The OR consumes the most expensive and often the highest volume of supplies in the hospital. OR managers want to make sure their chargemasters are up to date so patient bills will accurately reflect services provided. They also want to make sure they are complying with the complicated billing and reimbursement regulations.

In this series, Keith Siddel, MBA, an expert on health care business operations, answers questions about charging in surgical services. He is CEO of HRM Consulting, Creede, Colorado.

Part 1 addressed OR time charges. This part focuses on maintaining the chargemaster and charging for supplies.

**Q What do you suggest as best practices for maintaining the OR chargemaster?**

*Siddel:* There are 2 philosophies. One philosophy says, “Our OR charges are only departmental operations charges.” Under this philosophy, supplies are seen as a function of the central supply or materials management department, and that department is responsible for setting up and managing those charges. The OR then uses the same supply numbers and charge tickets as any other department. Accountability rests with central supply or materials management.

The other philosophy is that each department stands alone and is its own revenue center. The OR orders its own supplies, maintains its own inventory, and is responsible for assigning charges.

It doesn’t matter which philosophy is used as long as accountability is there. There should be also a standard process for categorizing supplies and assigning a markup regardless of where the accountability rests.

**Q What is your advice on managing the charging process?**

*Siddel:* The first step in charging is to assign the new device to a category. The second step is to apply the markup to set the price, and the third step is assigning the correct revenue code and CPT/HCPCS code. This can be a challenge, and a mistake at any point can result in lost revenue.

Managing the process needs to involve several departments and takes coordination. The business office assigns the revenue code and often the general ledger code. The health information management department (HIM) assists in assigning the correct CPT or HCPCS code. I say “assists” because HIM doesn’t necessarily understand what the item is or how it is used. So a clinical person also needs to be involved. A cost accounting per-
son also can be involved to ensure the charge structure results in a clean cost report. Some organizations have a revenue cycle department or guru who manages this process.

Often a vendor will suggest a code to use. I caution clients not to accept what vendors say carte blanche. That is not to say vendors are misleading, but often they are no more qualified to assign a code than you are without the right information, and they often pick the code that reimburses the most because it looks good for the sales process.

Regarding the markup, historically, hospitals have not marked up high-cost items as much as low-cost items. Let’s say a hospital buys a supply for $10; it may not have a problem charging $100 for that. On the other hand, if a device costs $25,000, the hospital won’t mark it up by 10 times. This is a situation CMS (Centers for Medicare and Medicaid Services) is trying to rectify. In the final IPPS (inpatient prospective payment system) rules for 2009, CMS indicated that it is beginning to focus on the cost markup for supplies. Remember, CMS uses a generic formula to ascertain your costs for supplies. An example is the $10 item for which you may be charging patients $100. CMS would look at your overall cost-to-charge ratio, which may be 40%. Under the formula, CMS would assume the $100 item really cost you $60 rather than $10. To solve this problem, CMS now requires providers to designate “high-cost supply items” from all other supply items. Most important—this is only the first step in this initiative.

Q How do you decide when an item is separately chargeable and/or separately billable?

Siddel: Ever since I have been in health care, we have begged CMS and other payers to come out with a list of what is chargeable. Unfortunately, there is no hard-and-fast list. Therefore, you need to go by broad categories.

There are things that are not chargeable—you can’t even put them on the bill—and things you can put on the bill but won’t be paid for. Generally, you won’t be paid for 80% of supplies anymore, but that doesn’t mean you shouldn’t charge for them. I will explain why later.

These are the broad categories of items that are not separately chargeable. (See the sidebar for descriptions of chargeable, billable, and other common charging terms.)

Routine supplies used for the staff

Any supplies used by the staff in providing services may not be separately charged or billed. That includes items like gowns, gloves, and hats.

Routine supplies used by the patient

The general rule is that any item used 70% of the time for most of your patients is not separately chargeable or billable. A lot of commercial payers say that if you don’t document an item, you can’t charge for it.

You also can’t charge for personal items given to patients, such as Kleenex. I tell providers this includes anything a hotel wouldn’t charge you for, like shampoo or toothpaste.

In the OR, this can get tricky. For example, you would not charge for a cover on a light handle because that is routine. But what about items used only when you perform a particular procedure? Most providers and CMS have never defined routine as being an item “routinely” used only for a certain type of procedure. When considering whether something is routine, look at the general patient population in a particular care area.
Capital equipment

Most capital equipment is not separately chargeable because these are items that are depreciated on the cost report.

Q Why should you charge for an item if you know you are not going to be paid?

Siddel: In today’s world, you have to know your costs. If you don’t know your costs, you won’t know where your problem areas are or where you need to grow or shrink your business. Unless you have a good cost-accounting system, charging for items is the only way you will know what you have used on a patient. You also need to know how much it costs, for example, for Dr X to perform an appendectomy.

In deciding whether to charge for an item, you also need to weigh the cost of the charging process. There is a cost associated with the process of tracking, monitoring, and assessing the charge. A lot of facilities say that if an item costs less than $100, they will not charge for it because it costs too much to generate and capture the charge.

Q What are the risks of charging for an item that is used off-label?

Siddel: This brings up the issue of medical necessity, which is a two-fold issue. The issue starts with the physician, who must decide what is medically necessary based on the patient’s condition. The payer also decides what is medically necessary. More and more, Medicare and other payers are drawing the line on medical necessity.

If a physician knowingly uses or prescribes something you believe may not be covered or appropriate, you need to have the patient sign an ABN (advanced beneficiary notice). An ABN notifies the patient that Medicare may not pay for the item. Then if Medicare doesn’t pay, you can bill the patient.

You also need your compliance and legal departments to sign off. That’s not to say the patient shouldn’t get the item. What you need to tell the patient is, “Your physician believes this is medically necessary. Your insurer may or may not believe it’s medically necessary. If they decide it’s not, you will need to pay for it.” Then you have the patient sign the ABN. (There are complex regulations regarding the ABN. This is a brief simplification.)

Chargeable versus billable

What is chargeable versus billable? Here are a few terms.

Chargeable

Chargeable means each patient will be charged for the item. Remember, just because something is chargeable doesn’t mean it will show up on the patient’s bill. Often charging is used for decision support because providers want to know where an item is being used and on what kind of patients. Some charges are set up as statistical or zero-charge items for internal tracking purposes. I recommend keeping these to a minimum.

Billable

Billable means an item can be billed on the patient’s claim. The item may
or may not be covered by the third-party payer or even by a patient, but it is acceptable to allow the charge to cross to the claim.

**Bundled**

These are items for which no separate payment will be made. They may or may not be billable. For example, Medicare recommends billing most of your bundled items either separately or ensure that the cost is included in the patient charge.

When these items are billed, Medicare assigns a status indicator “n,” meaning no separate reimbursement is made for that item. The problem is that many providers fail to bundle the charge or bill separately. This results in under-reporting to Medicare of procedure costs, and future reimbursement is reduced.

**Noncovered**

Noncovered means the third-party payer does not pay for that item or service. In some instances, these items are statutorily noncovered, which means you can bill them to the patient. If the item is noncovered for a unique reason, and you have notified the patient upfront that it is noncovered for them, it can be billed to the patient.