How should we charge for preadmission testing?

A column on managing the OR revenue cycle.

What are the rules for charging for preadmission testing and postop recovery? How should ORs handle charges for a patient who stays in the OR because a postanesthesia care bed is not available?

In this column, Keith Siddel, JD, MBA, an expert on the revenue cycle, answers questions about charging and revenue capture. He is an attorney with HBL Concepts LLC, Creede, Colorado.

Q: Is there a way we can charge for a patient’s preoperative care, including preoperative testing?

Siddel: Under Medicare rules, nondiagnostic services, including testing prior to surgery, furnished to Medicare patients in the 3 days preceding an inpatient admission are considered “operating costs of inpatient hospital services.”

That is, the surgery-related services a patient receives during that period are bundled into the DRG payment for those services.

For non-DRG hospitals and units, the payment window is 1 day. These are psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children’s hospitals, and cancer hospitals.

The payment window does not apply to critical access hospitals.

If the testing is routinely performed more than 3 days before the surgery and billed separately, that will attract attention from auditors.

Two new things to be aware of:
- The Health and Human Services Office of Inspector General will be auditing for compliance with the 3-day window in 2013.
- Medicare is discussing moving toward a 14-day window for bundled payment. This is consistent with the trend toward paying by an episode of care, that is, bundling payments for the physician, hospital, and posthospital care.

That will cause headaches because you will have to figure out whether some of these services were provided elsewhere.

Even though you don’t get paid separately for preop services, you should still bill the payer for them. The reason is that you have to account for your costs. Medicare uses these charges in determining the costs of services. The costs in turn are used in setting the cost-to-charge ratio, which Medicare uses to determine payment amounts. If you don’t charge, these services aren’t factored into the costs used in setting Medicare payments.

Q: What if a patient has unrelated outpatient services at our hospital, is discharged, and 2 days later is admitted with a myocardial infarction? Would that payment be bundled?
Siddel: The Medicare rule is that services that are bundled should be clinically related.

If the preadmission nondiagnostic services are unrelated to the inpatient hospital claims, that is, are clinically distinct or independent from the reason for the beneficiary’s inpatient admission, these unrelated costs are covered by Medicare Part B, and the hospital or any wholly owned or wholly operated entity should include the technical portion of the services in its billing.

The challenge is that almost no legacy computer system is equipped to figure out what is clinically related. Therefore, the payment is likely to be bundled, and you would have to appeal that.

Q After surgery, if a patient goes directly to the Phase 2 PACU (postanesthesia care unit), skipping Phase 1, our finance department says we don’t get paid for that. Is that correct?

Siddel: Yes, that’s true. But you don’t get paid separately for Phase 1 recovery anyway because that is bundled in the DRG payment for surgery.

Q If you keep a patient in the PACU longer than expected because of the oxygen saturation level, can you be paid for that?

Siddel: No, because the PACU stay is included in the DRG/APC payment. That is also true in the cath lab. For example, if a patient has a cardiac catheterization and stays in recovery for 7 or 8 hours, you will not be paid more for the recovery time, because Medicare says that is a normal recovery period and thus is included in the procedure payment.

Q How should we handle the charges if a patient is held in the OR for a time after the procedure because the PACU is full?

Siddel: It doesn’t matter where the patient is. If the patient is receiving the recommended level of care, you can charge for that level of care. Thus, if the patient is receiving the care he or she would receive in the PACU, you would charge for that level of care. Auditors check to see what level of care is being provided.

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Keith Siddel will respond to questions in the column. Send your questions to Pat Patterson, editor, at ppatterson@accessintel.com.

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