Is there a standard surgical supply markup?

How do we charge for invasive procedures performed at the bedside? What’s the correct way to bill for patients who stay in the recovery room because of a lack of beds in the ICU? In this column, Keith Siddel, MBA, an expert on health care business operations, responds to questions about these and other mysteries of charging and billing. He is CEO of HRM, Creede, Colorado.

What do we do about charging for invasive procedures performed at the patient’s bedside using OR staff and supplies?

Siddel: A lot of money can be lost or gained in this area. Too often, these procedures are not charged because neither the OR nor the patient care unit has a way to charge for them.

The general rule in charging is that your expenses and revenue must match. Thus, if you send OR staff and/or supplies to the patient unit to perform a procedure, the OR should charge for these because the OR is incurring the expense. You can either charge a flat procedure rate or a minor OR time charge to cover the staff cost.

Is there a standard markup for services and supplies?

Siddel: No, there isn’t. Markup schedules are all over the board. Markups do need to be reasonable. If a local reporter asked, “What’s included in your OR charges?” could you defend your charges?

When I ask OR directors what is included in their charges, they generally say their routine supplies and equipment. But you should be able to give me a list. It’s like when you take your car for an oil change, and the garage gives you a list of the items they are charging you for.

How do you determine what the markup should be? For supplies, that’s not a problem because you know the cost. For procedures, you can refer to the APC reimbursement; that is what Medicare considers the cost to be. The APC payment amounts are found in Addendum B to the Hospital Outpatient Payment System regulation (www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1232221&intNumPerPage=10).

In the addendum, you can look up the CPT code to see what the reimbursement is for that procedure. That will give you a number to which you can apply your standard markup to generate a patient charge.

You can also compare your charges with what other hospitals are charging using the Centers for Medicare and Medicaid Services MEDPAR database, which contains the
data from hospital cost reports. You can use the government’s website or purchase the data from vendors, such as the American Hospital Directory (www.ahd.com). Using this subscription service, you can enter a facility name and a CPT or DRG code, and it tells their reimbursement and charges.

With price transparency, more hospitals are putting their charges information on their websites. One example is Baptist Memorial Health Care in Tennessee, which has an online Expense Navigator (www.baptistonline.org/estimates/disclaimer.asp).

**Q** How should our OR bill for anesthesia services?

**Siddel:** As the surgical facility, you are billing for the anesthesia equipment and routine supplies. Your anesthesia billing should start when the anesthesia starts because that’s when you start using the equipment and supplies. That’s different from the anesthesia provider, who usually starts billing when he or she goes to see the patient in the preoperative area.

Similarly, your anesthesia billing stops when the anesthesia stops. That may not match the anesthesiologist’s or CRNA’s time, but it should pretty closely match the OR time.

**Q** What about billing for a regional block given in the holding area using the OR’s anesthesia tech and supplies?

**Siddel:** Again, when the anesthesia starts is when you bill. That doesn’t necessarily match the OR time.

If the patient is having a block in the holding area and having general anesthesia in the OR, you can bill for 2 different types of anesthesia. But be prepared for questions because it looks like you’re double billing even though you are not.

**Q** How do we handle charging for a patient who is held in the postanesthesia care unit (PACU) because there is no ICU bed available?

**Siddel:** You can bill an inpatient for a room beginning at midnight regardless of where the patient is staying if the patient is receiving inpatient services. Thus, at midnight, you can bill them as an ICU patient. Your finance office needs to set up an internal mechanism to move the costs from the PACU to the ICU. This is consistent with the principle that the cost of a service and the revenue for that service need to match.

**Q** If the patient is still in the PACU, we bill them by the hour until the patient goes to the ICU. Is that OK?

**Siddel:** No. You can’t charge for PACU services unless the patient needs to be in the PACU. You can charge them for the ICU because they are receiving the same level of care. But if the patient doesn’t need to be in the PACU, you would need to stop billing them for the PACU and bill them for the appropriate charge.

One benefit of charging the services to the ICU is that it provides documentation for the administration of the level of staffing actually needed for the ICU.