work. If you opened two packages not knowing which one would work, that is not a medical reason. Likewise, if the implant failed or was flawed, that is not a sufficient reason. But if the surgeon attempted to fit an implant to the patient, it turned out to be the wrong size, and the vendor billed the hospital for the implant you attempted to insert, this may be billable.

Q If our hospital buys 5 implants and gets one free, how do we decide which patient gets one for free?

Siddel: You can't give the 6th implant away free. You must calculate an average price for all 6 implants based on the price you paid for 5 and consider that the cost per implant. Then each patient is billed the same amount.❖

Have a question on the OR revenue cycle?

Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com.

At the OR Manager conference, October 24-26, in Las Vegas, you can hear Siddel's breakout, Taming the Charge Master.

Siddel will discuss how OR time should be charged, how to recover costs for equipment, and how Medicare determines implant costs. This session is part of the OR business manager track.

You can also reach Siddel at ksiddel@hraa.com.